AN INTERESTING CASE OF CONGENITAL CATARACT.

By CHARLES KILLICK, M.A., M.D., F.R.C.S.,
HONORARY SURGEON, KENT COUNTY OPHTHALMIC HOSPITAL.

MISS H., aged 36, was first brought to the Kent County Ophthalmic Hospital on October 23rd, 1909, not on her own initiative, as she regarded her case as hopeless, but by one of my old cataract patients, who had recently undergone a successful operation, and naturally took an interest in the afflicted woman.

Previous History.

The patient's father was born blind, and was operated upon as a baby by the late Mr. Woolcott at the Kent County Ophthalmic Hospital. She has a brother, aged 34, who was operated upon at the Moorfields Hospital when 3 years old for cataract. Another brother and three sisters, who are all younger than herself, are stated to have nothing wrong with their eyes. She herself was born blind, and when 3 months old was brought to the Maidstone Hospital where the left eye was operated upon by Mr. Adams, unfortunately without success, and no further steps were taken until she was between 4 and 5 years old, when she and her brother were taken to Moorfields Hospital and operated upon several times by the late Mr. George Critchett. She cannot remember seeing as a result of these operations, a statement which is corroborated by a lady fully acquainted with her past history, but nevertheless somewhat difficult to reconcile with a note upon the old Moorfields paper, dated August 20th, 1877, where it is expressly stated that all details of the right fundus could be clearly seen. The lady in question subsequently took her on several occasions to see Mr. Critchett privately, but the latter never prescribed glasses—saying that it would be useless to do so. Apparently the only benefit which the patient received consisted in the fact that she was thenceforth able to distinguish between certain colours, especially if bright; for example, she could, in certain lights, make out that grass was green, and could also tell when she was wearing a red dress.

When 9 years old she was admitted into the School for the Indigent Blind, Southwark, and remained there till 1901—that is, for nineteen years altogether. When 12 years old she suffered from a severe inflammation of the right eye, with the result that it became worse, and she has remained ever since in her present helpless condition. While in the institution she was taught how to use her hands and to find her way about unassisted in places with which she was familiar, her knowledge of the outside world being limited to what she was able to perceive by touch and sound. From 1901 up to the present time she has lived at home in Maidstone, helping her mother as much as she is able by knitting, and has sought no further advice about her eyes.

Condition when first Seen.

Examination of the eyes showed that they were habitually directed downwards, exhibited slow lateral nystagmus, and were so covered by the upper lids that only about half to two-thirds of the corneae were left exposed. The left eye was hopelessly disorganized, totally blind, and in an advanced condition of phthisis bulbi. The right eye, on the other hand, though appearing somewhat sunken and smaller than normal, the cornea only measuring about a centimetre in diameter, was much more hopeful in appearance. The cornea was transparent over its whole extent, except at one spot near the outer margin, where the scar of a needle puncture was visible; the anterior chamber was of average depth, and the iris appeared healthy, but was so drawn upwards, as a result of some previous operation, that not a trace of a pupil could be seen. The tension of the eyeball was T—?. Vision amounted to perception of light, but I found on trying the projection of light test in the dark room that the retina was perfectly sensitive and functional throughout its entire extent.

Operation.

Further examination having convinced me that an iridotomy could be done, and feeling that it would probably be of benefit to the patient, I accordingly advised her to consent to operation.

The operation was performed on October 29th, 1909, under adrenalin and cocaine. A small incision having been made with a keratome at the upper corneal margin, a pair of de Wecker's scissors were introduced, and iridotomy was easily performed; the iris immediately gaped, and a second incision, so as to complete the A-shaped section, was thus rendered unnecessary; there was no loss of vitreous. Both eyes were then bandaged, and the patient remained in bed for three days. No inflammation followed, and there was hardly a trace of redness throughout. On October 31st the case-book records that "the patient says she can see to get about. She was discharged from hospital on November 8th.

Present Condition of the Eye.

Careful examination of the eye on December 4th, 1909, reveals the following state of affairs: An elongated oval slit,

about $\frac{1}{2}$ cm. in length and about 2 mm. across at its widest part, traverses the iris in a downward and slightly inward direction, a little to the inner side of its centre.

Diagram of cornea magnified two times.
1, Needle puncture;
2, remains of clot;
3, remains of capsule;
4, iris.

(See diagram.) If the eye is examined by oblique focal illumination, a small blood clot is noticed in the centre of the aperture, while above and below this the space is partially occupied by fragments of lens capsule. Through the upper part of the opening, which is, however, habitually covered by the upper lid, a dim reflex is obtained, but no fundus details can be made out; vision, however, is not improved if the patient raises the lid with the fingers. As a +11 D. lens enabled the patient to see large objects a little better, it was prescribed for constant wear.

The increase of vision, then, to the patient, if measured by the ordinary standard of sight testing, does not appear to be very great; she is enabled to find her way about alone, to perceive objects dimly, to distinguish colours, and to count fingers with hesitation, but from her own point of view the gain is very great, and she says that her sight is better now than it has ever been in her life. Whether, later on, the blood clot will be absorbed by natural processes only time will show; but probably a further operation for tearing the capsule, to be undertaken at some future time—perhaps in six months—would, if successful, result in a still more definite improvement in visual power.

A CASE OF ANEURYSM IN A WOMAN.

By

H. G. FREAN, M.B., B.C.CAMB., M.R.C.S., L.R.C.P.,

With a Pathological Note by Dr. GIBSON.

THE following case, presenting some difficulties in diagnosis, and also some interesting points in the course of the disease, seems worth reporting.

Mrs. C., aged 65, was a gaunt, almost emaciated looking woman, accustomed all her life to the usual hard work of the poorer classes. She could not remember ever having a day's illness; she had brought up a large and apparently healthy family, and had had no miscarriages or stillbirths.

In August, 1908, I attended her for severe paroxysms of pain in the left side of the chest, which came on at irregular times of the day or night independent of any apparent cause. They were severe enough to make her cry out, and lasted "a minute or two." After about a fortnight they ceased, and she never had a recurrence. The condition of the alimentary and nervous systems calls for no comment.

I found the following physical signs when I first saw her: Pulses equal, small, irregular, and averaging 80. The arterial wall was not thick nor the course of the artery tortuous. Respirations quiet and usually 20. The apex beat was in its normal place. The chest wall seemed slightly fuller on the right side than the left. The sternum and front of the chest were visibly thrust forward at each beat of the heart. Pulsation was visible in the first four spaces on the right side for $2\frac{1}{2}$ in. from the mid-sternal line. This pulsating area was dull to percussion, and merged directly into the liver dullness below. The lower margin of the liver was 2 in. below the costal margin, and was strongly thrust down by each heart beat. On auscultation at the apex both sounds were clearly heard. Over the pulsating area the first sound was continued as a short soft bruit; the second sound was sharp and clear. The air entry seemed little better at the right than the left apex. Other extrinsic signs of aneurysm, such as unequal pupils, tracheal tugging, etc., were all absent.

At the end of December, 1908, I noticed visible pulsation in the intercostal spaces between the spine and the vertebral border of the left scapula. The spaces were absolutely dull to percussion, and on auscultation a faint systolic bruit was heard. The pulsation increased in force during the next month, and then slowly diminished. By the end of April the pulsation and the systolic bruit in this position had quite disappeared, and only the dullness to percussion remained. The other physical signs remained as when I first saw her. In May she began to suffer attacks of dyspnoea, and spent most of her time lying curled up on her left side. She died quietly on June 19th, 1909.

PATHOLOGICAL REPORT BY DR. GIBSON.

The body was that of an emaciated woman. There were adhesions in the right and left pleural cavities. The heart showed one milk spot posteriorly. There was slight hypertrophy of the left ventricle, but no other change in the cavities, valves, or walls of the heart. At the base of the aorta was a large patch of atheroma, swollen, soft, and whitish, but showing no parallel ridges. The coronary arteries showed patchy atheromatous change. The first part of the aorta was enormously dilated; the rest of the course of the thoracic aorta to about 2 in. above the diaphragmatic opening formed a huge

aneurysmal sac having compressed the left lung in front of it, and become attached thereto. The greater part of the cavity of the aneurysm was filled with laminated clot. The blood channel penetrated the clot posteriorly, and where the descending aorta began the degenerated wall formed the posterior boundary of the channel. No part of the thoracic aorta except the ascending part was normal to the naked eye. The lung was firmly bound to the wall of the aneurysm, and showed numerous scattered patches of grape-like tubercles. The liver on cross section presented numerous white, firm, opaque, triangular masses not larger than 3 or 4 mm. across, embedded in the upper part of the organ. They came into relation with the capsule, but this was not thickened. The kidneys showed very early sclerotic change. In the left was a small cyst the size of a pea containing a jelly-like substance. The suprarenals were normal. No abnormal change was detected in the pancreas or bowels.

Microscopically the aorta was in an advanced state of mes-aortitis; in parts there was little of the normal tissue left, and very little of the elastic tissue. The masses in the liver were granulomatous. They were all connected with Glisson's capsule. Many showed an increase of small bile ducts, and some of these presented advanced catarrh. The whole substance of these areas was permeated with round cells, epithelioid cells, and connective tissue cells in various proportions. Necrotic patches were seen in nearly every one of the areas. In parts there were many new blood vessels. No micro-organisms could be detected by the ordinary methods of staining, and no tubercle bacilli could be found after a careful search. The rest of the liver tissue was very hyperaemic in parts, and showed much increase in intracellular connective tissue. The arteries occasionally had thickened walls, but there was no marked change in the direction of endarteritis obliterans.

The case presents many interesting features besides the uncertainty of accurate diagnosis. Statistics show that aneurysm in women, as compared to men, is about in the

A, Diminished breath sounds; B, dullness, pulsation, soft systolic murmur in December, dullness only in April; C, nipple; D, apex beat; E, pulsation, dullness, soft systolic murmur, ringing second sound; F, transmitted pulsation. The shaded area shows absolute dullness.

proportion of 1 to 10, though a good many practitioners answering offhand would put down the proportion very much smaller.

The absence of a clinical history of syphilis, as compared with the *post-mortem* findings, is perhaps now common enough.

It is surprising, however, that with such a large tumour none of the usual pressure signs or so-called extrinsic signs of aneurysm could be obtained. It is difficult to understand how a tumour that reached from the front of the thorax on the right side to the back of the thorax on the left side, did not yet appear to interfere with, for instance, the oesophagus and the act of deglutition.

A point of great interest is that we were able to watch the growth of the aneurysmal sac and also its healing. I think it not unfair to assume that the few isolated attacks of pain in August, 1908, marked the time when the main dilatation began to bulge back into the left lung. If so, we can allow about three and a half months for this dilatation to reach the back wall, and another three and a half months before it was finally filled up with clot. In addition we must remember that the wall of the aneurysm was composed of degenerated and thickened aortic tissue. I do not know what information there is on the time taken for arterial walls to hypertrophy, and for an aneurysm to grow a certain size, or for a laminated clot to be formed.

It was further of interest that the apex beat was not displaced, and that, in spite of the enormous size of the aorta, even in its ascending portion, there was no regurgitant murmur at the aortic orifice, but, on the contrary, a sharp clear second sound.

SEVERE ANTE-PARTUM HAEMORRHAGE DUE TO SPONTANEOUS RUPTURE OF VAGINAL VARIX.

BY

C. E. PURSLOW, and GUY J. BRANSON,
M.D., M.R.C.P., B.A., M.D. LOND.

THE case appears to be worthy of record, in view of the prominence given by all writers to placenta praevia and accidental haemorrhage as being practically the only forms of haemorrhage occurring spontaneously in the later months of pregnancy. In all the authors consulted, the only possibilities really entertained appear to be these two.

Mrs. J., aged 27, was in the thirty-second week of her first pregnancy, which had been quite normal in every respect up to November 15th, 1909. On that morning, when she first got out of bed, she was seized with profuse haemorrhage from the vagina, and very soon fainted. Dr. Branson was sent for, and on his arrival found her greatly collapsed, exsanguine, and with an almost imperceptible pulse; a chamber utensil half filled with firm blood clot was produced, as representing a portion of the blood lost. The os was found high up, and quite closed; there was a vertex presentation, but the head was free above the pelvic brim, and there was no evidence of labour; the haemorrhage had ceased.

Dr. Purslow was called to see the case in consultation, and found the patient as above described, though she had rallied slightly, and had a perceptible, though very feeble, pulse; the bleeding had not recurred.

Placenta praevia was diagnosed, and, as the patient could not obtain adequate nursing at home and lived some distance from Dr. Branson's house, it was decided that it would be advisable to remove her to hospital. The vagina was firmly plugged and the patient removed on an ambulance to the Queen's Hospital, where she was admitted under the care of Dr. Purslow.

The vaginal plug was removed next day and the bleeding almost immediately recommenced. A Sims's speculum was then passed and the vagina well cleansed with swabs preparatory to further treatment. On making an inspection, the blood could be seen coming in a profuse and steady stream from the vaginal wall at a point about 1½ in. above the urethral orifice and slightly to the left of the middle line.

The patient was at once taken to the operating theatre, anaesthetized, and placed in the lithotomy position. On making a careful examination of the vagina, the bleeding spot was seen to be a hole in a localized varicosity of a vein. This opening was seized with catch forceps and the varicose portion of the vein drawn away from the vaginal wall; an incision through the mucous membrane was made around it, and the varicose portion with one or two adjoining veins, which appeared to form a small plexus, was ligatured and excised.

The tissue removed was hardened, and on section showed distinctly the varicose enlargement of the vein, with marked thinning of the wall around the site of the rupture.

There was no further haemorrhage and the patient went on well, except that there was troublesome retention of urine, requiring the catheter, during the greater part of her stay in hospital. She went home on November 25th and was again under the care of Dr. Branson; her progress was uneventful and there was no further sign of haemorrhage. She was delivered on December 15th of a macerated fetus and made a normal recovery.

From the time of the haemorrhage she never felt any fetal movements nor could movements or fetal heart sounds be detected either during or after her stay in hospital.

It is worthy of note that careful examination failed to disclose varicosity of veins in the vulva or legs, or in any other part of the body.

The main point of interest in the case is its extreme rarity; reference to a large number of textbooks shows that they practically all mention a varicose condition of the veins of the vulva as a possible source of serious bleeding, especially in connexion with traumatism—for example, a kick; they also mention the occurrence of vaginal haematoma or thrombus from rupture of a vein in the vaginal wall during the second stage of labour and subsequent extravasation into the tissues; but the possibility of serious haemorrhage from rupture of a vein in the vaginal wall during pregnancy is not referred to; one exception is Hirst's *Textbook of Obstetrics*, where on p. 217 it is stated:

Varices of the vagina may be dangerous if the veins are large and their walls thin. The part should be guarded from traumatism, which might result in rupture of the distended veins, and an alarming, if not a fatal, haemorrhage.

There appeared to be no traumatism in the case recorded above. The question of coitus was inquired into, and it was ascertained that the last act had taken place one week previously.