Hospital Practice and Clinical Memoranda.

A CASE OF OPTICO-CILIARY NEUROTOMY. FAILURE. ENUCLEATION.

BY DR. EDMOND LANDOLT, PARIS.

TRANSLATED BY HASKET DERBY, M. D.

[THE question as to whether the division of the optic nerve might not prevent an injured eye from affecting its fellow sympathetically, and thus render unnecessary its removal, has been seriously entertained by eminent surgeons. The weight of evidence, however, is gradually accumulating against the belief that enucleation may thus be superseded. The following case, recently published by my friend, Dr. Landolt, goes to confirm this statement. H. D.]

Jacquín, sixty-seven years old, came to my clinique April 15, 1880. His left eye had long been lost, and he now requested an examination of the right, inasmuch as it was the seat of pain, and its vision diminishing. I found: left, absolute amaurosis; right, myopia 20 dioptries, acuteness of vision 0.05.

History. Twenty-two years ago the patient was profoundly affected by the death of his brother, who expired in his arms. He soon suffered from hæmorrhages from both mouth and nose, and from a stomacic derangement that lasted five years. During all this time he could take no meal that was not immediately followed by vomiting. It was about then that, returning from a visit to one of his relations, he had a fall on the stairs of the Paris railway station. On being raised up he declared that he could not see. "They have put out the gas," he said. Severe pain came on in the left eye; for six weeks he was attended by an oculist, without any return of vision in either eye. Another oculist, who was consulted, stated the condition to be: "Left, numerous hæmorrhages, separation of the retina; right, impending separation." For three weeks he had derivative treatment, cupping, etc. Vision returned in the right eye. Great care was taken, the patient remained in a dark room, and refrained from work. For a long time, some fifteen years, his condition was tolerably satisfactory. He used his right eye, but never saw again with his left. Suddenly a fresh hæmorrhage occurred in the right eye, while he was at work; derivative treatment was again used, and was once more followed by a return of vision. There followed now another cessation of disturbance until 1880, the time of the patient's coming to me. This time the left eye became the seat of exquisite pain, the vision of the right fell to 0.05, sympathetic irritation became evident. In the left eye there was deep circum-corneal injection, the aqueous was turbid, the iris discolored, and there were numerous synechiæ. No reflex could be had from the fundus, the tension was increased, and the eye tender on pressure, especially in the ciliary region. In the right eye there was found an extensive inflammatory choroidal atrophy, a posterior staphyloma, circular in shape, and floating opacities of the vitreous. Visual field contracted.

I proposed the enucleation of the right eye, but the patient hesitated at this, and finally refused. Having probably heard something about neurotomy, he finally requested this operation, and declared he would go no farther.

This I performed, under chloroform, April 20th. I

passed a thread through the external rectus, and divided the muscle in front of the thread, then, seizing the stump with forceps, I introduced a pair of curved scissors, and divided the optic nerve. I then revolved the eyeball until its posterior pole presented at the palpebral aperture, excised the portion of the optic nerve still adherent to the globe, and freely incised the tissues round about the nerve. Bleeding was free; I replaced the eye, and reunited the muscle to its tendon. A compressive bandage was applied. There was but little inflammatory reaction, and sensitiveness disappeared.

April 24th the suture came away, pain ceased, and the corneal sensitiveness returned.

April 29th. Corneal haziness, ciliary pain.

May 10th. Corneal ulceration.

May 28th. I again measured the right field of vision, and found it still decidedly contracted (85° out, 45° in).

June 18th. Tension diminished, the keratitis has disappeared. Sensitiveness at the corneal centre, but not yet at its periphery.

On the 10th of June I again took the visual field, and found it even more contracted, extending but 60° out, and 42° in. The acuteness of vision kept pace with this diminution. The operation had evidently failed to arrest the progress of the disease, and I renewed my original proposal to remove the left eye.

The patient did not return till October 10th. The left cornea had become anæsthetic over its entire surface, the eye was phthisical. Operation again proposed, and again refused. January 31, 1881, I found the myopia to be 20 dioptries, the patient counting fingers at 2.5 metres. Posterior synechiæ, aqueous cloudy, iris yellowish. The eye was excessively sensitive at its lower part, beneath the cornea. A corresponding point of sensitiveness, slightly to the inside of this, was found in the left eye. I strongly represented the necessity of enucleation, telling the patient his sight would steadily diminish until total blindness ensued. The contraction of the visual field remained the same.

February 1st he returned, his vision was still falling off, the optic nerve was much congested.

March 2d. There had been for several days pain in the right side of the head; fingers could be counted in two metres. The patient, however, was no longer able to go about alone, and was hence made to realize the more forcibly the failure of his sight. There was the same exaggerated local sensitiveness in each eye. The right eye looked dull, pupil contracted, anterior chamber cloudy. Enucleation was at last agreed to, and performed the same day. Under chloroform it was done without difficulty. The patient slept the first night, pain having completely vanished. The right eye already looked better, although the pupil failed to respond to atropine. The patient left the clinique March 7th, finding his way about much better than before.

Optico-ciliary neurotomy has done good, a fact on which its friends have not failed to insist, but, as is the case with every new operation, it has been the old story over again. The inventor gets nothing but good results, his followers publish no others, a false sense of shame causing them, perhaps, to hold their peace, when their efforts have not been crowned with success. Such are the difficulties that beset a proper estimation of the value of a new operation. The case I here publish seems to me to afford, in itself alone, ample ground for the utter rejection of optico-ciliary neurotomy where sympathetic ophthalmia is dreaded. And I

hope my colleagues will publish broadcast their failures in order that light may be shed on the danger incurred by a patient who squanders precious time on an operation, the final result of which is not at once felt, instead of submitting to enucleation.

REPORT ON MALARIAL FEVER IN THE NEIGHBORHOOD OF PROVIDENCE, R. I.¹

BY HOMER BATCHELDER, M. D.

ON closing my first communication on the subject of Malarial Fever I had supposed that the disease had had its run and I should have no further occasion to speak of or treat any more cases of malarial disease. The number of attacks through the latter half of October had dwindled down to five or six cases, and none during the last week; I felt well assured that I should not be called upon to treat new cases. But on the fifth day of November I was summoned to a young man's bedside, who appeared to be very sick. After learning the previous history of the patient, with a careful examination and analysis of all the symptoms, I was quite forcibly impressed with the fact that this was still a case evidently suffering from the effects of malarial poison, yet differing in many essential features from the *intermittent type* of fever that I had been called upon to attend and treat during the preceding four months.

CASE I. This young man was nineteen years of age; had grown to manhood very rapidly; was robust and healthy. He had during his childhood and youth scarlatina, measles, and whooping-cough. When I first saw him his pulse did not beat over sixty-five times a minute, and was small and irregular. His tongue was not really coated, but exhibited a sort of erectile appearance of the villous coat, representing in color a bluish gray,—not very unlike that of the serous membranes lining the cavities.

He had been slightly ailing for two days or more, though I could not learn that he had had any real *ague chill*; but in the morning previous to my visit at four P. M. he had experienced a passing sensation of chilliness, with alternate flashes of heat. The most prominent symptom, as well as the one most urgent, was an almost intolerable oppression at and through the gastro-hepatic region. The slight chilly sensation was in no sense like the *ague chills* which are premonitory, almost invariably, of intermittent malarial fever; while here, as in true *ague*, his chilliness was subjective, as his temperature already indicated 2° F. above the natural standard. He now began to suffer quite severely from headache. His stomach appeared to be hyperæmic and his bowels distended with gas. Urine about the color of strong coffee. I diagnosed the case as one of malaria, but varying a good deal in its general developments from those I had previously attended.

After prescribing some palliative treatment I left, with the understanding that I would see him again in six or eight hours. At the end of eight hours I hastened to his bedside again. I now found his pulse much accelerated, 115 strokes the minute, not throbbing, irregular, but rather compressible. I found that the hot stage had steadily increased from the time of my first call, and for three or four hours he had been very much nauseated, and had vomited considerably with

little if any relief. I found him also with a flushed countenance and suffused eyes; and now he complained of a raging headache, with a distressingly painful sensation through his limbs, loins, and back. The surface of the body was much redder; he was constantly tossing and turning in bed.

These symptoms gradually waxed stronger during a period of nine hours, at which time they began to abate, the heat of the skin to subside, and the pain of the head was partially relieved. The stomach became more quiescent, and the patient found comparative rest.

Although some of the features of this long train of symptoms seemed very much to resemble those I had often witnessed in intermittent paroxysmal fever, yet the differences were sufficiently marked.

Three days later I was called to visit another case which exhibited the same phenomena, only the symptoms were less severe than those witnessed in the first case. At this time I began to believe that the symptoms as observed in these two cases in most of their features represented remittent malarial fever. The disease has held this remittent type, and continued through the months of November and December with four or five mild cases during the first half of January of the current year.

Since the thirty-first day of October I have attended forty-six cases of remittent fever, twenty-three in November, eighteen in December, and five in this month, January.

I have been thus particular in narrating the general symptoms as accurately observed in the first case, because the symptoms as described in that case predominated with slight modifications in every subsequent case.

There was no fatal case, or rather no one died here in this community from the effects of remittent fever. But there was a man, I should judge between fifty and sixty years of age, who had been a resident of the place three years or more, but had no relations here, a shoemaker by trade, who began to show signs of malarial disease early in October. The disease assumed a chronic form; his case grew more grave, and I advised him to go to his friends in Mendon, Mass. He died just three weeks after he left, but I know nothing of his history after he left Arlington.

The ages of the forty-six cases of remittent fever were about as stated below:—

The number under ten years	13
The number between ten and twenty years	7
The number between twenty and thirty years	8
The number between thirty and forty years	6
The number between forty and fifty years	4
The number between fifty and sixty years	4
The number between sixty and seventy years	3
The number between seventy and eighty years	1

Making a total of 46

A larger proportion of the above cases suffered from the fever in a protracted form than of those who had the intermittent type. Neither did the above patients rally from its prostrating results and vital constitutional disturbances in the same period of time as those mentioned in my former paper, nor was their restoration so complete.

Enlarged Spleen.—There were five cases in which the spleen became greatly enlarged as a direct result from intermittent malarial fever; and three cases after severe attacks of remittent fever. But they were all

¹ Continued from page 538.