DR. G. C. HARLAN, Philadelphia, said that ruptures of the sphincter are found frequently if they are carefully looked for. More rare are ruptures in continuity, radial ruptures. These are very difficult to distinguish because the wound does not gap. They are best seen with the ophthalmoscope with a high power lens. Dr. Harlan has seen two or three such cases.

TWO ADDITIONAL CASES OF SYMPATHECTOMY FOR GLAUCOMA.*

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I wish to put on record the following two additional cases of sympathectomy for glaucoma, as it seems very desirable that all cases of this character should be reported so that we may arrive at a proper estimate as to the efficacy of the operation.

CASE 1.—Frank K., aged 65, Bohemian, was first seen June 20, 1903. There was nothing in his previous history, so far as his general health was concerned, which had any special bearing on the present ocular trouble.

History.—He says that four years ago he "caught cold" in the left eye, with severe pain all over that side of his head. Vision failed and in eighteen weeks he was totally blind. In a year or two the left eye began to shrink.

Status Præsens.—Phthisis bulbi. It is not unlikely that the trouble four years ago in the left eye was glaucoma degenerating into glaucoma absolutum. Right eye: Recently the sight began to fail. He saw as through a mist, and the eye became red. The tension is +3, field contracted, measuring above 15 degrees, temporal 45, below 40 degrees, nasal 30. pupil moderately dilated and irresponsive to bright light; shallow anterior chamber; cornea insensitive; marked injection of globe, and pain. Vision was reduced to perception of light. Eserin was instilled several times with the result of contracting the pupil and reducing the tension to normal. He was given a .25 per cent. solution of eserin to use at home every two hours; three days later the condition of the eye was almost normal, and vision was 20/70. When eserin was discontinued the tension returned, so it was evident that an iridectomy or a sympathectomy would have to be done. Had it not been that the patient's other eye was blind, I should not have thought of doing a sympathectomy, for the almost unanimous consensus of opinion of observers is that if sympathectomy is ever indicated it is in cases of chronic glaucoma, not in the acute form of the disease. As he had lost his other eye, however, I felt warranted in making trial of an operation which did not necessitate opening the globe (in which opinion several of my colleagues concurred), although, of course, the possibility of infection after an iridectomy for glaucoma is very remote.

Operation.—On June 30, 1903, the superior cervical sympathetic ganglion was removed by Dr. John F. Erdmann in his usual skillful manner. No pupillary changes were noted at the moment of evulsion, as the eye was under the influence of eserin. The healing was prompt, and *per primam*—but there was some hoarseness for a few days.

Results.—On July 2, forty-eight hours after the operation, the pupil was small and the tension normal without eserin. Ten days after the operation the patient had another attack of acute glaucoma. T. +2, great pain in the eye, all reduced by the regular instillation of eserin. A few days after the operation the field was somewhat increased above and to the nasal side, compared with what it had been before the operation. The patient continued the use of eserin and disappeared.

* Read at the Fifty-fifth Annual Session of the American Medical Association, in the Section on Ophthalmology, and approved for publication by the Executive Committee: Drs. Frank Allport, John E. Weeks and R. L. Randolph.

On Sept. 15, 1903, he was readmitted to the hospital during the service of my colleague, Dr. Weeks, who did an iridectomy on the right eye. At that time he did not have the symptoms of an acute attack, but was entered as a case of chronic glaucoma. His vision has progressively failed and is to-day (May 15, 1904) reduced to the ability to count fingers at one foot. There is a deep glaucomatous excavation and the appearance of advanced atrophy of the optic nerve. The field is somewhat more contracted, especially above and to the nasal side than when taken some months ago. However, the atrophic element is most conspicuous, and his field shows concentric rather than the typical glaucomatous limitation to the nasal side. (Fig. 1.)

Fig. 1.—Right eye.

The contrast can be appreciated by comparing this field with that of the next patient. The importance of taking the fields carefully in these cases, and the significance of a concentric rather than a nasal limitation, has been emphasized, among others, by my colleague Dr. Gruening. That is in a case of chronic glaucoma, when the field is concentrically limited, especially if associated with impairment of color perception, there is, in all probability, a large element of atrophy present and we can consequently expect much less from an iridectomy.

Fig. 2.—Right eye.

CASE 2.—Chronic simple glaucoma. Mrs. D., age 61. United States.

History.—Was first seen Sept. 30, 1903. She had had a wide iridectomy skillfully performed a year and a half ago by Dr. Giles, to whose courtesy I am indebted for information as to the previous history of the patient.

Status Præsens.—Since the operation her vision has progressively diminished and is now in the right eye 20/100; left 10/200—unimproved in each. There is a deep excavation in each optic nerve, and the tension is +1 in each eye. The nasal half of the field (O. D.) is almost entirely gone, as the accompanying chart will show. (Fig. 2.)

Operation.—On Nov. 6, 1903, sympathectomy was done on the right side, again by my friend Dr. John F. Erdmann. The

healing was prompt and *per primam*. Following the operation there was narrowing of the palpebral fissure, with ptosis, also hoarseness, and a choking sensation in the throat as though there was a lump in the throat. The ptosis disappeared, but the hoarseness and choking sensation in the throat continued more or less.

Results.—November 13, one week after operation, with — 1 Ds. = + 1st Dc. 30, her vision was 20/50, although it seemed to come "in waves," as she expressed it. That is, one moment she would be able to read the letters on the card, and then they would all seem to disappear. The tension of the right eye was distinctly less than that of the left. I saw the patient once or twice more, the last time, Jan. 8, 1904. The hoarseness and feeling of constriction in the throat continued, the tension of the right eye remained apparently normal and less than that of the left. The slight visual improvement continued, she would slowly work her way down to the 20/50 line, stopping occasionally "to rest," as she said; and sometimes having read the letters one moment, she would seem not to be able to do so the next. With +3 Ds added to her distance glasses she could read Jaeger No. 7 at 30 c.m. slowly. The patient always insisted that the sight was worse after the operation than before; it wasn't "so steady."

The sudden death of the patient shortly after my last examination prevented my following the case further, as I should have liked to do. The impression of her family was that her vision was somewhat, though not much, better after the operation.

CONCLUSIONS.

As to the conclusions to be drawn from these cases I have seen where the operation was done (five), I would say:

First.—That it is not indicated in acute inflammatory glaucoma. In a paper on sympathectomy which I had the honor of reading before the New York State Medical Association in 1901, I referred to a case of Mohr's, which bears on this point. The operation of sympathectomy was done and two and a half months afterward the patient had an attack of acute glaucoma, for which an iridectomy was performed. Immediately after the section the iris protruded, followed by all the contents of the globe, with abundant hemorrhage and loss of the eye. In my first case reported to-day, the operation had apparently little effect on the process. In fact, the patient had an acute attack which was controlled by eserine while convalescing from the sympathectomy. Iridectomy likewise did not avail to prevent the progressive loss of sight.

Second.—If the operation is ever indicated, it is in cases of chronic simple glaucoma. In the second case reported by me to-day, and which was of this nature, there was apparently some slight improvement of vision. From a consideration of my own cases and those reported by others, I can not see a very brilliant future for the operation. The best that can be said for it is that it can not do any harm, and possibly may do some good. So long, however, as we have one such brilliant result as that which followed in Dr. C. W. Cutler's case, reported three years ago (this patient's vision is still 20/30 with a telescopic field) we certainly are warranted in suggesting the operation to these otherwise hopeless patients.

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DISCUSSION.

Dr. W. H. WILDER, Chicago, referred briefly to some of the cases of this kind that he reported at the last meeting of this section, three of which showed a very favorable result. The most remarkable one, in which the fields were markedly reduced and central vision greatly impaired, was greatly improved after the operation. The fields returned to nearly nor-

mal and this improvement has continued to the present time. The other two cases were too recent at the time of that report to justify any conclusions, but now, although he has not had an opportunity to examine them, he has communicated with them in the last few weeks, and they report that the favorable condition that followed the operation continues. Dr. Wilder inclined to favor sympathectomy in certain cases. He has only had three cases in the past year where he thought that iridectomy offered no chance. The patient had 20/120 central vision, but very greatly contracted fields. After operation, his central vision doubled in a week and the peripheral vision has increased. After operation, this prompt benefit has been observed in certain cases. However, it may be transitory. To give it anything like a fair trial, it should be done early. In other words, it would seem justifiable in these cases of chronic simple glaucoma to first do a sympathectomy and then, if necessary, an iridectomy. Dr. Wilder believes the patient's chances are not jeopardized by this method, and it is only when done in the early stages of the disease that one can hope to get the best results.

Dr. JOHN E. WEEKS, New York, stated that he has had some experience with the operation, and finds, in regard to the cases operated on more than one year ago, that in three of the six vision is about the same as when he reported them in New Orleans; that is, the vision has been retained, but in some of these cases there is an acute exacerbation of the glaucoma. He was obliged to perform iridectomy in two cases where it had not been done previously. He agreed with Dr. Wilder that in some cases of simple glaucoma sympathectomy would be permissible before iridectomy, but in the greater number of cases he should only perform it where iridectomy had failed and where sclerotomy had failed, and he might perform iridectomy twice on the same eye before doing a sympathectomy. In addition to the disturbance of the operative procedure, symptoms are apt to be produced which will greatly inconvenience the patient. In regard to performing iridectomy twice, he knew of a case, in the practice of Dr. Gruening, where iridectomy was done four or five times on one eye, and not until nearly all of the iris was removed was there arrest of the process.

Dr. W. B. MARPLE said that he did not want to be understood as saying that he would not do a sympathectomy, but only that he did not see any very brilliant future for it; it can not do any harm. He agreed with Dr. Weeks that one should see what iridectomy will do first. He had a case where, after the iridectomy, the patient had a return of acute glaucoma. In one case he did a second iridectomy, immediately after the original one, and after that there was no recurrence of the former trouble. He removed about two-thirds of the iris in that case.

BLASTOMYCOSIS OF THE EYELID.*

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The condition known as cutaneous blastomycosis which was first described in 1896 by Gilchrist¹ under the name blastomycetic dermatitis, is one that should be of interest to the ophthalmologist, inasmuch as among its favorite sites are the face and the eyelids.

The deformities produced by its action on the skin of these parts may prove to be very serious, and difficult to treat, as illustrated by the case that I shall record.

As stated by Drs. J. Nevins Hyde and Frank H.

* Read at the Fifty-fifth Annual Session of the American Medical Association, in the Section on Ophthalmology, and approved for publication by the Executive Committee: Drs. Frank Allport, John E. Weeks and R. L. Randolph.

1. Johns Hopkins Hospital Reports, 1896, vol. 1.