

turns of the screw backwards and forwards will usually suffice to clear the instrument, or Mr. L'Estrange's stilet may be used, if the male branch be grooved to allow of its passage.

It is only in exceptional cases, and when the stone is both small and very friable, that you expect to break it up at a single operation. The first proceeding should always be short, and when the passage becomes accustomed to the instruments, or less irritable, the operation may be prolonged for ten minutes at a time. This is a rule from which M. Civiale never deviates, and his opinion in this matter deserves the deepest attention. From three to eight days should elapse between each operation, to allow the fragments to pass away with the urine, and any irritation which the operation may have excited to subside. Such fragments of the calculus as are too large to come away with the urine must, of course, be treated as distinct calculi, and crushed separately. I shall refer to this point again.

In my next lecture, gentlemen, I shall consider the difficulties which may be encountered in the performance of lithotripsy, and the accidents which may accompany or follow it.

ERRATA.—In the last number, page 1, col. i., the following corrections should be made in the explanations attached to the drawings: Fig. 1 is the quadrupulus vesicae of Franco.—Figs. 2 and 3 represent the forceps of Hildanus, for the extraction of urethral calculi. Fig. 2 shows the instrument embracing a small calculus; fig. 3, the forceps.—Figs. 4 and 5 represent the ball-extractor of Alphonso Ferri. Fig. 4 shows the extremity of the three-bladed forceps; fig. 5, the instrument closed within the canula.

Clinical Lecture,

ON A CASE OF

GONORRHOEAL OPHTHALMIA.

By JOHN ADAMS, Esq.,

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CHAS. M'C—, wire-worker, aged nineteen, was admitted, under the care of Mr. Adams, suffering from gonorrhoeal ophthalmia, on March 5th, 1852. About six weeks before, he had contracted gonorrhoea, and he thinks it probable that he had infected his eye with the purulent discharge through the medium of his finger. He had discovered the existence of the disease the day before, by feeling as if he had something gritty, like sand, in his right eye, and had requested others to examine it for the purpose of removing the obnoxious particles. The disease had progressed for thirty-two hours previous to his admission, and had then assumed the following aspect:

Considerable purulent discharge, with eye completely closed from the excessive inflammation of eyelids; tears running freely down the cheeks; cornea quite clear; considerable chemosis of conjunctiva, forming a complete bed for the cornea, and in two parts overlapping it. This was accompanied with great pain in the right eye, forehead, and temples; pulse quick, with strong feverish symptoms and great depression of spirits; the left eye very slightly inflamed; tongue clean.

The following was the course of treatment adopted: Venesection to twelve ounces; calomel and jalap, one scruple, immediately, and afterwards, calomel, one grain; tartar-emetic, one-eighth of a grain, every fourth hour. Lotion: nitrate of silver, eight grains; distilled water one ounce; two drops to be instilled into the external canthus hourly.—Seven P.M.: Pain still great in the temples and head, with increased inflammation of the eye. Ordered, twelve leeches to the eyelids. Pulse 78.—Nine P.M.: Greatly relieved by the leeches; bowels freely relieved.

March 6th.—Pulse 84; pain in the head not so great; bowels open; discharge much diminished; tongue clean; inflammation gradually subsiding. Lotion ordered to be applied every two hours.

7th.—Going on favourably, though the conjunctiva still remains considerably injected; the cornea quite clear, and sight very good. The effects of the calomel being apparent, the pill is ordered to be taken every six hours; the lotion every three hours.

8th.—Rapidly mending; mouth being sore, the pill is discontinued.

19th.—After this the eye resumed gradually a more healthy appearance, but still for a considerable time a pink blush was visible over the surface of the sclerotica, and its aspect was not unlike that presented in rheumatic scleritis. This, however, has almost disappeared. The urethral discharge has nearly ceased; but he was ordered copaiba mixture.

The above case affords an excellent illustration of one of the most formidable affections of the eye. The disease is one

which, if not very speedily arrested, leads to the entire destruction of vision in many instances, or, its destructive effects being checked by appropriate treatment, it still leaves behind vestiges of its ravages, in the form of partial opacities of the cornea, and much consequent impairment of the function of the eye. Can we, therefore, occupy ourselves better than by briefly referring to the circumstances of this case, and dwelling on the means which in this instance have been successfully put in requisition? I am induced to direct your attention to this case, because we have had lately three similar instances treated in an analogous manner, with slight modification, and all ending satisfactorily.

If you consult authorities on this subject, you will find that all who have written from experience on this disease, as Lawrence, Middlemore, and Mackenzie, agree in the great fatality of the affection: I use the term, of course, as applicable to vision. I believe I am right in asserting that in nearly one half of the cases mentioned has the issue been destructive of vision by sloughing cornea. The characters of this disease can scarcely be mistaken; there is great chemosis of the conjunctiva, so as to encroach upon the cornea to a greater or less extent; the eyelids are swollen, so that it is difficult to get a view of the surface of the eye; profuse lacrymation and a constant escape of pus or muco-pus from the eye over the cheek, are also present; and all these symptoms are accompanied with constitutional irritation, intolerance of light, pain in the head. One of the prominent signs of the disease, although not a diagnostic symptom, is, at its commencement, the sensation of a foreign body, as grains of sand or dust, in the eye.

The patient is usually the subject of gonorrhoea; but I believe there is no doubt that the disease may be conveyed by the contact of gonorrhoeal matter from one person to another; indeed, some deny that an individual can infect himself. In this respect, however, I may tell you that experiments have been made by surgeons themselves, which lead to this conclusion; but I do not think they are to be depended on, for it is well known that some individuals are altogether proof against the gonorrhoeal poison. In the case before us, there is good ground for believing that the patient infected his own eye with the discharge from his own urethra; and my opinion is, that the disease is usually induced in this manner. In the case of a little boy under my care some few months back, there was reason for believing that he became infected from the gonorrhoeal matter of another person with whom he slept.

The diagnosis of the disease in its acute stage is easy, but in its modified form it may be confounded with common purulent ophthalmia, which prevails occasionally in an epidemic form, and is itself highly contagious. The history of the case will, in a great measure, assist us in the diagnosis. In the latter form of disease, for instance, the inflammation is more confined to the palpebral conjunctiva at its commencement, and is slow in its progress, although frequently destructive in its effects; it also usually attacks both eyes, and this is not common in gonorrhoeal ophthalmia.

The prognosis in these cases is, as I have already stated, unfavourable; but if the disease be understood, and active measures be commenced and well carried out, many eyes may, even under the most unfavourable circumstances, be saved from destruction. The treatment must be modified according to the existing condition of the eye; for where the cornea has commenced to slough, active antiphlogistic means are to be discontinued. The treatment pursued in the case just detailed has been successful; it presents nothing new, but we cannot do wrong in reviewing it; and although my own experience is limited, I should have no hesitation in adopting it if another similar case came under my observation.

First, then, if the patient be young, you must take away sixteen or eighteen ounces of blood from the arm, *pleno vivo*. Of course this is inadmissible in old subjects, or where the constitution is much impaired. In a vigorous person you may bleed *ad deliquium*. You are then to apply leeches to the eye, and purge your patient briskly. It is desirable that he should speedily be put under the influence of mercury—not that mercury will of itself cure the patient, for it has over and over again been found to fail. You are also freely to scarify the conjunctiva, to unload the blood-vessels—and not with the view to get rid of the venereal matter, which the old surgeons thought was distending the conjunctiva—or you may snip out pieces of the overhanging conjunctiva. The late Mr. Tyrrell (a very good authority in such cases) advised that the scarifications should be made so as to radiate from the margin of the cornea. He thought that the cornea perished from the strangulation of its vessels, and he adopted this plan to pre-

vent this. The practice is undoubtedly good, although the principle on which it is recommended may not be correct.

But a most important part of the treatment consists in the use of a stimulating application to the eye; and the best method of employing this is to drop a strong solution of nitrate of silver, six or eight grains to the ounce of distilled water, into the eye, and to repeat it every hour, so that its immediate effect may not be permitted to pass off before it is repeated. You should, in order to do this effectually, let the eyelids be carefully separated, and wash clean the surface of the eye by dropping in some tepid water, and immediately afterwards allow a few drops of the solution to fall into the external canthus, so that, by the action of the orbicularis palpebrarum, it may be swept fairly over the whole surface of the inflamed conjunctiva. This must be persevered in until the puriform secretion is entirely arrested, when it will be found that the swelling of the conjunctiva will gradually subside, and the disease may then be fairly said to be cured, although for some time afterwards there will remain some traces of inflammation, which gradually disappear.

It appears to me that in these formidable cases we must trust to a combination of active measures, rather than found our expectations entirely on any single class of remedies.

When, unfortunately, sloughing of the cornea has commenced, all active antiphlogistic treatment must be discontinued; but the stimulating plan, somewhat modified, may be pursued; or the use of an astringent collyrium, as a weak solution of alum, may be employed with advantage; and the constitution being supported by a more generous diet, and tonics, the sloughing process will be arrested, and cicatrization of the cornea may be anticipated, leaving in all probability a very slight opacity.

ILLUSTRATIONS OF THE SUCCESSFUL TREATMENT OF CLEFT PALATE.

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IN THE LANCET of September 2, 1850, I published a paper containing three illustrations of the complete cure of cleft palate by the division of the above-mentioned muscles. I then endeavoured to show why the incisions proposed by Professor Fergusson were entitled to greater confidence than any hitherto proposed, and concluded with the remark, that if the operation were properly performed, according to this method, I felt convinced success would *in future* be the rule, and failure the exception, being exactly the reverse of what had before happened in this country. I have much pleasure, therefore, in now bringing forward four additional illustrations of success, to show the correctness of those anticipations; at the same time, I may observe that I have not as yet had a single instance of failure.

CASE 1.—A man, aged eighteen, living in Park-lane, Waltham Cross, healthy, and in good condition, came into the Charing-cross Hospital, October 11th, 1850. A cleft extended entirely through the soft palate, and rather better than half an inch into the hard palate, its anterior extremity being obtusely rounded off at the posterior edge of the palate bone: the cleft was about half an inch wide. Both sides were nearly equal in size and of good thickness throughout. The operation was performed on the 18th of October, 1850. It was obvious here, as in the second case related in the former paper, where the cleft extended much farther into the hard palate, that the simple division of the muscles would not suffice to close the anterior part of the fissure. Therefore, after freely dividing the levator palati above, and the palato-pharyngeus in the posterior arch, the mucous membrane and fibrous tissue were carefully peeled off from the under surface of the palate bones, and then, with pointed scissors, curved on the flat, the soft palate was completely severed from the posterior edge of the palate bones, upwards into the nostrils, leaving the mucous membrane towards the mouth entire through the whole length of the flap, in the manner advised by Dr. Warren. In doing this, a slight nick was accidentally made in the edge of the right flap, which afterwards interfered a good deal with the proper adjustment of the parts. The edges were pared by piercing with a small double-edged scalpel, which removed a small band about half a line in thickness along the whole length of the flap. Five sutures were necessary, those in the palate entering fully half an inch

from the edge of the flap. They were tied, beginning with the most anterior, with the knot described in the last paper. As there was still a little tension on the right side after the ligatures were tied, the palato-glossus was divided in the anterior arch of the palate. The nick above mentioned, in the right flap, prevented perfect adaptation, and made me anticipate mischief at this point. It was caused by using a knife which had not been made according to order, and came in only just before the operation; consequently it could not be proved, as any new instrument ought to be, before use.

Barley-water, beef-tea, thickened in various ways, wine and water, were freely given when the patient felt inclined to take them. For the first three or four days, injections of beef-tea and sherry were administered morning and evening. He was very comfortable the first evening after the operation, and slept well. On the 21st, the third day having been completed, No. 4 ligature was removed. The ends of the uvula had slightly separated; the other ligatures held well. On the following day, No. 1 was removed. There was sloughing about it, which appeared to spring from the nick alluded to, and which I feared would be extensive. The breath was very foetid; he fed well; his bowels were kept open by purgative enemata. The sutures were all away on the sixth day, and then the sloughy part at the anterior angle separated and left an opening in front which would admit the forefinger, but between this and the open ends of the uvula there was perfect union. It was gratifying to see how the opening in front diminished from day to day, as also did the slight separation of the ends of the uvula, assisted by the occasional use of the concentrated solution of cantharides in acetic acid, advised by Dieffenbach. On the 26th Nov., he left the hospital, with a slight separation of the uvula, and the opening in front scarcely admitting the end of the little finger. He was instructed in the use of the blistering fluid, and came back in two months with the opening nearly closed, and shortly after it was perfectly so. The details of the latter part of the case are dwelt upon to show that from the almost certainty of the union which the division of the muscles allows to take place in the largest and thickest part of the velum, any accident in front of or behind this point really makes very little difference in the ultimate result. This observation I have been able to verify on two or three occasions where the operation was not performed by myself.

CASE 2.—A man, living in Market-street, Oxford-street, aged forty-one, a shoemaker, in good health, came into the hospital a few days after the preceding case. The cleft commenced half an inch behind the hard palate, and divided the velum as well as the uvula very equally, the flaps touching each other on attempting to swallow. The operation was performed on the 24th October, 1850. A free division of the levator and palato-pharyngeus muscles rendered the flaps quite flaccid, and after paring the edges, four sutures sufficed to keep the parts in apposition without the slightest strain. The duration of the operation was very much curtailed by not having, as in the former instance, to separate the soft parts from the bone. He suffered very little in consequence. The rules as to diet were precisely the same as in the last case. He progressed without the slightest bad symptom. On the 28th—four days completed—No. 1 ligature was removed; on the 29th, No. 4; and on the 30th—the fifth day—the remaining two ligatures were taken away; and it was not until that time it was observed the uvula was slightly separated at the point. Everywhere else the union was quite firm, and in a few days he left the hospital (Nov. 7, 1850).

CASE 3.—This case surpasses any of the others in point of interest, in respect to the particular method, and shows very conspicuously to what an extent one can rely on the security the division of muscles gives, under very disadvantageous circumstances. The patient, a married lady, aged thirty-five, fair, and of very delicate frame, was brought to me from the neighbourhood of Brighton, by Mr. John Lawrence, on the 12th of September, 1851. He wished me to perform the operation on the following morning, being anxious to get back to Brighton. The patient had been operated on ten or twelve years before, according to the old method, and I need not add, with all the skill and knowledge that could have been afforded at the time, when I name the justly celebrated operator, Mr. Guthrie, sen. I understand two other attempts were subsequently made whilst the parts were still fresh.

The anterior extremity of the cleft was a good deal rounded off; a considerable deficiency was also observed in the depth of the bony arch, formed by the palatal processes of the superior maxillary and the horizontal plates of the palate bones. This deficiency was made up by a proportionately greater depth of