

showed a shallow laceration. The other abdominal viscera were normal. There were no fractured ribs or injury to the spinal column.

The chief feature of this case is the extensive injury to the lungs, including complete detachment of one of them, in the absence of any fracture of the ribs or spine.

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#### NOTE ON A CASE OF ANGIO-NEUROTIC OEDEMA OF THE LARYNX.

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THIS case is of interest, I think, from the following points of view. In the first place, the recorded cases of angio-neurotic oedema of the larynx are, so far as I can discover, few in number. Secondly, it is of interest from the point of view of diagnosis. And, thirdly, the resemblance in some respects of the symptoms caused by this condition and bronchial asthma.

The patient was a boy at Clayesmore School, aged eight years. He went to bed on Oct. 11th apparently in his usual state of health. At 12 o'clock he woke up and called to the nurse, who slept in a room adjoining the dormitory in which the boy was sleeping. He complained of a tickling in his throat and pain on swallowing. The temperature was 99° F. As there was nothing in his condition to cause the nurse any alarm she gave him something hot to drink and he went off to sleep. At 2 A.M. the nurse was wakened up by hearing a choking sound. She went and looked at the boy. He was breathing rapidly, looked flushed, and his temperature was 102°. He complained of his throat hurting him. He vomited but complained of no abdominal pain. He was moved out of the dormitory into a room by himself and I was sent for.

At 4 A.M. I saw the boy. He was then in a most alarming condition. His face was pale and cyanosed and he was tossing about in bed struggling for breath. The alæ nasi were working. There was stridor on respiration, suggesting laryngeal obstruction. The respirations were 28, the pulse was 140, and the temperature was 102°. There were considerable over-action of the respiratory muscles and sucking in of the intercostal spaces. On auscultation of the chest there were no adventitious sounds. On examining his throat there was a very little general inflammation of the tonsils, soft palate, and back of the pharynx. No enlarged glands could be detected in the neck. It struck me that this was probably the beginning of a case of diphtheria. I therefore immediately injected 2000 units of diphtheritic antitoxin into the abdominal wall. I took a swab from the throat for examination and gave him a teaspoonful of vinum ipecacuanhæ; this gave him considerable pain to swallow and shortly made him vomit. Not being at all satisfied with the case I asked Mr. N. H. Joy, the medical officer to Bradfield College, to come over and consult with me. He saw the patient about 8 A.M. and formed the opinion that it was probably an early case of diphtheria. The boy was isolated. During the day the breathing gradually got easier and the cyanosis and restlessness passed away. At 6 P.M. he was breathing quite comfortably; he could swallow liquids without trouble, his face was flushed, and he was sweating considerably. The temperature was 102°. The tonsils were now a good deal swollen, but there was no change in the appearance of the pharynx.

On the following morning, after a good night, the patient was apparently in his usual state of health, though his temperature was still raised. The swelling of the tonsils had subsided. Another swab was taken from the throat; both this one and the one taken on the previous day turned out to be negative. There was no cough or discharge from the throat or nose throughout the attack. His recovery was uninterrupted.

I am afraid that the diagnosis of this case was based chiefly on the elimination of other diseases and conditions which could give rise to the signs and symptoms met with in this case. With regard to diphtheria there was no trace of any membrane. The result of the examination of both swabs was negative. And although there were half a dozen boys sleeping in the same dormitory there have been no cases of diphtheria either before or after. Since the beginning of the term the village has been "out of bounds" for the school, so that there was no chance of this boy

having been exposed to any infection that the other boys had not been exposed to.

The condition of this patient when I first saw him in some ways resembled a person in an attack of bronchial asthma; the chief differences were: instead of the chest being fixed there was excessive movement, the high temperature (it was 102° and only became normal at the end of the second day), and the absence of all expectoration. Nevertheless, I think there is probably a close connexion between the condition described and bronchial asthma. If we follow the theory of Traube, that the attack (of asthma) is due to the swelling of the bronchial mucous membrane, it is quite reasonable to expect that a swelling (oedema) of the trachea or larynx would give rise to signs very similar to those seen in bronchial asthma. As a matter of fact, this patient has a fairly strong family history of asthma, both his maternal and paternal grandfathers having suffered from this disease.

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## Medical Societies.

### OPHTHALMOLOGICAL SOCIETY.

*The Pupillary Membrane.—Sarcoma of the Choroid.—Total Avulsion of Iris with Retention of Vision.*

A MEETING of this society was held on Dec. 13th, 1906, Mr. PRIESTLEY SMITH, the President, being in the chair.

Mr. E. TREACHER COLLINS described the macroscopic and microscopic appearances of an Adhesion of a Persistent Pupillary Membrane to the Cornea in the Eye of a Cat, and compared these with four other recorded cases of a similar nature. It was suggested that they might be divided into three classes with the following characteristics: (1) A cicatrix of a perforating ulcer of the cornea, with the pupillary membrane attached to the scar (Wintersteiner); (2) a cornea in all respects normal, except for a defect in the endothelium on its posterior surface at the seat of attachment of the pupillary membrane (Collins, Ballantyne); and (3) a cornea in all respects normal, except for an absence of Descemet's membrane and its lining endothelium at the position where the substantia propria and pupillary membrane become blended (von Hippel). The case, the subject of this communication, came under the third heading. In Class 1 the cause of the adhesion was undoubtedly inflammatory in origin. In the cases belonging to the other two classes there was an absence of all signs of past or present inflammatory changes, and in some of the eyes there were other congenital malformations which could not be inflammatory in origin. The balance of evidence in them would seem to be strongly in favour of the abnormality being due to an arrest of development, in Class 2 the arrest occurring in the differentiation of the mesoblastic tissue posterior to the hyaline layer of Descemet's membrane into endothelium and pupillary membrane, and in Class 3 the arrest occurring in the formation of a partition of the hyaline layer and the differentiation of the mesoblastic tissue between the lens and surface epithelium into two parts.

Mr. L. V. CARGILL and Mr. M. S. MAYOU described a case of a Flat Sarcoma of the Choroid. The patient, a man, aged 61 years, was first seen in August, 1904, when he complained of failure of sight of the left eye. At the outer side of the macula was a patch looking like an area of choroido-retinitis. The retina had an oedematous appearance and at the lower border of this area were some dark choroidal pigment spots, with other spots less pigmented; the patch was not definitely elevated but there was a scotoma corresponding to it; the vision was  $\frac{1}{8}$ . The right eye was normal. In spite of warning the patient did not show himself for a year and then the retina was partially detached, with much pigment along the border of the detachment. Vision was  $\frac{2}{4}$ . The use of Leber's transilluminator rendered the diagnosis of tumour certain. He was not again seen until March, 1906, when he had secondary glaucoma. Tension was + 2 and the vision equalled perception of light. The eye was removed and a funnel-shaped detachment of the retina was present. In the outer half of the globe there was a flat, darkly pigmented growth. In the region of the ora serrata it was raised and tended to spread in a