Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

LIVERPOOL NORTHERN HOSPITAL.

NEURALGIA TREATED BY OPIATE INJECTIONS.

Under the care of A. T. H. WATERS, M.R.C.P., Physician to the Hospital.

[Communicated by NEWTON HEELAS, ESQ., Junior House-Surgeon.]

THE following case illustrates well the beneficial results occasionally to be derived from the use of opiate injections in the treatment of neuralgia.

Joseph Lewis, aged 27, was admitted into the Hospital on June 6th, 1860. He had been ill about nine days, with severe pain in the head, attended with nausea. The pain was seated on the right side, not passing the median line, and proceeded chiefly from over the orbit, and the back of the head. He had had but little sleep from the commencement of the attack, and had a peculiar "pinched" expression of countenance, indicative of acute suffering. He was ordered five grains of quinine three times a day, with eight grains of iodide of potassium and half a drachm of laudanum at night, and good diet. From some peculiarity, the opium produced wakefulness, bad dreams, and, as he expressed it, made him quite "wild"; it was omitted.

He continued the quinine and iodide of potassium up to the 22nd, when he was much better, the pain being much diminished in extent; it was now almost entirely confined to one spot over the eye, from which, he said, he could distinctly trace it. On passing a coin along the margin of the orbit, great pain was felt on pressing in the situation of the supraorbital nerve. Fifteen minims of Battley's solution were injected on to the nerve; at the moment of operation, he felt great pain, but this very soon left him. The quinine was omitted, and he was ordered four ounces of wine daily.

June 26th. With the exception of two or three slight momentary twinges, he has been quite free from pain since the injection; his aspect is improved, and much less expressive of suffering; he is anxious to have the operation repeated. Fifteen minims of the same solution were again injected.

June 30th. He has had no return of pain on the forehead since the last injection; but there is one spot on the temple where he has an occasional twinge. The injection was repeated at the seat of pain.

July 2nd. He expressed himself as being quite well, and was discharged.

On each occasion of injection, the patient suffered more or less from constitutional symptoms, similar to those produced when the first dose of opium was administered internally.

The relief obtained by the injections was of so decided a nature, as to greatly impress the patient with the efficacy of the remedy.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

CASES OF GLAUCOMA TREATED BY DIVISION OF THE CILIARY MUSCLE.

By JAMES ROUSE, ESQ.

As it is possible that some of the readers of this JOURNAL may not know the exact steps of Mr. Hancock's operation for the relief of glaucoma, the following extract from that gentleman's lecture, published in the *Lancet* of Feb. 11th, may be deemed acceptable:—"I introduce a Beer's cataract knife at the outer and lower margin of the cornea, where it joins the sclerotic; the point of the knife is pushed obliquely backwards and downwards, until the fibres of the sclerotic are divided obliquely for rather more than one-eighth of an inch; by this incision, the ciliary muscle is divided, whilst the accumulated fluid flows by the side of the knife."

If the reader will refer to the lecture from which the above extract is taken, he will find that Mr. Hancock was induced to perform the operation just described from having noticed in several cases of acute glaucoma a peculiar constriction around

the cornea corresponding to the situation occupied by the ciliary muscle; the operation was followed by most satisfactory results.

The following cases are the more interesting, inasmuch as they did not present that peculiarity; and it will be seen that the operation was equally successful.

CASE I. H. W., aged 46, married, the mother of children, was admitted under my care on May 4th. During the last eleven years, she had suffered from occasional attacks of pain (accompanied by dimness of vision) in the left eye. Two months ago she was attacked with pain in the left eye, which prevented her from following her usual occupations. A week ago the pain became so intense, that she could not procure sleep. During this time her sight was very limited; she could not see more than two yards before her, and then the objects looked confused: beyond that distance, everything appeared to be dense fog. She complained of intense throbbing pain in the eyeball of the left eye, circumorbital pain, and occasional flashes of light. The pain was more severe at night, and at times appeared to affect the whole head. She could not distinguish any object. On examining the eye, the cornea was found to be slightly ulcerated. The anterior chamber was very much flattened, partly from pushing forwards of the iris, and partly from the stretching of the cornea from the intraocular effusion. The pupil was large and immovable. The conjunctival and choroidal veins were large. Pressure on the eyeball caused extreme pain. She had had no sleep for a week.

May 4th, 2 p.m. The ciliary muscle was divided; a considerable amount of fluid escaped. Within an hour after the operation the pain was relieved, and she passed a most excellent night.

May 18th. She had had no pain since the operation; and, on a watch being given to her, she could tell the time; and could distinguish silver from gold. The eye had nearly regained its natural appearance. The anterior chamber was of the same depth as that of the right eye. The ulceration of the cornea had healed, leaving only a slight cloud.

May 28th. She had had no return of pain, and saw perfectly. The cornea was rapidly clearing. She was made an out-patient.

June 15th. She came to show herself, stating that she was perfectly well.

CASE II. A. H., aged 47, married, the mother of seven children, looking at least ten years more than her age, was admitted on May 18th under my care. Four years ago, her sight began to get weak, not being able to thread a needle without glasses. One night in the middle of last September, she was attacked with violent pain in both eyes and around the orbits, especially the left. The following day, the pain increased in intensity, and compelled her to keep her bed. The sight of the left eye became seriously affected, vision being very limited and indistinct. The right eye was affected, but in a less degree.

In December, she came to the Hospital as an out-patient; at that time the sight of the left eye was completely lost; the pupil was large and somewhat irregular; the vitreous body was too opaque to allow ophthalmoscopic examination. The pain was so intense in that eye and side of the head, that she could not sleep. Under these circumstances, the ciliary muscle was divided. The operation completely relieved the pain; but there was no return of vision. The right eye improved very much after the operation; in fact, she was so much better that she ceased to attend.

May 16th. She again applied for advice; the right eye had become so much worse, that she could no longer see to read. She could distinguish large objects, but not sufficiently to recognise a face. The pupil was large and fixed, the cornea was flattened, and the iris pushed against it. The vitreous body was semiopaque. She complained of great pain in the right temple and side of the head. She felt so giddy, that she did not like to move about.

May 18th. She was admitted into the Hospital; and the ciliary muscle was divided.

May 30th. She had progressed favourably since the operation, the mist had entirely gone, and she was able to read for a short time without inconvenience, but it caused subsequent uneasiness. She stated that she could not look very long at an object without the eye becoming slightly "dazzled". She was made an out-patient.

June 15th. The sight was improving—every day becoming stronger. She could now look at an object for a much longer time without inconvenience. She saw everything perfectly.

August 13th. The sight perfectly good in the right eye.

She finds that if she takes cold there is slight mistiness for a day or two. During the last month there is slight return of sight in the left eye. She can now perceive the window-frames.

CASE III. L. N., aged 30, single, a dressmaker, was admitted under my care on June 8th. Two years since the sight began to get dim and misty; she had had pain from time to time in the temples across the forehead; after each attack the sight was less good. A year ago, she became decidedly worse. The pain in the eyes and temples was more severe, and the sight was so much affected that she could no longer see anything distinctly. She could only read large print, and see to do the coarsest work, and this very indifferently. She had not menstruated for two years.

On admission, the pupils were large and fixed; the refractive media were turbid. Ophthalmoscopic examination showed dilated veins on both retinae. The optic discs could only be seen imperfectly; they appeared slightly cupped. The eyes were very hard, and the anterior chambers and corneae were flattened. She complained of iridescent vision, and pain in the eyes and head. She was given a watch, but she could not positively tell the face from the back. She thought she could distinguish very large type, but the attempt to read caused pain and dizziness in the head. The ciliary muscle was divided in both eyes.

June 18th. She had had no pain since the operation. The irides had assumed the natural size, and acted perfectly. This morning she threaded a needle, and read some ordinary sized print. She said she had not seen so well since the first attack two years ago.

August 13th. The sight continues satisfactory.

Original Communications.

SCROFULOUS DISEASES OF THE EXTERNAL LYMPHATIC GLANDS:

THEIR NATURE, VARIETY, AND TREATMENT.

By P. C. PRICE, Esq., Surgeon to the Great Northern Hospital; the Metropolitan Infirmary for Scrofulous Children at Margate; etc.

I.—INFLAMMATORY CONDITIONS OF THE EXTERNAL LYMPHATIC GLANDS IN SCROFULOUS SUBJECTS.

[Continued from page 600.]

Recognition. The correct appreciation of this form of glandular enlargement is, as already observed, of very great importance, as it at once relieves the patient of much anxiety, and enables the surgeon to adopt measures which, when correctly employed, are very frequently followed with the greatest advantage. But due recognition is oftentimes attended with difficulty, for there are certain abnormal conditions of the lymphatic and other parts, which more or less closely resemble enlargement from slow chronic inflammatory disturbance.

The following conditions are those which appear to possess a more or less close analogy. *Firstly.* Hypertrophy of lymphatic glands from apparent non-vascular derangement. *Secondly.* A true tuberculous condition of the glands. *Thirdly.* Encysted and fatty tumours. *Fourthly.* Chronic abscesses. *Fifthly.* Goitre or enlargement of the thyroid gland.

Firstly. Chronic inflammatory glandular enlargement is not always easy of distinction from that form of hypertrophy which obtains without any apparent inflammatory action. In an early stage, and when arising from any cause which is likely to lead to vascular disturbance, this kind of enlargement may, as a rule, be more generally anticipated. But there are occasions when no discriminative examination will serve to distinguish it, save that afforded by manipulation. To the touch, such enlargements will generally be found less hard, more elastic, and less defined, than those arising from simple chronic hypertrophy. Nevertheless, the pain on handling, no matter how slight, is often the only deduction that can be obtained from manipulation. In still more dubious cases, therapeutical management is the sole means which enables a correct appreciation of the nature of the affection; for while the resolution of hypertrophy, the result of a low and tardy form of inflammation, is sometimes compara-

tively easy, the resolution of that resulting from non-vascular causes is much more difficult. Chronic inflammation, although of a very low form, is, moreover, more rapid in its progress, frequent in its relapses, and ordinarily attacks such glands as are not commonly included in non-inflammatory hypertrophy. In young people, as well as in those more advanced in years, both forms of enlargement are frequent, although chronic adenitis is more usually the immediate result of certain appreciable causes. Both forms are met with in the cervical and facial glands, although true hypertrophy is more commonly limited, I believe, to the deeper layer of the glands of the neck, and, unlike inflammatory glandular lesions, at least, so far as I am aware, very rarely involves the glands of the armpit and groin.

Secondly. In the earlier stages of development, the greatest difficulty is often experienced in ascertaining whether enlarged glands seated in the neck, etc., result from simple inflammatory changes or from decided tuberculous degeneration. A variety of comparisons will, however, frequently enable the surgeon to pronounce as to the specific action that is taking place, although the analogy is often so strong that an early and direct decision is often impossible. The difficulty of early appreciation is, however, further increased owing to tuberculous depositions seldom ensuing before some enlargement of the glandular structure has taken place. When the increase in size is unaccompanied by any marked symptom of a decided tuberculous character, arises from any known causes, and exhibits a tendency to resolution, then, in all probability, the glandular mischief is devoid of any specific complication, and entirely depends on temporary derangement of one or more portions of the lymphatic system. At a later period, provided the affected glands have attained considerable dimensions, and that tuberculous disease exist definitely marked in other portions of the body, then it is more than probable that the deposition of tubercle has become the direct source of irritation. Should destructive inflammation ensue, and extend to the cellular tissue and skin, additional evidence will be still more in favour of tuberculous complication; while an examination of the pus, should suppuration occur, will at once decide any further doubt. But, as will be presently shown, deposition of tubercle is oftentimes unaccompanied, or followed, even at a remote period, by inflammatory changes, ending in ulceration and suppuration. A sure diagnosis in such instances is therefore, as may be readily conceived, of still greater uncertainty; and the surgeon will oftentimes have to wait patiently, till time and the use of therapeutical means have decided the correct nature of the puzzling affection.

Thirdly. Encysted and fatty tumours, when situated on the neck, especially near the base of the lower jaw, and in and over the parotid gland, often give rise to some speculation as to whether they may not be closely simulated by chronic glandular swellings. I have often myself been struck with the near analogy that exists between these various morbid conditions; and experience has taught the value of careful investigation before pronouncing as to their precise nature.

When an encysted tumour is situated near to one or more of the cervical lymphatic ganglia, an erroneous impression, without regard to certain symptoms, is by no means improbable; but if the cyst become inflamed, its due recognition, as M. Guersant has pointed out, is at once easy, by reason of the peculiar nature of its contents. One point of importance, as bearing on the diagnosis of an encysted growth is, that while it is comparatively infrequent to find a single gland included in chronic inflammation, to the exclusion of others forming, perhaps, the same plexus, it is equally rare to find more than one encysted tumour occupying the same region, without it be on the hairy scalp. Manipulative distinction, a careful insight into the nature of the origin and duration of the enlargement, and an inquiry into the constitutional habitus of the individual, will generally at once lead to a truthful appreciation.

With regard to the similarity existing between fatty tumours and simple chronic inflammatory swellings of the lymphatic ganglia: I have known such growths, occupying the region of the neck and armpit, to give rise to the suspicion of glandular enlargement, although the soft, elastic, and generally painless character of the adipose swelling, usually allows a correct diagnosis.

Fourthly. It is by no means infrequent to find chronic abscesses presenting points of almost positive identity to this form of glandular disturbance; and the analogy is oftentimes so close, that great care is required in arriving at the real nature of the swelling. Although fluctuation is not always obtained in the case of chronic abscess, still it is generally appreciated;