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[NEW SERIES.]

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

SOUTH LONDON OPHTHALMIC HOSPITAL.

TWO CASES OF DIPLOPIA.

By J. ZACHARIAH LAURENCE, Esq., Surgeon to the Hospital.

CASE I. A gentleman, aged 50, consulted me last June. He went to bed one night in his usual health, and on rising in the morning, he found to his great surprise "that he could scarcely see." On trying his eyes further, he found that in attempting to take something off the mantelpiece, he altogether missed his distance. Being obliged to go into the country that morning, he with great difficulty walked to the railway station, and was perplexed to find that his ticket appeared two tickets, and that his change appeared double what it ought to have been. This state of things had been going on for about a month, when he first came under my care.

I found that the principal defect of sight under which he laboured was double vision (diplopia). He saw everything double; but he could recognise one image to be an illusory one—a spectrum—the other, a reality. The curious feature in his case was that, on looking at a lighted taper, for example, when he looked down at it, it appeared single, but in proportion as he looked upwards, a second taper seemed to rise up from behind the real one. *When he used either eye alone, all diplopia ceased.* On requesting him to read the bottom of the page of a book and to follow the lines with his finger, using one eye alone, his finger ran correctly along the line he was reading; but with both eyes open, his finger ran along the white margin, or even altogether below the book. In fact, he was obliged to wear a shade over one eye to enable him to pursue his avocations.

On examining his eyes carefully, all I could detect was a slight but decided *squint of both eyes*, and a very contracted state of the pupils. My friend and colleague, Mr. Holthouse, states very intelligibly the cause of the diplopia in such a case as this: "Where the inversion or eversion of the eye is great, the images will be so far apart that the wrong one becomes placed altogether beyond the field of vision of the good eye . . . for this reason, squinters seldom experience this symptom . . . indeed, as a general rule, this symptom will be found to occur more frequently in slight distortions." (In our case, the muscle affected appeared to be the *upper* or *lower* rectus.)

Viewing this case as one of spasm of the recti muscles, depending on some disturbed innervation, I ordered my patient five grains of the citrate of quinine and iron three times a day, and an occasional leech to the eye. Under this treatment he was, when I last saw him, gradually recovering his usual vision.

Shortly afterwards, I met with a very similar case in my practice at the South London Ophthalmic Hospital.

CASE II. Wm. F., aged 39, consulted me at the Ophthalmic Hospital, on August 14th, 1858. On getting up the day before, he found a "confusion of vision" when he used both eyes.

If he closed either eye, his sight was perfect; but when he used both eyes, he saw everything double. In his case, the lower image appeared to him to be the illusory one. I could not detect any positive squint; as in the first case, both pupils were unusually small. Under the treatment already mentioned, he made a complete recovery.

A SERIES OF CASES OF TEALE'S AMPUTATION.

THE practical suggestion of Mr. Teale has been received with attention in London, and we append several cases in which it has been put in practice. They do not embrace all the amputations that have been performed, and we hope to lay before our readers, shortly, another series, which may assist them in forming an estimate of this method of operating. As far as our own observation goes, it seems to us that the great advantage of the operation consists in the less necessity that exists for the painful and tedious dressings which are required in the older methods of amputation. Thus, in Mr. Pollock's case (Case III), the only dressing used was a piece of simple cerate laid over the end of the limb; and in every case it may be confidently anticipated, that if the patient's health be in a reasonably good condition, sufficient union will have taken place to hold the flaps in contact after the removal of the sutures, without further means of support. The great advantage of this, especially in children, no one who has had to dress stumps will be slow in appreciating. The list of cases we publish is from accidental circumstances a very unfavourable one; as in most of them the amputation was performed merely as a last resource, and as a preferable alternative to leaving the patient to an otherwise inevitable death. Hence several of the cases exhibited extensive sloughing of the flaps, and this was in one respect a testimony to the efficiency of Mr. Teale's method, as it showed how large a quantity of the stump might be destroyed by gangrene, and yet a sufficient covering for the bones be left. In Mr. Hawkins's case, indeed, the commencement of necrosis in the end of the stump of the bone suggested a difficulty in the treatment of cases presenting this complication, since the extremity of the bone is buried in soft parts, which will probably have closed over it to such an extent, as to render its future extraction difficult, if not impossible, without incision, and to lead to the formation of troublesome sinuses in the stump. Against this occasional inconvenience, we may, however, fairly set the far less probability that exists for the occurrence of such a complication at all; since, when the end of the stump dies, it is almost always the result of exposure, from deficiency of covering, or abscess in the stump. The form of the flap will prevent the former, and the depending opening the latter condition. The recovery of two patients (Cases I and II) who were labouring under symptoms of phthisis, seems to show that the healing of the stump in these cases makes less call upon the constitution than in the ordinary methods; and the rapid recovery of the patients (see Cases IV and VI) appears to point to the same conclusion. Whether the operation will be found to be as effectual in guarding against pyæmia as Mr. Teale anticipates, is a question which can only be settled by experience. Out of the three fatal cases recorded here, none seems to have been caused by that affection.

ST. BARTHOLOMEW'S HOSPITAL.

TWO CASES OF TEALE'S AMPUTATION.

[From Notes by G. F. HELME, Esq., House-Surgeon.]

Under the care of W. LAWRENCE, Esq.

CASE I. Elizabeth Burns, aged 54, was admitted January 28th, under the care of Mr. Lawrence, suffering from disease of the bones of the leg. She stated that her leg had been bad for four years. At the commencement, there was no swelling, nor any tenderness at any part, but constant pain in the tibia and fibula at their upper part. In September 1857, she was in this Hospital, and remained until December 24th, 1858. During that time, Mr. Lawrence removed what turned out to be a malignant growth from the tibia, which had caused the skin to ulcerate over it, and then protruded. This proceeding was adopted in consequence of the woman refusing to allow her limb to be removed. The wound healed, but the limb was left