

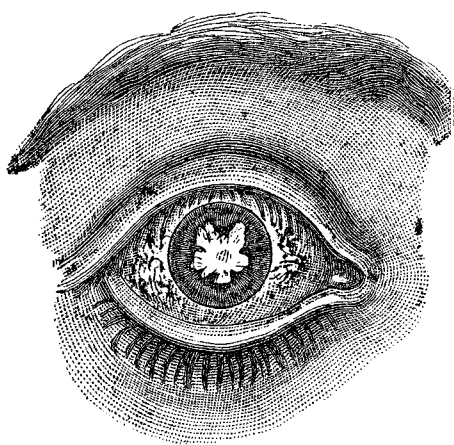
those given in my previous paper. They show some improvement in the averages of number of times the lithotrite was introduced, duration of operation, and stay in hospital in each case; but it will be seen that the average weight of the calculi dealt with is lower in this list, and a large number of cases of small stones in young children come to be dealt with very rapidly after some experience, and this will, of course, show itself in an average statement, somewhat obscuring the fact that large stones, if at all hard, will always take time to crush and evacuate. Thus in Case 208 the removal of a calculus weighing three ounces and two grains took as long as eighty-two minutes from the moment of introducing the lithotrite to that of withdrawing the cannula for the last time, while other very small soft calculi if found and seized at once were pulverised by a single turn of the lithotrite handle and evacuated within a couple of minutes.

Matlock Bath.

NOTES ON A CASE OF APPARENTLY INCURABLE BLINDNESS IN WHICH SIGHT WAS RESTORED.

By CHARLES BELL TAYLOR, M.D., F.R.C.S. EDIN.,
SURGEON TO THE NOTTINGHAM AND MIDLAND EYE INFIRMARY.

THE patient, a girl, twenty-two years of age, who was presented to the notice of the president and members of the Nottingham Medico-Chirurgical Society, on March 25th, 1897, came under my care in September, 1896. At that time she was quite blind, having bare perception of light with either eye. She had been in this condition for upwards of three years, during which period several ophthalmic surgeons had been consulted, with the result that she was declared incurable, and advised to enter an asylum for the blind without delay. "Is it any use going elsewhere for advice," she asked. "Not a bit! no one can do you any good!" Under these circumstances I told the friends that it would be hardly worth their while to incur the expense of a railway journey; but as an uncle of hers—formerly blind from detached retina, and who had been sent to me by Dr. Metcalf, of Lancaster—had regained his sight, they were very persistent, and I consented to receive her as an Eye Infirmary patient. On admission I found both pupils contracted, adherent to the capsule of the lens, and blocked by dense calcareous masses, while the eyes themselves were



Cataracta complicata accreta.

so shrunken and soft that minus three according to Sir W. Bowman's formula was barely sufficient to express their condition. I concluded that the opacity and calcareous degeneration of the lens—cataracta complicata accreta—was a secondary phenomenon; that sight was probably lost before the pupils were blocked; that there had been impairment of the circulation in the vessels of the uveal tract, liquefaction of the vitreous, and possibly also detachment of the retina in both eyes¹—a diagnosis which was

¹ "Inflammation of the anterior portion of the uveal tract, and especially the ciliary processes—in other words, cyclitis, or degeneration of the vessels of the uveal tract—leads to impairment of the nutrient supply of the vitreous and altered consistency, liquefaction or sychysis, and the retina, losing the support of the vitreous, is apt to become detached."—Leber and Nordensen.

to some extent borne out by notes of the case which were kindly sent to me by Mr. Bickerton, of Liverpool, from which it appeared that she had originally suffered from cyclitis preceded by choroidal changes and complicated with facial paralysis. She had been for some time an in-patient in the ophthalmic wards of a general hospital before coming under Mr. Bickerton's notice, and was subsequently seen and prescribed for by other specialists. I treated her with constitutional remedies *secundum artem*, with the constant galvanic current, and sub-conjunctival injections, and, when the improved condition of the eyeballs and increased perception of light seemed to warrant the procedure, extracted both lenses with the capsule entire and without iridectomy. The operation—despite extensive adhesions and so many contra-indications and drawbacks—was perfectly successful, and she was very soon able to go about the crowded streets—even after nightfall and in the winter months—unaccompanied, to read the signs over the shop windows, and to enjoy a degree of freedom which was highly appreciated after having been led about for years. A continuance of the treatment, after recovery from the operation, was followed by daily improvement, until the death of a relative compelled her return home, since which time I have had letters from her as well written as any I am in the habit of receiving.

"Shall I ever see again?" is a pathetic query which is often addressed to us, and it is one which it is not so easy to answer as might *a priori* be supposed. I have patients who have recovered their sight after blindness of upwards of thirty years—even loss of perception of light is not always a contra-indication to treatment. Indeed, I have one patient from the Blind Asylum who recovered excellent sight by treatment alone, both for reading and distance, after prolonged loss of all perception of light; and it is quite certain that now and again apparently hopeless cases—such as the one I have recorded—may be restored to all the blessings attendant upon the exercise of that function without which life itself is worth little.

Nottingham.

CONGENITAL LARYNGEAL OBSTRUCTION.

By G. A. SUTHERLAND, M.D. EDIN., M.R.C.P. LOND.,
PHYSICIAN TO OUT-PATIENTS, PADDINGTON-GREEN CHILDREN'S HOSPITAL,
AND TO THE NORTH LONDON HOSPITAL FOR CONSUMPTION;

AND

H. LAMBERT LACK, M.D. LOND., F.R.C.S. ENG.,
SURGEON TO THE EAR AND THROAT DEPARTMENT, PADDINGTON-GREEN
CHILDREN'S HOSPITAL, AND ASSISTANT PHYSICIAN TO THE HOSPITAL
FOR DISEASES OF THE THROAT, GOLDEN-SQUARE.

THIS affection may be described as a form of persistent laryngeal obstruction commencing at, or soon after, birth and accompanied by a peculiar stridor. The affection is not very rare, but is probably often unrecognised, and there are but few references to it in medical literature. Dr. Lees has described a case as a peculiar form of obstructed respiration. Dr. Gee discusses some cases under the heading of "Respiratory Croaking in Babies," and the same affection is evidently referred to by Dr. Goodhart as "infantile laryngeal spasm," by Dr. Löri, of Pesth, as "clonic spasm of the glottis," and by Dr. Robertson as "posticus paralysis." Dr. Thomson, of Edinburgh, has written an admirable and full paper on the subject under the title of "Infantile Respiratory Spasm." Within recent years a few cases under various designations have been shown at medical societies, but so far as we are aware no contribution has appeared tending to the further elucidation of the subject. The pathology of the affection has never yet been definitely determined, and the importance of some of its symptoms is not fully recognised. We propose to give an account of the clinical signs and symptoms founded upon the observation of eighteen well-marked cases, to trace the progress of the patients, and to describe exactly the pathological condition of the larynx, which we believe to be the basis of the affection. For the notes of two of the cases we are indebted to our colleague, Dr. Leonard Guthrie.

Predisposing circumstances.—This subject formed part of our investigation, but we have not succeeded in eliciting any facts of importance. Inquiry has been made as to any hereditary tendency to this affection, or hereditary disease associated with it, as to whether any localities are specially