paralysis of a special nerve (right third), from which he has recovered.

Now, although syphilitic deafness from cerebral disease is very rare in the acquired form of the disease, it is far from being so in that which is inherited. In my little work on *Syphilitic Diseases of the Eye and Ear*, I have described a form of deafness almost the exact counterpart of that from which our present patient has suffered; and ending, as in him, after a short course, in utter extinction of the special sense. Of this I have adduced numerous instances; but all were in the subjects of inherited syphilis. I had not then seen a single well-marked example in acquired syphilis. A similar remark may be made in reference to cerebral amaurosis, which we not very unfrequently meet with in the subjects of inherited disease, but only rarely in those who have acquired the taint *de novo*.

It may, perhaps, not be without its interest, if I read to you the notes of the last case I have seen of syphilitic cerebral amaurosis. It was one of the best marked that I have ever had an opportunity of investigating. You will notice some points of close analogy between what we may designate syphilitic cerebral deafness and syphilitic cerebral blindness. In both the progress is rapid and usually symmetrical, and in both the extinction of function is mostly complete. In both, a few other slight cerebral symptoms are usually present, such as ringing in the ears, giddiness, etc.; and in both, there is a remarkable absence of any symptoms referable to the external organ of the special sense. Let me add, that both are most intractable under treatment. You will notice that each of our patients had been salivated, the one for impending blindness due to inherited syphilis, the other for impending deafness due to acquired syphilis; and in neither did this measure retard the course of the disease. I have witnessed a similar failure in many other cases; cases, too, in which there was no doubt whatever as to the diagnosis. Iodide of potassium, in these affections, is a far more reliable remedy than is mercury.

PROFESSIONAL INDISCRETION. Owing to the appearance of a most injudicious and ill-advised paragraph in the *Kentish Gazette*, an inquest was held on the body of Thomas Bedwell, a labourer, living at St. Dunstan's, who died somewhat suddenly, while under the care of Mr. Rigden. It appears that the poor man was subject to epileptic fits, for which Mr. Rigden treated him. He had seen the man on Sunday morning, and sent him some medicine. In the afternoon he became worse; and, Mr. Rigden being away from home, Mr. A. B. Andrews was called in. From some utterly inexplicable cause, this gentleman thought fit to hand over the medicine supplied by Mr. Rigden to the care of the police; and hence arose a rumour to which our cotemporary, with a most reprehensible want of caution, gave circulation that Mr. Rigden had administered to the patient opium in such a manner as to cause his death. At an inquest held to clear up the affair, it was shown that the rumours were completely groundless. Mr. Andrews himself stated at the inquest that the deceased had "had three epileptic fits in his presence, which fits were the cause of his death." The coroner said, that but for the paragraph in the newspaper no inquest would have been necessary. The evidence was very plain, and Mr. Rigden was entirely clear of all blame. (*Kent Paper*.)

Illustrations OF HOSPITAL PRACTICE: METROPOLITAN AND PROVINCIAL.

ST. MARY'S HOSPITAL.

CLINICAL REPORTS ON THE PAPULAR DISEASES OF
THE SKIN.

By GEORGE NAYLER, F.R.C.S., Assistant-Surgeon to
the Royal Orthopædic Hospital; Pathological
Curator of the Museum of St. Mary's
Medical School.

[Continued from page 583 of last volume.]

LICHEN PILARIS, so called from its involving the hairs which pierce the papules in their centre, is a rare variety. The hair-follicle becomes filled with epithelium and its debris; and a number of small acuminate papule are observed in place of the papillæ, having each on its apex a single hair. It is chiefly developed on those parts which are covered with soft fine hair, as the neck or chest. I had the opportunity of seeing, some months ago, a remarkable instance of this kind among the out-patients in Mr. Startin's practice, in a boy, where the disease was mostly seen on the back of the neck, and appeared not unlike the small rough eminences on the surface of an echinus. In this case, the loins and shoulders were also covered with lichen in its ordinary form.

Lichen lividus, like the preceding, is also uncommon. Mr. Startin has noticed its occurrence about once in 1800 cases; and Rayer relates having only seen it twice. It is almost always united with broken-down or feeble health, and is generally seated on the extremities. The spots are of a purple colour, intermingled with petechiæ.

J. G. (No. 99,449), aged 52 years, applied for relief, on October 13th, 1862, at the Skin Hospital, with the eruption chiefly seen on the inner side of the legs. It was like a number of purple dots, each of an average diameter of a pea; some were distinct, others more or less fused. To the hand, the surface appeared slightly raised. He was in delicate health, and complained of the least exertion being attended with fatigue. When in bed, the spots assumed a brighter colour, and occasioned some degree of irritation. For several years, he had been subject to rheumatism. He was ordered to take a mixture of steel with colchicum twice a day, and to sponge the parts with a mixture of nitric acid lotion and red lotion (two ounces of each, with eight ounces of water). (The first of these contains half a drachm of dilute nitric acid to an ounce of water; and the second, two grains of the bichloride and one of the bisulphuret of mercury to an ounce of water.) He rapidly improved under this treatment; and on the 1st of November he was nearly well. Anxious to know how he was getting on, I heard from him some months afterwards, when he informed me that he since had another slight attack, from getting wet through. He then took the same remedies, and soon recovered.

Lichen circumscriptus is the name given to the disease when it forms a circumscribed patch, having a defined border, or is represented by several small patches. It is not unfrequent on the hands, or the popliteal space, or the nape of the neck. Its colour is of a dark red. In some instances, it is prolonged

for years by the outbreak of fresh patches, which, like those of lepra, enlarge at the expense of their circumference, and decline at their centre. As an example of its truly chronic nature, I may quote the case of C. B., a tailor, aged 60, in whom the disease had existed as a patch on the back of neck, and of the size of the palm of the hand, for twelve years. The papules were large, closely aggregated, and in colour of a purplish red. It caused much irritation, if he became heated. On April 3rd, 1862, he was ordered to take the tenth of a grain of bichloride of mercury, and the fortieth of a grain of arsenious acid twice a day; and to apply at night an ointment containing six minims of creasote, half a drachm of mercurial ointment, ten grains of levigated nitric oxide of mercury, and an ounce of cerate. April 17th. He was much better; only a few spots were left, and those of a lighter colour. May 22nd. He was nearly cured. June 22nd. He returned a letter of thanks to the hospital.

Syphilitic lichen is of frequent occurrence. The disease is recognised by the coppery colour of the papules; the small amount of pain by which it is commonly attended; its tendency to become tubercular; and, lastly, by its seat, which, in addition to other parts, will generally appear on the forehead, and not seldom on the soles of the feet. The tongue also is sometimes fissured; and what may commonly be seen, characteristic of syphilitic lichen, are a number of small superficial pits or cicatrices, in most cases on the face only, the result of ulcerations following the eruption, and not unlike those produced by variola. Syphilitic lichen, like other skin affections of this class, has no special characters; and the eruptions that succeed to, or are dependent upon, syphilis, as Dr. Jenner has observed, always deviate from the original disease in its true type, whatever it may be.

Treatment. The treatment of simple lichen may be summed up in a few words. The same will also apply to tropical or any less severe kind of lichen. It consists in proper attention to the bowels, and in the avoidance of any exciting cause. In early life, it is too often the practice of the mother to cram the child with milk or indigestible food, or to overload it with clothes. Flannel will sometimes irritate the skin, and so even will soap; or the child may be insufficiently dried after washing. I need not enter into further detail, or suggest the obvious mode of dealing with these cases. As far as the medical treatment is concerned, it will be enough to administer a few grains of rhubarb and soda in the first instance, followed afterwards by a light tonic. When lichen occurs in the acute stage, the use of purgatives should not be neglected; as the *mistura magnesiae cum colchico* of the *Pharmacopœia*, to which antimony may be added; and, as an external application, either goulard lotion, or one holding in weak solution creasote and the bichloride of mercury, one grain of the latter to an ounce of water. The *lotio carbonis* is also of considerable benefit in these cases. After the irritation has subsided, or in chronic lichen, as *lichen agrius*, small doses of mercury should be given; and, indeed, in the greater number of papular complaints, this mineral will generally be required, the amount not exceeding one-sixth of a grain of the biniodide, or the eighth of that of the bichloride. Before going to bed, some mercurial ointment should be rubbed into the affected surface. That in use at the hospital is the *unguentum rubrum*, or the compound mercurial ointment. In the *lichen urticatus* of children, the same means may be adopted, regard being had to the age. Thus, to a patient of three years old, the carbon lotion should be diluted with an equal amount of water, and the mercury diminished by two-thirds for

a dose. Where the eruption is confined to a few spots, or takes place in a weakly subject, quinine or iron may be prescribed with advantage; the local treatment remaining the same. The tincture of aconite, in certain cases, is highly spoken of by Néligan; and, as a local measure, the same author recommends conium, given thus: one drachm of succus conii, half a drachm of glycerine, and five grains of soda, to an ounce of water. Baths are highly serviceable in the papular eruptions; they lessen the irritability so frequent in this class of diseases. The patient should, however, be warned not to take one of too high a temperature; indeed, in all cases a tepid bath is to be preferred at the commencement; and, as he becomes accustomed to its use, he may remain in it for a longer period. If the irritation be very great, and in the later stages of the disease, where the skin is still rough and dry, a starch or gelatinous bath will be attended with considerable comfort. An alkaline bath is occasionally beneficial; and, in confirmed cases, the sulphur springs of St. Sauveur, Louesche, or Aix-la-Chapelle, may be tried.

I have now to draw attention to the two varieties of lichen specially mentioned by Hebra, and described by him with much precision and minuteness. The first, or lichen *scrofulosus*, is a constant companion of caries, lupus, and tuberculosis. It is characterised by pimples of the size of ordinary lichen, and of the same colour as the epidermis, or pale yellow, or brownish red. Some degree of desquamation is often met with in this variety, which, as it is unaccompanied by pruritus, does not, therefore, show those little scabs of dry blood produced by excoriation. The papules, in short, remain unaltered. Unlike any other species of lichen, this variety is mostly seen on the trunk, abdomen, breast, and loins, and seldom on the extremities. In progress, it is very slow, and generally remains unheeded by the patient until the disease reaches the limbs or the face, or unless other symptoms occur in the papules, as their attaining the size of a lentil, and assuming a bluish red colour; or containing, like acne, a small quantity of pus; or drying up, leaving a circular dark stain. The skin between the papules is generally scurfy, or covered with incipient scabs like bran, and dull-looking.

The disease is always connected with enlargement of the lymphatic glands. Hebra further states it to be peculiar to the male sex. Not one instance does he record of its affecting the female; nor, in so far as his observations extend, is the complaint influenced by season or occupation.

Still more remarkable in its symptoms, progress, and termination, is lichen *ruber*, noticed, I believe, by Hebra alone, and distinguished by the dark red colour of its papules, whence the name. Observing throughout their course the usual size, the papules are at first scattered or separated, and covered with small thin scales, which cause slight itching, but not such as to lead to excoriation or scabbing. The intervals left unoccupied by the former pimples are soon dotted with a new group; and, as these become more thickly sown, large red plots are seen covered, as I have just said, with numerous fine scales. The movements of the muscles become considerably impeded; those in particular of the hands and feet. The fingers are kept in a semiflexed position, and present painful cracks. The nails of these, as well as of the toes, also suffer. They are thickened, do not reach their usual length, and are apt to break. In colour, they approach a yellowish brown. The course of lichen *ruber* is from bad to worse in the greater number of instances. As the disease advances, which it generally does, the patient becomes emaciated, and at length falls into a state of marasmus, and sinks.

Fourteen cases form the entire number mentioned by Hebra, of which one occurred in a woman; and in one instance only was the disease arrested in its course. In the treatment of scrofulous lichen, which appears between the ages of fifteen and twenty-five years, cod-liver has proved an excellent agent, and the only one in Hebra's hands. It is given, however, in half-ounce doses twice a day, a less quantity proving of no benefit. He also advises its external application, and directs the patient in the meantime to wear flannel or woollen clothes. For the relief of the other, or red lichen, Hebra places the most reliance on arsenic. The reader is referred, for further information, to Hebra's article in Virchow's *Handbuch der Speciellen Pathologie und Therapie*, Bd. iii, Lief 2.

[To be continued.]

Original Communications.

PRACTICAL REMARKS ON THE TREATMENT OF CONGENITAL CATARACT.

By GEORGE LAWSON, Esq., Assistant-Surgeon to the Royal London Ophthalmic and the Middlesex Hospitals.

[Concluded from page 33.]

As a rule, no urgent symptoms follow the first stage of the operation of linear extraction. Frequently, some little irritation exists for a few days; but oftentimes the eye continues so quiet, that one can hardly imagine that any operation has been performed. Still, on the other hand, grave symptoms occasionally arise, and require to be actively dealt with; for an eye with a congenital cataract is usually below the standard of strength, and succumbs quickly to sharp inflammatory action.

Supposing the operation to have been well conducted, and the case apparently a good one, the great cause of untoward symptoms arising, is pressure of the swollen lens itself, or of some of its particles on the posterior surface of the iris. Large pieces of lens matter may float freely in the anterior chamber—may even apparently almost fill it—and fragments may lie on the anterior surface of the iris, without producing any unpleasant symptoms, but the pressure of a portion on the posterior surface may act as such an irritant, as to kindle an amount of inflammatory action sufficient to destroy the eye.

To avoid, as far as possible, the chance of such a contingency, the pupil should be kept widely dilated with atropine, so that the particles of lens matter as they swell and detach themselves from within the capsule, may float through the widely dilated pupil into the anterior chamber. Sometimes, although the capsule has been freely broken on its anterior surface, yet the matter within has not been sufficiently comminuted, so that the lens, swollen by the action of the aqueous on its substance, and unable to discharge itself by fragments into the anterior chamber, presses by its entire surface on the posterior or uveal surface of the iris, and so becomes the source of great irritation. The reverse of this may, however, take place. The lenticular matter may have been freely broken up, but the aperture in the lens capsule may not have been made sufficiently large to allow of the ready escape of the particles after they have become swollen from the action of the aqueous on them, and so the enlarged lens presses on the back of the iris.

The symptoms which would be present would be those of great irritation; severe neuralgia over the

brow, around the orbit and in the eye itself, with a considerable amount of photophobia; the eye more red than normal, and the ciliary zone manifest; the aqueous muddy, and the pupil at first sluggish, then quite inactive and incapable of being dilated with atropine. Such symptoms as these call for immediate treatment. If they commence a few hours after the operation, or on the following day, it will be well to apply one or two leeches to the temple, and repeat one night and morning for two or three times. This local abstraction of blood often affords a most speedy relief, and at once arrests all excessive action. Act freely on the bowels with some moderate purgative, and keep the eye cool with a piece of linen moistened with cold water applied over it, and let the room in which the patient resides be darkened.

If no abatement follows the treatment, and the symptoms of irritation continue, the cause is very probably the swollen lens pressing on the iris, and it is advisable to get rid of this source of irritation by removing it, or as much of it as possible, and at once to perform the second part of the operation of linear extraction.

The second stage of linear extraction consists in removing the broken-down lens through a small linear opening in the cornea. Before it is attempted, if all has gone well, and nothing has happened since the first operation to necessitate its immediate performance, sufficient time should be allowed to elapse to allow all the transparent portion of the lens to become opaque and somewhat macerated by the aqueous. From three to six days will be about the time required for the desired changes to take place, but much depends on the condition of the cataract at the time of the operation, and upon the extent to which the capsule has been torn and the lenticular matter broken up. This stage of the operation requires great caution.

1. As to the part at which the broad needle should be introduced, and the mode in which the opening should be made in the cornea.

2. In allowing the lens, which is now diffuent, to run off on a curette, taking care not to bruise or in any way to injure the iris, or the posterior layer of the lens capsule.

The patient lying on his back with the face to the light, the eye is to be kept open with a spring speculum, and steadied by being held by the operator with a pair of forceps. The broad needle is used in his right hand for the right eye, and in his left hand for the left eye, to make the linear opening in the cornea. The outer portion of the cornea is the most convenient, and the part usually selected in each eye for this operation.

1. With reference to the opening to be made in the cornea. The pupil being widely dilated with atropine, the needle should be made to perforate the cornea at the point just external to where the pupillary margin of the iris is seen, and instead of penetrating it directly from before backwards it should be made, as Mr. Bowman has suggested, to pass obliquely inwards through the lamellæ of the cornea, and then by a slight cutting motion in its withdrawal, to enlarge the opening to its necessary length. The aperture thus made will be valve shaped, the external opening in the cornea being nearer to the circumferential margin than the internal, the object being, that the curette in and after its introduction, shall not press at all upon the iris, but in making the many movements which are required, shall rest solely on the inner lip of the valve-shaped orifice in the cornea. Frequently before withdrawing the broad needle it may be well to dip it towards the lens, and break up more completely any large fragments which may remain. Another advantage in thus making the opening well within the margin of the cornea is, that