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THE VALUE OF MERCURY IN OPHTHALMIC PRACTICE.¹

By A. EMRYS-JONES, M.D.,

SURGEON TO THE ROYAL EYE HOSPITAL, MANCHESTER; OPHTHALMIC SURGEON TO THE BOLTON INFIRMARY.

It will be my aim in this paper to lay before you the result of my own clinical observation during the past twelve years at the Eye Hospital, at the ophthalmic department of the Bolton Infirmary, and also in private practice. As it is to be a *resumé* of personal experience, I shall not burden you with references to the opinions of others, but shall content myself with the selection of typical examples of the various affections of the eye in which I have found mercury of decided value. I must explain that it is to the *constitutional* effects of mercury that I refer, and therefore I shall not enter into details as to the value of mercurial preparations, like the red oxide, the yellow oxide, calomel, etc., in the treatment of blepharitis, phlyctenular conjunctivitis, and keratitis; nor to the antiseptic value of highly diluted solutions of the perchloride.

The topical, rather than the chronological, order will be observed. The first case that I shall therefore refer to is a case of—

Primary Chancre of Eyelid.—Thomas A——, æt. twenty-two, attended the Eye Hospital on the 4th March, 1882. For the past six weeks he has suffered from a hard chancre on his penis, and also from what he described as a little inflammation of the right lower eyelid, which gradually got harder and more swollen. On examination, I found a considerable area of the lower lid punched out with its edges very hard and brawny, injection of the conjunctival sac, and swelling of the præ-auricular gland on the same side. Under the influence of mercurial ointment and the application of black wash externally, the condition of the eyelid became quite normal. He was then advised to continue under medical observation. This brief history

¹ Paper read before the Clinical Society of Manchester, February 21st, 1888.

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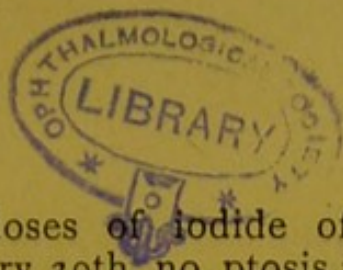
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well represents the course of this, by no means, common affection. My colleague, Dr. Mules, has at present (Feb., 1888) a very peculiar example under his care at the Eye Hospital, which he was good enough to draw my attention to. A boy of seven was brought by his mother for what she considered an inflammation in the right eyelid. On examination, it turned out to be a well-marked primary chancre, accompanied by great swelling of the præ-auricular and sub-maxillary glands. He was at once put under mercury (inunction) with the very best results. It was impossible in this case to obtain any history as to how the disease had been contracted, but the necessity of accurate diagnosis will be apparent to all of you.

The next group of cases I shall refer to, is paralytic affection of the third nerve—

Paralysis of Third Nerve—Ptosis.—Sarah M——, æt. thirty-three, attended at the Eye Hospital, November 17th, 1883. There was history of syphilis communicated by her husband two years ago, and of continued ill-health, and, lately, great giddiness. At this date, well-marked ptosis in right eyelid, pupil sluggish to light, active to accommodation, movements of muscles inwards, upwards, and downwards much diminished. Ordered mercury in five-grain pills taken up to slight salivation.—December 21st, ptosis completely disappeared, and all the ocular movements normal. She afterwards took iodide of potassium, and has had no relapse.

Ptosis and Paralysis of Third Nerve.—Mary Yates, æt. three years, admitted to the Bolton Infirmary, December 22nd, 1885. Her mother said that seven weeks ago she noticed almost complete drooping of the *left* eyelid, and about a week later of the *right* eyelid. She could give no history of the cause, but said it was possible the child had been exposed to draughts. At that date we noticed there was ptosis of both eyelids. In the *left eye*, complete paralysis of internal and inferior recti muscles. In the *right eye*, paralysis of superior and inferior recti muscles. No dilatation of the pupils; vision normal in both eyes; urine, sp. gr., 1020, no phosphates, no albumen. The child was admitted as an in-patient, and mercurial inunction was resorted to.—On the 30th, she was fully under the influence of mercury, and inunction stopped. Already the ptosis was less marked, and the action of the paralysed



recti restored slightly. Half-grain doses of iodide of potassium thrice daily ordered.—January 20th, no ptosis; ocular movements perfect; and the eyes, in every respect, normal. The rapidity with which the child was affected by mercury is explained by the fact that she had been taking it in small doses before she was put under my care. I could detect no symptoms indicating a central lesion in this case, but it affords an instructive example of the value of the drug in such cases.

I have not met with typical examples of *gummatous growths in the orbit*, causing exophthalmos, etc., but a recent case under the care of Dr. Mules, which he has kindly permitted me to mention, will answer my purpose very well. The patient was a middle-aged woman, with a large solid growth, pushing the eye downwards and slightly outwards, and with very obscure history. Dr. Mules, one day, was almost tempted to make an exploratory incision, but before doing so he determined to try mercury, and after giving it for some weeks without producing very marked effects on the growth, iodide of potassium was substituted with the happy result that the growth entirely disappeared, and the eye resumed its normal position.

Before entering upon affections of the cornea, I would like to say that in the *interstitial form of keratitis*, due to inherited syphilis, I have found mercury of comparatively little use. I have often tried it, but have been almost invariably disappointed with the results. Mr. Jonathan Hutchison speaks well of the use of hydrarg. c. creta. in one grain doses thrice daily.

In Descemetitis—i.e., deposits of flakes on Descemet's membrane—i.e., the posterior corneal layer often associated with, and due to deeper-seated diseases of the iris, and choroid; mercury is of signal service, and, in some cases, it acts with extreme rapidity as in the following case:—George W——, æt. sixteen, first seen September 11th, 1886. He said his vision was quite good up to a fortnight ago. At date, vision in right eye $\frac{6}{18}$; well-marked coarse deposits on Descemet's membrane; choroiditis; and recent exudation above the optic disc. Ordered pil. hydrarg., gr. 3, thrice daily.—On the 25th, the deposits on the cornea and the retinal effusion had entirely disappeared, and the vision quite normal.

Iritis with Descemetitis.—Chas. W——, æt. seventeen,

Huddersfield, admitted an in-patient to the Eye Hospital on December 7th, 1887. Right eye inflamed two years ago; got better, but was inflamed again one year ago; no history of gout or syphilis. Left eye normal in appearance, and vision. Right eye small patch of punctated keratitis; pupil irregular; numerous synechiæ posterior. Details of fundus cannot be satisfactorily examined; vision, $\frac{6}{18}$. Ordered pil. hydrarg. and mist. pot. iod.; atropine.—December 17th. Fewer adhesions; vision, R. = $\frac{6}{9}$. On February 3rd, 1888, I saw him again: vision in both eyes normal, and Descemet's membrane quite clear.

I shall enumerate several cases of *affections of the iris*, as we have in mercury a valuable aid in their treatment. In all cases of iritis the surgeon should endeavour by the frequent instillation of atropine (four grains to the ounce of water) to dilate the pupil fully. If the attempt be successful in the course of a few days, atropine alone will complete the cure; but if not, it will be necessary to administer mercury in some form or another. The plan I personally prefer, where it can be adopted (and by this I mean where the patient can be kept in a uniform temperature, and under careful observation) is by *inunction*. Either the ordinary mercurial ointment, or the oleates, may be spread on a piece of flannel, and bandaged on to the arm. Rubbing is sometimes recommended, but it may produce irritation, and considerably impair the absorbing power of the skin. This plan of administration is much less liable to disagree or produce unpleasant sensations and digestive derangements than by giving it internally. I know of no proof of the direct action of a drug similar to that of the action of mercury on iritic adhesions, if not of too long standing. Atropine by its aid seems to break down one tag after another, until the pupil is dilated equally all round. As soon as the adhesions are completely broken down, or even before, if the gums are tender, the mercury should be stopped, and iodide of potassium substituted, and if necessary, mercury may be afterwards resorted to.

Syphilitic Iritis.—Sarah McL., æt. 35, admitted as an in-patient, Bolton Infirmary, October 19th, 1886. She said her eyes were quite strong up to ten days ago, when they became very dim and foggy. She had had a syphilitic rash for four months, and sore throat. At present her vision is

very bad, and she can scarcely see her way about. On examination well-marked iritis in both eyes; the iris is muddy, and its structure masked by the abundant exudation; the pupillary space seems filled with uveal pigment; adhesions all round, and atropine has but little effect in dilating the pupil. Immediately after her admission she was ordered perchloride of mercury in large doses, as she had also taken mercury before her admission.

In less than a week there was slight salivation, and evidence of one iritic adhesion after another giving way. December 16th—*i.e.*, less than a month after her admission—every trace of iritic adhesion had disappeared, iris seemed natural in colour, no vitreous opacities. Vision R. and L., with correcting glasses, normal. She was sent home and ordered iodide of potassium.

This case is a typical example of the value of mercury in this frequent affection; but it is the experience of all ophthalmic surgeons that cases of syphilitic iritis that are not diagnosed early, and put under anti-specific treatment, go on to complete annular synechiæ, develop glaucomatous symptoms, and result very badly.

Janet F., æt. twenty-five, admitted as an in-patient at the Eye Hospital, December 13th, 1882. She gave the following history: She was confined on the 2nd of August, 1882, and for six weeks prior to that date, she had been out of sorts, but had no spots on the body—no sore throat. Three days after her confinement spots came out all over her body; she had severe sore throat, and noticed an alarming falling off of her hair. The baby was quite clear when born, but when about two months old she noticed some purple spots, especially on the buttocks. Last September she began to be troubled with her eyes, suffering from severe pain and dimness, and inability to bear the light. At that date there was deep conjunctival injection in both eyes. Iris muddy; extensive synechiæ, which did not give way in the least after the frequent instillation of atropine for three days. Findus oculi cannot be detected on account of the hazy media in both eyes. Vision in R. and L. $\frac{6}{36}$ scarcely. She was ordered mercurial inunction on the day of her admission, and in a week slight salivation was noticed, and the following notes made: Right eye—pupil fairly dilated all round; Left eye—extensive adhesions. Patient looks much better. Mercury

stopped and iodide ordered.—December 27th. Vision: R. eye, $\frac{6}{6}$, i.e. normal, iris clear, pupil wide; L. eye, $\frac{6}{12}$, iris clear, still a few adhesions. Patient looks quite well, and expresses herself as feeling quite a "new being." Spots on body completely disappeared.

Recurrent Iritis—Condyloma—Recurrent.—Mrs. P., æt. thirty-one, consulted me on the 29th of December, 1883. She said the left eye had been bad since September, and that she thought she had caught the ophthalmia from the children at her school. The sight was fairly good up to the first week in December. When I saw her—Vision: L. eye, $\frac{6}{60}$. I could detect a large condyloma below encroaching on the pupil. Vitreous hazy; iris muddy. Ordered gtt. atrop. and ung. hyd.—January 14th. Condyloma has disappeared, pupil dilated, no pain; vision normal. Ordered mist. pot. iod. She came back again on the 2nd March, 1884, and said she had a cold on her journey home. Vision: left eye counts two fingers; pupils fairly dilated, but media very hazy. Ordered hydrarg. perchlor. and pil. hyd. iod. vir.—March 14th. Abundant adhesions (synechiæ posterior); cannot see retina; vision 19 Jager vix. Mercury pushed to salivation, which occurred on March 28th, and at this date I ordered syr. ferri iod. and ext. sarsæ liq.—August 23rd. A few synechiæ; O. nerve healthy; no pain; no active inflammation. Vision normal, $1\frac{6}{6}$, and has remained so up to now.

In this case I never succeeded in getting an admission of syphilis, but I had not the slightest doubt of it, and I consequently pursued the treatment on the right lines, and obtained satisfactory results. This case points to the necessity of *prolonged* treatment and watching, and that it is necessary to be guarded when we are asked if there be any danger of recurrence.

Iritis—Retinitis.—Ellen W., æt. twenty-six, of Padiham, first consulted me on the 2nd of December, 1882. Two years previously she had severe inflammation in both eyes, and was attended to for some time by a local doctor. Was an in-patient at the Eye Hospital for twelve months, and had undergone a double ireductomy. She has had no active inflammation since, up to date (December, 1882); but her sight has been getting gradually worse, and she has been told that nothing more could be done. On examination I found evidence of retinitis in both eyes, and

although I could get no admission of specific inoculation (Vision: R. 16 J.; L. 20 J.) I ordered her large doses of Donovan's mixture, and the vision in less than a month improved to R. $\frac{6}{80}$; L. 19, and her health was improved. — March 31st, 1883. Vision same in L.; R. $\frac{6}{80}$ c. + 4d. = 1 J. Vision kept moderately good up to March, 1887, when she came again with both eyes very bad. Vision: R. perception; L. 20. I ordered her ung. hydrarg. and used it to salivation. Vision improved to R. 20 J., L. 16 J.

I have seen her again just lately (December, 1887) and in spite of all treatment her vision has gradually deteriorated, and now she can scarcely see her way about, and the tension is below normal in both eyes.

This case presents several features of interest. At first, and for some time, it shows a decided improvement under mercurial treatment, but it further illustrates the necessity of watching our cases for a long time before giving a too-decided prognosis.

Retinitis.—Emma S. æt. 41, Oldham, first attended at the Eye Hospital on the 30th of September, 1881. She said she had been in good health up to two years ago, when she began to suffer from very severe headache, which had been growing worse lately. No history of syphilis, no sore throat, no spots. Vision: R. 1 J. $\frac{6}{12}$; L. 20 J.

Ophthalmoscopically—the retina in both eyes was very hazy; margins of optic nerves fairly well-defined. Ordered ung. hydrarg. externally, and mist. quin. et ferri internally. On the 8th November, 1881, the retinæ were clear, headache entirely disappeared, and vision quite normal.

I have seen many cases of simple retinitis recover very rapidly under the influence of mercury carefully administered.

Neuro-Retinitis, Syphilitic.—Ann P., æt. thirty-seven, first attended at the Eye Hospital, November 30th, 1881. She had been complaining of bad sight for the past seven months, and was much troubled with black spots and floating bodies since her confinement, in May. She had suffered from sore throat, and at the time of her visit she had a copious coppery eruption over her body, and her child had shown syphilitic symptoms.

Vision R. and L. $\frac{6}{80}$. Ophthalmoscopically it was found to be a well-marked case of neuro-retinitis; margins of optic nerves ill defined, and a general haze all over the

retina. There was no iritis. Ordered ung. hydrarg. externally, and iodide of potassium internally.—December 7th, 1881. Vision: R. and L. $\frac{6}{12}$, and on June 11th, 1882, when I last saw her, her vision was R. and L. $\frac{6}{9}$, optic nerves and retinæ clear.

Atrophy of the Optic Nerves following Optic Neuritis.—James D—, æt. nineteen, admitted as an out-patient in the Royal Eye Hospital, February 3rd, 1883. He said that he was quite well up to a few days ago, and could see well with both eyes. He felt pricking pains in both eyes, and last Tuesday—i.e., four days ago, he noticed he could not see at all with the left eye; no vomiting; no headache. He complains of stiffness and numbness of hands and feet. When walking he separates his legs, and plants them with difficulty; the staggering is a good deal worse when his eyes are closed. Tendo reflex exaggerated.

V. Right; 19 J. vix. } Well marked optic neuritis in
Left; fingers at 4 inches } both eyes; veins engorged,
arteries small; optic nerves woolly, with ill-defined margins. Ordered potass. iod.—February 14th, 1883, he was admitted an in-patient. Pupils active and normal in both eyes. Optic neuritis not so marked; veins engorged: discs irregular in their outline. Vision: R. 14, L. 16 J.—February 21st. R. $12\frac{6}{60}$, L. 14 J. Tendo reflex highly exaggerated; also ankle clonus.—February 28th. Vision: R. $1\frac{6}{18}$, L. $14\frac{6}{60}$.—March 7th: left hospital; both optic nerves look pale; no neuritis. I lost sight of this case entirely until the 17th of February, 1887, when he was again admitted as an in-patient at the Eye Hospital, when he reported that since we saw him before, the sight in both eyes had varied greatly. At this date both optic nerves were pale and atrophic; slight choroiditis at their outer margins; vessels good size. Fields for white contracted; fields for red much contracted; especially in the right eye. Vision: R. $+4d = \frac{6}{24}$, L. J. 20 vix. Ordered perchloride of mercury and iodide of potassium.—March 19th, 1887: R. $\frac{6}{9}$, L. $\frac{6}{60}$.—February 10th, 1888. I sent for him, and made a complete examination. Vision: R. $\frac{6}{12}$, L. $\frac{6}{18}$; optic nerves quite pale and white. He has had no attacks for a year. Fields still contracted.

Atrophy of Optic Nerves. Ptosis and Paralysis 3rd Nerve.—Lewis G—, æt. forty-five, admitted an in-patient to the Eye Hospital on October 7th, 1885. History: The

sight of both eyes has been failing markedly for three years, and getting gradually worse. No admission of syphilis. Palms of hands and fingers show some fissures, and appear moist and scaly. Tendo reflex good. He has been a heavy smoker. Vision: Right eye, 20 J. vix. Optic nerves pale and atrophic, especially at outer part. Left eye: Entire absence of movements inwards; also of direct movements upwards and downwards. On attempting to look upwards the eye is moved slightly up, but it also rotates inwards; and in attempting to look down the eye is slightly rotated outwards. Vision, left eye: shadows. Optic nerve paler than the right. Ordered ung. hydrarg. to be pushed.—October 21st, 1885. Signs of salivation. Vision: R. 6 n4, L. 19. At this time the fields of vision were carefully taken by Mr. Roberts, the house surgeon. Right: Field for white considerably contracted all round; field for red much contracted; central scotoma of considerable size. Left: Field for white much more contracted than right; field for red slightly larger; central scotoma of equal size.—November 7th, 1885. Vision: R. $\frac{6}{9}$, L. $\frac{6}{60}$.—December 20th, 1885. Stopped hydrarg. Vision: R. $\frac{0}{12}$ 6 J., L. $\frac{6}{60}$. Field again taken. No central scotoma in right, and in left only a very small central scotoma for red, but not for white. Green called white in both eyes. Not much difference in the appearance of optic nerves. This patient wrote lately to say that his vision had further improved since I last saw him, and that he had been able to follow his employment, although at one time before I saw him he had given up all hopes of ever being able to do so.

Atrophy of Optic Nerves.—Thomas D——, æt. twenty-two, admitted as an in-patient, Eye Hospital, July 11th, 1882. History: He came as an out-patient on May 13th, 1882, when he said his vision was quite good up to two months ago. A fortnight ago he noticed that the left eye was the worst. He has smoked one ounce of thick twist a week, and drinks beer, but not to excess. History of syphilis (hard chancre) eight years ago, but has felt no evil results since. His vision then was, R. 1 $\frac{6}{6}$ —i.e., normal, L. 4 $\frac{6}{60}$.—June 24th. R. $\frac{6}{6}$, normal; L. 19 J. Ophthalmoscopically: Left optic nerve very pale. Ordered mist. quin. et. strych. On admission as in-patient his vision was—R. shadows; pupil active; signs of incipient atrophy

of nerve. L. 19 Jager; pupil active; optic nerve pale and atrophic. Ordered mercurial inunction. In a week salivation. Mercury stopped and iodide ordered.—August 2nd. Vision greatly improved: R. and L. 4 J., $\frac{6}{36}$.—August 11th. House surgeon notes discs pale, vessels small. Vision: R. $1\frac{6}{18}$, L. $1\frac{6}{24}$.

Optic Neuritis with Hæmorrhages.—John M—, æt. forty-nine, first attended the Eye Hospital on January 19th, 1884, when he gave the following history: His sight was good up to six months ago; since then gradually failing; no pain in head; no vomiting; no loss of memory; no staggering gait. Two children living and healthy. Pupils fairly active. Ophthalmoscopically: some vitreous haziness in both eyes. Right eye: Blurring of disc and surrounding retina; apparently not much swelling of disc, but almost complete obscuration of edges; one hæmorrhagic spot on the inner side. Left eye same, but no hæmorrhages. Vision: R. $\frac{3}{36}$ vix, L. $\frac{3}{60}$. He was ordered ung. hydrarg. and iodide of potassium by Dr. Mules, under whose care he was at that time; and by February 27th, 1884, his vision had improved: R. $\frac{6}{60}$, L. $\frac{6}{60}$ vix. On March 6th, 1884, there was a large membranous opacity in the right vitreous. Left vitreous clear; still swelling of disc and opacity of surrounding retina. On December 13th, 1884, he came under my care, when I noticed that both discs and surrounding retinæ were hazy. No hæmorrhages. Vision: 19 J. both eyes. Ordered Donovan's mixture.—February 18th, 16 J. R. and L. At this date ordered mist. hydrarg. perchlor. Vision continued same.—March 10th, 1885. Gave mist. Donovan. Vision at this date R. +6=9; appearance of optic nerves healthier.—January 10th, 1885. Vision: R. $18\frac{6}{60}$, L. 18. Still films in vitreous. The result in this case is by no means brilliant; but I believe the use of mercury in various forms prevented the nerves becoming completely atrophied.

Choroiditis Disseminata.—Owen J—, æt. forty-nine, of Beaumaris, consulted me on the 4th of December, 1881. He said that he had had "slow fever" a year previously, and had been in bad health, and this led me to suspect its syphilitic origin; he had seen things double, and could see better at twilight, and could not retain retinal impressions for any length of time. Field of vision much

contracted all round in both eyes. He has not been a heavy smoker. Ophthalmoscopic examination revealed:—Right eye, a large atrophic patch in region of yellow spot; Vision: 16 Jager scarcely. Left eye, extensive choroiditis, with numerous exudations, and a few small hæmorrhages, and patches of pigment. Although I could not get any history of syphilis, I inferred it, and ordered ten-grain doses of potass. iodid.—November 23rd, 1881. Saw again; vision in left eye slightly improved, L. $12\frac{6}{12}$. I determined then to try mercurial ointment. He continued with this until February, 1882, where slight salivation occurred, and his vision then was, R. 16; L. $10\frac{6}{18}$, c. + 4d. = 6 J. As he was now in a low general condition, I ordered him maltine, and cod liver oil, and strychnine, and by March he had gained six lbs. in weight, and had entirely got rid of his feelings of depression and nervousness. For three months longer, tonics and mercurials were prescribed alternately, and when I saw him last on the 11th of October, 1882, he had gained ten lbs. more in weight, *i.e.*, sixteen lb. since I first saw him a year previously. The vision in the worst eye, the Right, had improved to 14 J., $\frac{6}{36}$; Left eye, $\frac{6}{18}$, c. + 4d. = 1 Jager easily. This gentleman had been under skilled treatment for more than a year before I saw him, and his vision went gradually worse. I attribute the success entirely to the detection of the cause, which was undoubtedly somewhat obscure.

Central Choroido-Retinitis-Macular.—Amy McC——, æt. thirteen, Manchester, first seen as an out-patient, Royal Eye Hospital, June 26th, 1886, then her paper was marked amblyopia, with correcting glasses = $\frac{6}{9}$, after atropine + 2d. = $\frac{6}{9}$, R. and L. sight bad for six months.—January 30th, 1886. Peripheral fields, with fingers contracted R. and L. (tested with fingers), with + 1d. sph. = $\frac{6}{24}$; no retinal change detected.—July 3rd, 1886. Again seen, but no retinal change noted. She went to London, and was seen by Mr. Couper, at Moorfields, on the 27th of July, 1886, when her vision was marked R. and L. 20—sees hand. Glasses do not improve. The following notes I copy from the paper sent with her from London: Left eye; greyish change and ædematous halo round the macula; atrophy of pigment at macula; fine granular change very marked at fovea. Right eye, ditto. She was ordered syr. ferri iod. and pulv. hyd. c. cret., gr. $\frac{1}{2}$, twice a day. August 24th,

1886. Vision: R. and L. $\frac{6}{60}$; ordered gr. i. of the hyd. c. cret.—September 7th, 1886. R. and L. $\frac{6}{60}$, c. + id. = $\frac{6}{24}$ nearly. Left macula change less easily seen. Right, also; but halo still visible. She then returned to Manchester, and I saw her on the 15th of September, 1886, when the condition was as described by Mr. Couper. Ordered her to continue with the hyd. c. cret.—December 28th, 1886, c. + id. = $\frac{6}{9}$ R. and L.—May 24th, 1887. Left off treatment. Vision quite normal in both eyes; no ophthalmoscopic changes can be detected.

Central Choroiditis with Retinitis.—Arthur C——, æt. twenty, Romiley, admitted as an in-patient, Royal Eye Hospital, on the 23rd of October, 1887. He is by occupation a clerk. He says he does not remember seeing very well with the Right eye, and the Left has been failing him for the past ten weeks. He has no headaches. Health not strong, but he has not complained of any special disease. No history of syphilis. Ophthalmoscopic examination: Right eye, a small crater-shaped central choroiditis can be detected. Vision: $\frac{6}{36}$. Left eye: optic disc blurred; margin indistinct; small patch of choroiditis, with a few retinal hæmorrhages. Vision: $\frac{6}{60}$. Ordered ung. hydrarg. November 12th, 1887. Vision same; less choroido-retinitis in left eye.—November 19th. Vision improved in both eyes: R. $\frac{6}{18}$, L. $\frac{6}{9}$.—November 26th. Vision relapsed to R. $\frac{6}{18}$, L. $\frac{6}{12}$. Ordered perchloride of mercury internally. Saw again February 3rd: R. $\frac{6}{18}$, L. $\frac{6}{2}$. Fundus clearer.—February 10th, 1888. Vision R. and L. normal. The atrophic patches can still be discerned on both retinal, and he continues under treatment and observation.

I must express my indebtedness to the house surgeons at the Manchester Eye Hospital and the Bolton Infirmary for their careful record of the cases under my care, and I hope that the interesting group of cases now presented will be of service as commentaries to my professional brethren.



