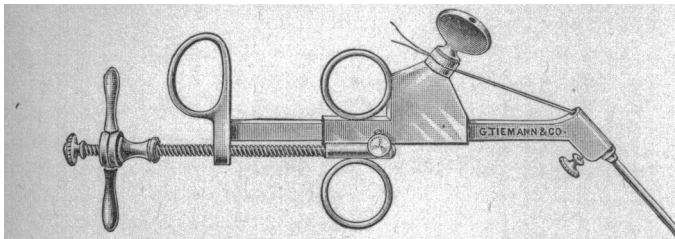


TONSIL SNARE.

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SAN FRANCISCO.

The use of the snare with a cold steel wire for the removal of the tonsil requires an instrument simple in construction and strong in all parts. The instrument here shown covers, I think, these requisites.

No provision is made for the re-use of the same wire because the snare can be so quickly threaded and a loop once used loses its best form. The general shape and mechanism is that of snares that are well known to be satisfactory. The parts have been adapted to the uses to which it is to be put. The canula is strong and has a button on the end to prevent its splitting. The screw for the attachment of the wire is set firmly into a strong



piece of steel; over this fits a button and then a loose washer. Both button and washer are made of chilled steel and milled so that by means of the strong thumb-screw the wire can be secured and quickly fastened. Most snares fail to provide for the quick and secure fastening of the wire, it often being made fast by clumsy and slow twisting. When the loop has engaged the tonsil the wire is drawn taut and then the cutting slowly accomplished by the windlass. This crushes the vessels and makes bleeding less to be feared.

CHRYSOPHANIC ACID KERATO-CONJUNCTIVITIS.

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NEWARK, N. J.

The fact that chrysophanic acid or chrysarobin, when applied in the form of a salve to any part of the face and even to other parts of the body, will give rise in some individuals to a conjunctivitis of greater or less severity is known to dermatologists and is mentioned in many text-books on diseases of the skin. Recently this drug seems to have come into favor again, at least I have been told by apothecaries that it is prescribed more frequently now than for several years past, and this is one reason which has induced me to put the following case on record:

Patient.—N. C. L., aged 63, in good health, of temperate habits, a clerk by occupation, came to me on May 5, 1906.

Examination.—He was led into my office with a bandage over his eyes, and his companion told me that he was blind. I found that the eyelids of both eyes were red, shining and edematous. The edges of the lids were glued together by secretions. After soaking the lashes with warm water, the lids were opened and tears streamed from the conjunctival sac. There was not much secretion in the conjunctival sac. The palpebral conjunctiva was very red and swollen, the bulbar conjunctiva was edematous and intensely injected. The cornea of both eyes were hazy, but the epithelial layer was apparently intact. The pupil was small, but there was no iritis and no disease of the posterior half of the eye. Both eyes were in about the same condition. The patient was complaining bitterly of pain and intense burning in his eyes and of photo-

phobia. He was unable to keep his eyes open long enough to determine the refraction of the eyes and the amount of vision.

History.—This is the first time in his life that his eyes have been inflamed. For some years the tip of his nose has been somewhat red from enlargement of the blood vessels in the skin, and this has annoyed him a good deal, especially as he never indulges in alcoholic drinks. He was told that this condition could be removed, and thereon he consulted his family physician, a homeopath, who prescribed a salve which was to be applied to the skin of the nose every night and washed away again the following morning. He applied this salve only once, and on the following morning tried to wash it off, and in doing so he probably got some of it in his eyes. His eyes, which previous to this time had been in normal condition, began to give him pain soon afterward, and the lids began to swell in the afternoon of the same day. The pain and the swelling of the lids increased very much during the following night. He slept but little in consequence of the pain. I saw him forty-eight hours after he had rubbed the salve in his eyes. He showed me the salve he had been using. It looked like chrysarobin salve, but to make sure of its composition I applied to the apothecary who had compounded the salve for a copy of this prescription. It showed the salve to be composed of chrysophanic acid 3ii and lard 3vi.

Treatment.—An examination of the secretion from the conjunctiva showed it to contain a few pneumococci. I advised the patient to apply cold compresses to his lids, a salve of ammoniated mercury to the edges of the lids, and to put a drop of a 0.5 per cent solution of sulphate of atropin and 1 per cent. cocain in each eye six times daily. The cold application failed to give relief, and I substituted for them compresses wet with a warm solution of boracic acid. During the next two days his condition remained unchanged. I brushed the excoriated edges of the lids with a 1 per cent. solution of nitrate of silver once daily. On the third day the epithelium of the cornea was wanting in a number of places, mostly in the horizontal meridian, and in the right eye somewhat more than in the left, and the whole cornea appeared somewhat more hazy. The lids were now less swollen and much paler than previously. On the fifth day the deficiency in the epithelial layer of the cornea extended across the whole cornea and was about 1 mm. in width. The adjoining parts of the cornea were decidedly hazy; both eyes were in about the same condition. At this time there was but little secretion from the conjunctiva. On the sixth day the entire lower half of the cornea of the right eye was very hazy. The deficiency of the epithelial layer had not increased in extent. The left eye remained as before. He had but little pain, but the photophobia continued. On the ninth day there was a decided improvement in the condition of the cornea of both eyes. There was less haziness, and the deficiency in the epithelial layer was gradually filling in. On the fourteenth day the cornea were clear and there was no longer a defect in the epithelial layer, the lids were normal or very nearly so, and there was no secretion from the conjunctiva. He was free from pain, but still had photophobia. On the twentieth day both eyes were normal. The refraction was hypermetropia 2 D. S. 6/5, both eyes alike.

There can be no doubt, I think, that the eye disease was caused by the entrance of the chrysarobin salve in the conjunctival sac. Whether the corneal disease was due to the direct action of the chrysarobin or was caused by the conjunctivitis, I am unable to say. The disease of the cornea certainly made the case a much more serious one, as it endangered the sight of the eye. Fortunately, it passed away without leaving even a slight opacity of the cornea.

With regard to the treatment given in this case, I may add that I should not use cocain in such a case unless the pain could not be relieved by the other means employed. The tendency to exfoliation of the epithelium of the cornea is always great in such cases and is

doubtless increased by the cocain, especially if the eyes are kept open. In this case the eyes were kept closed for several days and I do not think that the shedding of the epithelium was caused by the use of the cocain. Holocain, which is also a local anesthetic for the cornea, is said to be free from this objectionable quality, but my experience does not confirm this. In most cases atropin and warm applications to the lids is all that is required to subdue the pain.

A primary disease of the cornea as the result of the application of a 20 per cent. chrysarobin salve to other parts of the body than the head, beginning after four weeks' use of the salve, is described by P. Krause.¹ In this case a ring-shaped opacity developed in the parenchyma of the cornea, which disappeared in a short time under the use of warm applications and instillation of atropin, but returned after the applications of the chrysarobin were resumed, and again disappeared under the above mentioned treatment in eleven days. He reports also another case in which furrows running radially somewhat like herpetic eruptions on the cornea were present. In this case the eye disease developed on the fifth day after the beginning of the chrysarobin application. The eyes were normal in about a month.

The fullest account of this affection is to be found in the recent work of Lewin and Guillery.² It is there stated that the development of a conjunctivitis has been observed after the external use of chrysarobin, even in cases in which it was not applied to the face. In 4 to 5 per cent. of patients treated with chrysarobin chloroform solution, a conjunctivitis was observed after twelve to twenty-four hours first in one eye, and a few hours later in the other. In the beginning the patient experiences an intense smarting and burning and edema, unpleasant sensations of heaviness in the eyes. The pain increases, blepharospasms appear, lachrymation is increased, and sometimes there is also a slight degree of photophobia. The conjunctiva of the eyeball and of the lids, especially that of the lower lid, is intensely injected. The conjunctiva of the upper lid may be intact. The cornea need not be affected, although ulcers of the cornea have sometimes occurred in connection with the conjunctivitis. The ante-period of this affection lasts three to four days. The injection of the conjunctiva continues for a longer period. The eyes are normal again after eight to ten days with or without treatment. There is no secretion from the conjunctiva. In the eye last affected the symptoms are usually less severe and disappear more quickly than in the eye first affected. The affection may disappear spontaneously, but may also be followed by unpleasant sequences. This conjunctivitis is to be regarded as a resorptive action, more especially since small quantities of the chrysarobin chloroform solution when introduced in the eye produce a mucopurulent inflammation, but such is not the case in the chrysarobin conjunctivitis, also because an infection by means of the fingers could be excluded, because the conjunctivitis reappears with every new application of the chrysarobin and because the resorption from the skin was proved. If chrysarobin enters the conjunctival sac in the form of a powder or as a salve, a catarrhal conjunctivitis is developed which may be followed by chemosis and even by ulcers of the cornea.

In the discussion following the reading of a paper

entitled "The Therapeutic Value of Chrysophanic Acid in Dermatology," read by Dr. Charles James Fox,³ Dr. Henry C. Baum said that he thought the chrysarobin should be used on the scalp only in exceptional cases. Kaposi himself had warned his pupils regarding the possible dangers of applying the drug in that locality. Dr. Baum said that he had seen a number of cases of violent dermatitis follow the use of chrysarobin on the scalp. He recalled an instance where a physician had applied a small amount of chrysarobin to a ringworm on the nose of a young woman. It produced a violent dermatitis, which extended to the eyes and culminated in complete blindness. In every instance in which this drug was applied to the face or scalp the case should be watched with the greatest care, and only a small area treated at a time until the individual idiosyncrasy of the patient can be determined. In the same discussion Drs. R. A. McDonald and Edmund L. Cocks said that they had applied the drug to the scalp with very satisfactory results and without producing conjunctivitis. Dr. L. Weiss said that in using chrysarobin on the face and scalp the possible resulting dermatitis could be prevented from spreading by the application of zinc gelatin which acts as a compress.

My patient, after he had recovered from his eye trouble, commented on his own case as follows: Vanity caused me to apply to a doctor to remove the redness from my nose; his salve did not cost much, but it disabled me for work for three weeks. I have suffered much pain and I still have my red nose.

MALIGNANT TUMOR OF THE TESTICLE.

DAVID L. WALMSLEY, M.D.

DETROIT.

Two cases of this disease are reported in *THE JOURNAL* February 9 and March 30. I wish to add a third case:

Patient.—On July 22, 1906, Mr. W., aged 40, married, one child, healthy up to the present, consulted me for the first time.

History.—The case dates back to injury to the right testicle by a baseball during high-school days. Pain and swelling followed the injury, and atrophy followed the subsidence of the local symptoms. The left testicle was normal. The man became reconciled to his injury, and being fully developed in every respect, paid no further attention to the deformity until the beginning of July, 1906, when his attention was drawn to it by a feeling of fulness and slight uneasiness of the atrophied organ. His family history is good. I advised close watching of the parts. On September 20 I again examined the patient, finding the atrophied testicle the size of an ostrich egg. The tumor was semisolid, smooth and egg-shaped. Light, not transmitted, slightly tender on pressure.

Treatment and Result.—Feeling suspicious of malignancy, I removed a specimen and submitted it to Dr. E. H. Hayward, pathologist to the board of health, whose examination determined malignancy, and I operated Sept. 22, 1906. The patient made a good recovery and was dismissed with instructions to return for inspection.

Dec. 4, 1906: He returned complaining of slight uneasiness in the stump, which he thought was enlarging. I discovered a nodule on the end of the stump and advised removal at once; this, however, was delayed until Jan. 6, 1907, when I removed the cord high up and with it the lymphatic glands and adipose tissue, hoping thereby to ward off recurrence. To date of writing (April 25) there are no indications of recurrence. The patient feels well and enjoys living, were it not for the eternal dread of returning trouble.

1. *Ztschr. f. Augenheilkunde*, xv, 233.

2. Die Wirkungen von Arzneimitteln und Giften auf das Auge, II, 775.

3. *THE JOURNAL A. M. A.*, June 23, 1906, p. 1909.