thought of the misfortune to the other as the cause of the younger. There is no other blindness in the family, nor have they intermarried; neither father or mother suffered from any nervous disease. Another case at the school would also appear to be congenital. Three of this number were males, and four females. The total number of cases of congenital blindness is 12, or 16.4 per cent. None under this class are found among the cases reported at the Workshops.

Optic Atrophy.—At the Blind School, 11 owe their affliction to this cause, or 15.2 per cent. : 9 of this number are females, and 2 males. One lost her sight at 21, and another at 11; the others generally when aged 4 or 5. As far as can be ascertained, the histories resembled those of meningitis: in one, the blindness occurred after whooping-cough (a fit), and another had a blow on the head with a shovel when aged 2.

At the Workshops, there are 8 blind from atrophy of the optic nerve, or 21 per cent. One man, now aged 26, lost his sight at 7 years of age, during scarlet fever; another, now aged 35, at 14 was knocked down by an engine, lost his senses, and when consciousness returned, he could not see, and his mind was affected for eighteen months. Another, also, at 15 lost his sight with head-symptoms; he was a file-cutter (saturine neuritis?). The only female among this series became blind at 19; she was under observation with double optic neuritis, passing into atrophy; cerebral and specific indications were present. The ages at which the others lost their sight were 43, 27, 22, and 20. This last was struck on the eye by a piece of grease. He lost consciousness for a time; there was no vomiting; the sight of the left eye was lost immediately; of the right, about three weeks later. There was no evidence of injury in the fundus of the left eye; both optic papillæ were papery white.

The 19 cases in all comprise, out of the 111, a total of 18 per cent. It is worthy of remark that, in three of these instances, there is a history of head-injury.

Cornea.—Affections of the cornea are responsible for 5 cases at the Blind School, or 6.8 per cent. There are 2 males and 3 females. Two of these instances here resulted from interstitial keratitis; one is absolutely deaf. Another case had corneal staphyloma; the globe was painful, and was excised by me before admission into the school; the other eye had corneal fistula, and the little sight then possessed rapidly failed. She died of erysipelas. The other two are stated to have lost their sight whilst "teething;" one, with leucomata, possesses fair sight after iridectomies by Dr. Little, of Manchester, and myself; in the other, the globe (left) is shrunken; an operation had been performed on it in London; the right cornea is cloudily, the pupil closed; it looks as if iridectomy had been attempted.

At the Workshops, there is one case suffering from the effects of diffuse keratitis. The left cornea is fairly clear, the right still nebulous; she possesses fair sight.

Iris.—The only case coming under this head deserves longer notice; it is one of irido-choroiditis, associated with blanching of the eyelashes. He is employed at the Workshops. In March 1877, he came under my care at the Infirmary. He was then the subject of irido-choroiditis in both eyes. He had first noticed something wrong with his eyes sixteen months before; the left commenced about a fortnight before the right. The eyelashes in both eyelids, on each side, were observed to have become whitened. This alteration in the eyelashes had been first noticed two or three months before coming to me. The colour of the hair and eyebrows was brown. I showed the man (then aged 21) to the members of the Sheffield Medico-Chirurgical Society on March 15th, 1877, as a "probably unique case." A little later he went to Moorfields, and was under the care of Mr. Jonathan Hutchinson, who has referred to the case in his lectures at the Royal College of Surgeons. Two iridectomies were performed on the right eye. Now (June, 1885) the right globe is shrunken; in the left eye, the pupil was plugged; the iris bulged forward; there is no perception of light. The eyelashes still remain whitened on both sides; in the upper eyelids, a few darker ones are interspersed.

I will close this report by referring to miscellaneous cases, which I do not otherwise classify.

Coloboma of Iris and Choroid.—The subject had been always defective in sight; at 20, he was struck by lightning, and lost sight in a few days; he is now aged 47. In both eyes there is coloboma below of iris, reaching through the choroid. In the right eye, it embraces the optic disc and affects the sheath. He declined to allow a mydriatic to be used for a thorough examination.

Retinitis Pigmentosa.—A male, aged 43, had nyctalopia as a child. He could read up to 12 years, holding the book very near. His sight gradually failed, and he has worked in a blind factory for more than twenty years. There was a large quantity of pigment in each fundus, reaching close up to the discs, which are white and waxy-looking.

There are hypermetropia and nystagmus. His father and mother are not relatives; vision of the family is good.

Choroido-retinitis.—The subject is a male, aged 42. His sight commenced to fail at twelve years of age; specific history is denied. In both eyes are atrophic and pigmentary patches; the right eye is less opaque and has perception of light, the left lens is becoming opaque and the vitreous humour cloudy, preventing a perfect view of the fundus; perception of light is defective. He was under observation many years ago.

Hydrophthalmos and Cataract.—A female, aged 38, has been blind since 4½. The right eye is hydrophthalmic, and has no perception of light. In the left the lens is opaque, the pupil active; there is good perception of light. Her condition, it is possible, might be improved by operation.

The following are among the inmates at the Blind School.

In a boy aged 7: "One eye was extracted at 18 months, and the other at 3½ years, for cancers," so says the medical certificate. The case was not seen by me, and no further information is obtainable.

Another boy, aged 8½ years, lost his sight at 12 months. There is nystagmus, and examination is very difficult; in each fundus are large pigmentary patches; the discs are atrophied.

Malingering.—This case, a girl, aged 18½, operated on by Mr. Higgins, for squint (left eye), was sent from a London workhouse, as totally blind. Shortly after admission to the Blind School, sight commenced gradually to recover. When she was examined, hypermetropia was found, and excellent vision; the left eye was amblyopic. She has since done work at the school, as general servant. I think it likely she feigned blindness at the workhouse, to avoid work, and that she found the education of the blind more irksome than anticipated, and gradually recovered vision.

In conclusion, I must acknowledge the kind services rendered in the preparation of this report by my friend, Mr. J. R. Turner.

TREATMENT OF VARICOCELE BY EXCISION.

By A. W. MAYO ROBSON, F.R.C.S.,

Honorary Surgeon to the Leeds General Infirmary

THE various methods adopted for the cure of varicocele go far to prove that, as yet, no one means is so thoroughly satisfactory as to leave nothing to be desired. Of the various measures I have myself adopted, I have found none to equal, in completeness and safety, the complete excision of the bundle of enlarged veins. After any radical operation for varicocele, there must of necessity be a greatly disturbed circulation in the scrotum, and a liability to hydrocele or slight orchitis, and this I have found occasionally even in subcutaneous ligation of the veins; but, as will be seen by the following cases, which have occurred in my practice during the last year, orchitis supervened only once, and then in a syphilitic subject, who had had specific orchitis a short time before being treated for varicocele.

The train of nervous symptoms frequently accompanying varicocele is often so severe as to demand treatment; and, when some tangible cause is found, such as a varicose condition of the pampiniform plexus, producing congestion and neuralgia and ultimately atrophy of the testis, it is the surgeon's duty to give relief, especially when it can be done without danger. The operation of excision is performed as follows.

The skin of the scrotum, having been shaved and well washed, is enveloped in a carbolic dressing, which is left on for twelve or twenty-four hours preceding operation.

After the patient has been anaesthetised, and every antiseptic precaution adopted, the cord of the affected side is caught between the left finger and thumb over the site of the varicocele; the vas deferens, which is easily felt, is allowed to slip backwards, leaving the enlarged veins within the grasp.

A vertical incision of three-quarters of an inch is now made through skin and fascia, quite down to the veins which immediately bulge through the wound, and are caught between the finger and thumb of the right hand; the finger-nail then serves to break through a film of fascia which separates the veins from the vas deferens. A double No. 2 catgut ligature is passed round the bundle of veins, and the two ligatures thus placed *in situ* are tied about an inch or more apart, the intermediate varicocele being completely cut away.

No bleeding occurs, as a rule, and the wound is so small, and falls so well together, that sutures are scarcely required. A small catgut drain may be left in, but this is not absolutely necessary. The wound is covered with carbolic gauze, and over this is placed a good pad of salicylic silk or wool. In some cases, the dressings are not removed for a week, when the wound is completely healed; but, when

a drainage-tube has been left in, it should be removed on the second day.

CASE I.—Mr. A., aged 23, residing in Leeds, a member of a learned profession, suffered from varicocele on the left side, neuralgia of the left testicle, and constant aching. He was hypochondriacal, and said he was quite unfitted for work, on account of his depressed mental condition. The operation was performed under eucalyptus-air; healing by first intention occurred, and the patient was out in a fortnight. He is now quite well, physically and mentally, and I constantly see him in active work. There is no visible scar where the wound was, and nothing to indicate that there has ever been an abnormality.

CASE II.—Mr. W., a colliery-proprietor, residing near Leeds, consulted me for a gleet discharge, "prostatic," from which he had suffered for several years, and for which various operations had been done. He had, associated with a large varicocele, neuralgia of the left genito-crural nerve, dragging pains, atrophy of the left testicle, and intense mental depression. After treatment of various kinds, without much improvement, I advised and performed excision of the varicocele. The operation was followed by a slight hydrocele, which disappeared after three months. The patient reported himself after six months, looking quite a different individual, having lost his nervous symptoms and his gleet discharge, and being quite free from pain. There was no sign of the hydrocele, and the testicles were of normal size. He was then about to marry.

CASE III.—Mr. B., a schoolmaster, residing in Bramley, suffered from such intense nervous debility, that he felt quite unable to carry on his duties, and had thoughts of suicide. His attention was morbidly centred on a large left varicocele, which had apparently caused atrophy of the left testicle, as it was only half the size of the right. He complained of neuralgia and dragging pains. I advised operation, to which he consented. The wound healed by first intention, and he returned home in a fortnight. He reported himself after three months, saying, "I am quite a new man, and my work is a pleasure." In place of a large soft pulse, pale face, dilated pupils, cold clammy hands, and general want of briskness, he stepped sharply into my room, looked happy, had a firm good pulse, and plenty of red blood in his cheeks, and warmth in his hands.

CASE IV.—G. E., aged 19, wished to go into the army, but could not pass because of a left varicocele of considerable size. It caused a dragging and aching pain, but not so much as to require treatment, had it not been for his wish to enter the service. He had been twice operated on by ligature, without relief. Excision was performed in the usual way, but, unfortunately, he displaced the dressing the first night, and the wound suppurated; the inguinal glands inflamed but did not suppurate. He was discharged cured in five weeks.

CASE V.—F. P., aged 24, was admitted to the Infirmary, with the usual nervous symptoms, and neuralgic and dragging pains. Excision was performed, and he was discharged cured in a fortnight.

CASE VI.—J. W. R., aged 30, was operated on by me in April, 1884, for double varicocele, by subcutaneous ligature; this was followed by slight orchitis, which soon subsided. He returned in six months with the varicoceles quite as large as before operation. He had in the meantime been suffering from syphilitic orchitis. His discomfort necessitated something being done, hence I excised both varicoceles in October. The wounds healed kindly, and he had no pain; but the orchitis returned in the right side, and required specific treatment.

CASE VII.—J. H. was admitted to the Infirmary, suffering from left varicocele on August 18th. The operation was done on August 21st, and he was discharged cured September 7th, 1884.

CASE VIII.—J. W., aged 20, was admitted to the Infirmary on account of dragging and pain in the left side of the scrotum, due to a large varicocele, which was excised under eucalyptus-air on April 2nd, 1885. He was made an out-patient in twelve days.

CASE IX.—J. W., aged 32, was admitted into the Infirmary on January 1st for a large left varicocele, which caused a dragging pain, and prevented him from lifting. Excision was performed on January 9th, neither sutures nor drainage being employed. He was discharged cured in ten days.

CASE X.—A. W., aged 44, was admitted December 8th on account of severe left genito-crural pain, apparently dependent on a large left varicocele, which was excised on December 10th. The wound healed by first intention, and he was discharged in a fortnight.

The description of further cases would be tedious; but the foregoing will, I trust, serve to illustrate the safety and efficiency of complete excision, if done strictly antiseptically.

A NOTE ON SO-CALLED LEAD-NEURITIS.

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Surgeon to the Northumberland, Durham and Newcastle Infirmary for Diseases of the Eye.

DR. OLIVER'S very interesting and instructive clinical lecture on lead-poisoning leads me to make a few remarks upon the ocular symptoms in these cases.

It is upwards of fourteen years since this special form of neuritis was introduced to the profession, and perhaps it is time now that our knowledge upon the subject should be passed in review, and we should see whether the experience gathered during this period tends to confirm or weaken previous impressions as to the reality of the disease. When professional notice was first directed pointedly to its symptoms, I was professionally connected, and had been for some time, with one of the largest lead-works on the Tyne. The question interested me much at the time, and I made numerous observations and notes upon the cases that came under my care. Since then, I have had many opportunities of following up the subject; and I must own that I am somewhat sceptical as to the existence of any special form of neuro-retinitis which may be said to depend directly upon lead-poisoning.

That lead-poisoning was an occasional cause of blindness, was common knowledge to the profession years before the ophthalmoscope came into use; but I believe it is due to Mr. Jonathan Hutchinson that this special form of neuritis finds its place in the index of most of our text-books, although the information they give is of the most meagre and sketchy nature. Here I would point out how extremely ready the profession are to add new maladies to the already long list with which they are provided, especially if the new-comer have the benefit of being introduced to the world of disease by a man of position and repute. He is welcomed, and takes up his position often unchallenged. Other writers copy what has been previously written of him, and thus he is handed down from generation to generation. It so happened that, at the time Mr. Jonathan Hutchinson published his paper, in the seventh volume of the *Royal Ophthalmic Hospital Reports*, Dr. Clifford Allbutt had in preparation his work on the *Ophthalmoscope in Medicine*. He introduced Mr. Hutchinson's paper *verbatim* into this work, which attracted much attention, and had a very large circulation; and, since then, lead-neuritis and neuro-retinitis have acquired an established position.

Now, I think if lead-poisoning were capable of producing a special form of inflammation of the optic nerve and retina, we might reasonably expect to meet with cases of this kind in the out-patient department of our ophthalmic hospitals. We are here surrounded by numerous lead factories, and we not unfrequently see cases in which the effects of lead are manifest in the optic discs and papillæ of patients, as a secondary, but never as a primary or independent condition. We are never applied to by patients suffering from slight symptoms of lead-poisoning, who exhibit neuritis and neuro-retinitis which we could call of a specific kind. Ten or twelve years ago, I passed in review a large number of the hands, both male and female, engaged at the largest lead works here; and, although many exhibited the blue line, significant of saturnine poisoning, I found no case of neuritis or neuro-retinitis. Latterly, I have repeated this experiment upon a large number of female hands (who are most prone to suffer), and in no case could I discover either neuritis or neuro-retinitis.

But, if lead-poisoning is incapable of producing a specific neuro-retinitis, it frequently brings about conditions in which neuritis is common. The renal affection is, of course, well known; and, no doubt, in many of the cases, this is the cause of the neuro-retinitis, although the albuminuria may not be a permanent condition. Another condition, however, and one to which all ophthalmic surgeons would attribute considerable importance, is the suppression of the catamenia. Dr. Oliver, in his lecture, says nothing upon this question. Yet, as far as my experience goes, this is one of the first and most important symptoms of lead-poisoning in females, and it is one in which, quite independent of any specific action of lead, neuro-retinitis and papillitis are not uncommonly developed. Cases of papillitis, in females suffering from suppression and great irregularities of the menses, are coming much more frequently before our notice. The third condition, which, to my mind, plays the most important part in the development of papillitis in cases of lead-poisoning, and to which most of these cases are, to my mind, due, is the tendency to sudden effusion into the ventricles of the brain and subarachnoid space in case of lead-poisoning.

I have seen not a few cases in which the ophthalmoscopic sym-