

far as the ora serrata. Both eyes presented the appearance of pronounced atrophy of the optic nerves, but whether this had resulted from a neuritis descendens following a basilar meningitis, or from intracranial pressure during the height of the meningitis, it was almost impossible to say. Still the process had lasted but two months, dating from the onset of the inflammation, and as there were absolutely no signs of any proliferation either in the papilla or retina, which would naturally result from an interstitial neuritis, and as such proliferation could hardly fail to leave behind it some traces of its presence; I am inclined to the belief that the nerve atrophy was the result of pressure. It would be interesting to know whether such pressure had occurred over the course of the optic tracts, or whether its situation was more posterior, and involved the optic thalami or crura cerebri. In this third case the hearing was apparently unaffected, and hence the intracranial pressure was probably limited in extent.

NO. 7 WEST 46TH ST., NEW YORK.

ART. IX.—*Two Cases of Syphilis, in one of which the Primary Lesion was seated on the Internal Surface of the Eyelid, in the other on the Cheek.* By F. R. STURGIS, M.D., Assistant Surgeon Manhattan Eye and Ear Hospital, New York City.

H. B., 22 months old, was taken about the latter part of May, 1871, to my friend, Dr. E. G. Loring, for a curious affection of the inside of the right lower lid and at the outer angle. The following is Dr. Loring's description of the symptoms.

Lid swollen and inflamed; eye bloodshot at outer canthus. On everting the lower lid, a dusky-red papule was visible; this speedily changed into an ulcer with a clean granulating surface of a reddish colour. This ulcer was not indurated at first, and there being no reason to suspect syphilis, the glands were not examined. The mother says that the swelling of the lid began two weeks before the child was seen by Dr. L.

This ulcer was repeatedly touched with arg. nitr., but without benefit.

In the latter part of June, 1871, he had a febrile attack, during which an eruption appeared upon his stomach and chest.

I saw him for the first time in the middle of July, 1871. The lid was red, swollen, and indurated; this latter well marked.

On everting the lid a red granular ulcer was seen at the lower portion of the outer canthus, covered here and there with the opaline spots which mark the transition stage of the primary lesion into a mucous patch. On the body, arms, and legs, a roseola in the stage of decline. In the mouth and on the tongue, mucous patches in full blast.

Convinced what the trouble was, I sought the solution of it in the mother, but an examination made of her then and subsequently has shown no signs of disease. I then questioned her about the child's playmates and companions, and learning that one of her sisters, who was very fond of the child, was in the habit of kissing him, I asked the mother to bring

her to me, which was done, but with no better success than in the mother's case.

In despair, I then asked for the father. After I had seen him, I was no nearer the solution of the problem. He assured me he had had no venereal disease in his life, and certainly I had no reason to doubt his word. I have, therefore, never been able to find out how the boy's disease originated. I warned the mother about the danger of contracting the disease from kissing the boy herself, or allowing any one else to do so, until I was satisfied that he had no longer any patches in the mouth. This advice was disregarded, however, and on the 13th February, 1872, the mother came to me, stating that her little girl, six years old, had a sore upon her left cheek, which had begun a short time before as a red papule, "looking like a flea-bite," as she described it. I saw the child on the 16th day of the same month, and found a typical chancre.

The induration of its base was not well marked, but that of the sub-maxillary and post-auricular glands was characteristic. She subsequently had roseola, mucous patches, etc.

These cases are interesting from their seat and as occurring in patients so young. Although not unknown in these regions, primary lesions of the eyelids and of the cheeks are far from being common, as may readily be seen on glancing at the following tables :—

Table 1. In 472 cases of indurated chancres recorded at the *Hôpital du Midi*, the lesion was seated

On the penis and in the urethra in	434 cases.
“ scrotum	7 “
“ peno-scrotal angle	4 “
“ anus	6 “
“ lips	12 “
“ tongue	3 “
“ nose	1 “
“ pituitary membrane	1 “
“ eyelid	1 “
“ fingers	1 “
“ leg	1 “
“ foot	1 “

472

(FOURNIER, *Leçons sur le Chancre*, p. 364.)

Table 2. In 10 cases, the chancres were seated

On the lower lip in	4 cases.
“ upper lip	2 “
“ cheek	1 “
“ forearm	1 “
“ fingers	1 “
“ nipple	1 “

10

(BRYANT, *London Lancet*, 1868, vol. i. p. 525.)

Table 3. In 93 cases, the chancres were seated

On the genital organs in	4 cases.
“ upper lip	27 “
“ lower lip	29 “
“ tongue	11 “
“ naso-labial groove	1 “
“ face { chin, forehead, } and cheek. }	4 “
“ finger	2 “
“ upper eyelid	2 “
“ gum	2 “
“ labial commissure	7 “
In the nose	2 “
On the tonsil	1 “
“ palate	1 “

93

(PUCHE FOURNIER ET ALII, *quoted in Fournier, Etude sur le Chancre céphalique.*)

Table 4. In 31 cases, the chancres were seated

On the lips in	14 cases.
“ perineum	2 “
“ tongue	2 “
“ anus	2 “
“ pubes	2 “
“ groins	1 “
“ thigh	2 “
“ uvula	1 “
“ eyelid	1 “
“ nose	1 “
“ forehead	1 “
“ internal angle of right eye	1 “
“ pituitary membrane	1 “

31

(AIMÉ MARTIN, *De l'Accident primitive de la Syphilis constitut.*)

Table 5. In 21 cases, the chancres were seated

On the lips in	17 cases.
“ tongue	3 “
“ labial commissure	1 “

21

(BUZENET, *Le Chancre de la Bouche, etc. Thèse de Paris, 1858.*)

Table 6. Of 373 cases, the chancres were seated

On the penis and in the urethra in	342 cases.
“ scrotum	6 “
“ pubic and hypogastric regions	2 “
“ lips	13 “
“ tongue	4 “
In the anus	1 “
On the thigh	1 “
“ fingers	1 “
“ gum	1 “
“ cheek	1 “
“ groin	1 “

373

(BASSEREAU, *Traité des Affec. de la Peau, Symptom. de la Syphilis.*)

Table 7. In 403 cases, the chancres were seated

On the penis in	390 cases.
“ scrotum	3 “
“ pubes	2 “
“ lips	5 “
“ tongue	1 “
“ thigh	1 “
“ eyelid	1 “
	<hr/> 403

(CLERC, *Traité pratique des Mal. veneriennes.*)

Table 8. Out of 113 cases, the chancres were seated

On and in the genitals in	75 cases.
On the perineum	4 “
In the anus	7 “
On the thighs	6 “
“ groins	2 “
“ lips	7 “
“ tongue	1 “
“ uvula	1 “
In the mouth (no other designation)	4 “
On the nose	3 “
“ forehead	2 “
“ neck	1 “
	<hr/> 113

(Idem.)

Table 9. In 130 cases, the chancres were seated

On the genitals in	89 cases.
In the anus	12 “
On the groins	1 “
“ thighs	1 “
“ lips	10 “
“ labial commissures	1 “
“ nostrils	2 “
“ breasts	9 “
“ undesignated	5 “
	<hr/> 130

(ROLLET, *Traité des Mal. veneriennes*, p. 705.)

Besides these tabulated cases, others are reported by various authors. Cullerier¹ gives the plates of two cases of chancres of the lids; Bumstead,² one on the internal surface of the upper lid; Desmarres³ and Lawrence⁴ on various parts of the lid, and the writer⁵ one on the cheek.

From this it will be seen that out of 1646 tabulated cases of the seat of indurated chancres, it occurred only six times on the eyelids, and three times on the cheeks.

¹ Atlas of Venereal Diseases, translated by Bumstead, plate 14, figs. 2, 3,

² On Venereal Diseases, 3d ed. p. 415.

³ Maladies de Yeux, vol. i. p. 621.

⁴ Diseases of the Eye.

⁵ Medical Record, vol. iii. p. 530.

Diagnosis.—In persons so young as these whose history forms the text of this paper, the diagnosis will not always be easy to make; first, from its comparative rarity, and second, from the youth of the sufferers, which would prevent the true character of the lesions from being appreciated. But in one of its peculiarities we are really furnished a means of detecting its true nature, viz., in its position.

Any ulcer seated upon the face, the character of which cannot be determined upon, should at once awaken suspicions of syphilis, no matter who the patients may be, nor their own or their friends' assertions to the contrary.

Syphilis is common to all ranks in life and to all ages, and the primary lesion may appear on any part of the body.

Another point of great importance, of more than any other, perhaps, in forming a diagnosis, is to *ascertain the condition of the glands nearest the lesion*. It not infrequently happens that the induration of the sore is absent or but slightly marked (*parcheminée*); in such a case the diagnosis is difficult. But it is very rare, indeed I may say it never occurs, that glandular induration and that of the ulcer are both absent at the same time. Go, therefore, to the nearest chain of glands for the information that the ulcer has denied, there the answer will probably be given.

There only remains one other point to speak upon, and that seems almost superfluous. I refer to the possibility of these cases being congenital. It is unlikely; first, because both parents were examined, were found free from disease, and denied ever having any. This, however, I have elsewhere shown, goes for very little, inasmuch as patients, at the time of the examination, may have arrived at the period of incubation, or repose between the disappearance of one train of symptoms and the advent of the next, and show absolutely nothing. The strongest proof against it lies in the lesions themselves; congenital syphilis does not commence with a primary lesion, nor does it lie latent for two years before declaring itself, and upon these grounds, if on no others, the question of their being congenital may be entirely disposed of.

16 WEST 32D ST., NEW YORK.

ART. X.—*A Case of Dermoid Tumour of the Cornea*. Reported by
GEORGE STRAWBRIDGE, M.D., Lecturer on Diseases of the Eye and
Ear in the University of Pennsylvania, Ophthalmic Surgeon to the
Presbyterian Hospital in Philadelphia, etc. (With a wood-cut.)

Miss M. presented herself on account of a tumour of the left cornea, which was congenital and characterized as follows: Arising on the outer