MANCHESTER EYE HOSPITAL.

TOTAL ABSENCE OF THE IRIS IN BOTH EYES.

By A. SAMELSON, M.D., Surgeon to the Hospital.

R. L., of Bradwell, in Derbyshire, born before wedlock, unmarried, 38 years old, six feet high, of swarthy complexion, otherwise healthy, and rather stout, consecutively employed as labourer on farms, railroads, water-works, and as shepherd; was "always considered to have weak eyes, as the cold always flew to them," but could see to thread a needle, holding it as far as a foot distant from the eye, as well as "a sheep half a mile off on the hill side." There had been no marked sensitiveness to light. The patient, very intelligent for his station, had not been taught to read. His parents, brother, and sister, had never anything the matter with their eyes.

In September 1861, whilst almost always working in water, he got one day wet through, and could next morning see nothing but "same as ribs of fire over each eye, from temple to nose, all red." He put himself under medical treatment in February last, and was twice salivated. I saw him first in the month of July. A seton was then placed in his neck; and iodide of potassium ordered him for internal and external use. All this has been continued to the present time. The eyes, most restless before, have since become much more steady; the sun, as well as a flame, are now by the patient seen "in their natural colours," whilst previously they had appeared to him "like blood." The dizziness, formerly much complained of, has abated. The difficulties of ophthalmoscopic examination being also considerably lessened, the symptoms at present observable are as follow.

The eyes present a peculiarly dark aspect, and within the corneal area generally a deep slate colour. A gleam, as from a polished copper plate, is seen to issue from the right eye, especially when looked into from above or sideways; the reflexion from the left eye is of a paler hue. Linear greyish streaks of a fatty appearance appear along the upper margin of each cornea; the corneæ themselves are irregular in outline, acquiring a more elliptical shape with a transverse long diameter. No rudiment of the iris is visible. A milk-white dot of the size of a pin's-head, near the anterior as well as the posterior capsule, is centrally situated in the left lens, apparently higher in the right; and there are five or six equidistant curved striæ resembling the spokes of a wheel nearer the posterior surface in each lens; the rest also of the lenticular mass is not uniformly clear. The right lens is somewhat displaced, its inferior edge being fully three lines distant from and raised above the lower circumference of the cornea; whilst upwards the lens very closely approaches the cornea, and the top of the former is, as it were, hidden behind the limbus. The border of the lens being slightly jagged, this latter appears somewhat reduced in volume; the space for the aqueous humour is likewise diminished in size. Of the ciliary processes no trace can be detected by any method of examination. In the right eye, the optic nerve entrance is seen to be abnormally small, not quite regular in contour, of a chalky hue, frankly excavated; the vessels upon it are thin, scanty, bent over the edge, and almost limited to the outer portion of the disc (inverted image). The vessels and pigment of the choroid appear to be uniformly wasted. In the left eye, nothing can be discerned of the fundus, except occasionally the wavy glare of what resembles a bright fold of detached retina. The size and tension of the eyes are noways abnormal; the sensibility of the corneæ is perfect; no remarkable sclerotic injection is observable; the perception of light is moderate, the flame of an argand burner, raised one inch, being seen at twenty feet distance. There is still some nystagmus, with every now and then a more clonic rotatory jerk in either eye.

The patient states that there is "always a mist like

steam before him, same as if it made him drunk"; that he can see better for an hour in the morning; and that his left eye is by far the best of the two.

HULL GENERAL INFIRMARY.

CASES ILLUSTRATING THE TREATMENT OF JAUNDICE.

Reported by C. J. EVANS, Esq., House-Surgeon.

CASE I. *Organic Disease of the Liver, with Intercurrent Inflammatory Attacks.* W. B., aged 35, by occupation a groom, and of good constitution, was admitted under the care of Sir H. Cooper on January 16th, 1863, with symptoms of jaundice strongly marked. The conjunctive were of a bright yellow colour, the skin possessing rather more of a tawny hue; it was cool and moist, and the adipose tissue was scanty. The urine was dark coloured, like porter, containing a considerable amount of bile-pigment; when tested with sulphuric acid and sugar, scarcely any purple colour was produced. The stools were of a perfectly pipe-clay colour, and had been so for many weeks.

The symptoms had commenced about ten or twelve weeks before admission, and he had been under medical treatment. Immediately before the yellowness of the skin showed itself, he had fasted for some hours, and then had eaten a heavy meal. At the commencement, he had occasional vomiting, with a constant feeling of nausea, and this continued for about three weeks. He also complained, in the early stage, of general pains, not located in any particular part, accompanied with considerable itching of the skin, and this latter symptom existed in some degree at the time of admission. He had had no previous attacks of jaundice. He was ordered to take night and morning a pill containing one-third of a grain of podophyllin and two grains of extract of hops; and three drachms of compound decoction of aloes, with five drachms of camphor mixture, three times a day; and to have common diet.

Jan. 23rd. No improvement having taken place in any of the symptoms, the above treatment was discontinued, and the following prescribed instead:—Benzoic acid ʒss; camphor mixture ʒviij; an ounce to be taken three times a day.

Jan. 30th. Ten additional grains of benzoic acid were added to the mixture.

Feb. 1st. A relapse in the symptoms had now taken place. He complained of severe pain in the region of the liver; the yellow colour of the skin had become intensely bright, and the urine much darker, depositing abundant sediment. Six leeches were ordered to be applied to the region of the liver, and a calomel and antimony pill to be taken three times a day. The benzoic acid mixture was ordered to be omitted. Much relief followed the application of the leeches.

Feb. 7th. Rather more pain was complained of, and six leeches were again applied, and followed in a similar manner by marked relief. The leech-bites bled very freely, and required continued pressure with the fingers to stop the flow. He had no rigors. Considerable improvement was manifest also in the general symptoms about this time. The bright colour of the skin faded to a great degree; the stools became browner; and the urine assumed an almost natural colour. He was ordered to take an ounce of nitrate of potass mixture three times a day; and ten grains of Dover's powder at bedtime.

Feb. 11th. The gums were rather sore; and the calomel and antimony pill was ordered to be taken at night only. He appeared to be progressing favourably, though slowly; and was ordered to take, on the 19th, infusion of quassia with nitromuriatic acid every four hours.

Feb. 21st. Severe pain was again complained of in