Some diseases of the eyelids, etc. / by W.S. Collins.

SOME

DISEASES OF THE EYELIDS,

ETC.

BY

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Fig. 1.

Fig. 2.

Fig. 3.

Fig. 4.

From Photographs.

Danielsson & Co., Photo Print.

DESCRIPTION OF PLATE IV.

Illustrating Dr. W. J. Collins's cases of Affections of the Eyelids. From photographs.

FIG. 1.—Case of Henry A—. Spontaneous symmetrical œdema of eyelids came on rapidly and passed off in a few hours. (*Vide* p. 1.)

FIG. 2.—Case of Louisa L—, æt. 21. Spurious partial ptosis of left side due to paresis of left frontalis muscle. (*Vide* p. 6.)

FIG. 3.—Case of Alice Maria L—, æt. 23, with partial ptosis of right side. Overaction of the right frontalis muscle well shown. The ptosis was first transient and recurrent, and apparently hysterical, later on it became complete, actual, and persistent. (*Vide* p. 5.)

FIG. 4.—The same patient after removal of semilunar slip of skin from above right upper lid. There is still overaction of the frontalis, and on both sides.

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Spontaneous, symmetrical, transient œdema of eyelids.

By W. J. Collins, M.D.

(With Plate IV, fig. 1.)

Henry A—, æt. 7, was in good health (except infantile spinal paralysis of right leg) until two hours before he was brought to hospital, when his mother noticed rapid swelling of his eyelids amounting to complete closure. He was sitting quietly at the table when this happened. No other symptoms; no cough; no fits; no albumen in urine; no morbus cordis; no anasarca of limbs. No history of a previous attack.

The swelling had subsided a little when the accompanying photograph was taken. The skin was translucent, unchanged in colour, no extravasation. Vision good and fundi normal.

Rapid resolution occurred, and no return observed during the three or four weeks he attended hospital.

(*Card specimen. May 3rd,* 1888.)

Chancre or tertiary syphilitic ulcer of lower lid.

By W. J. Collins, M.D.

E. C—, æt. 36, a sailor, from Harwich. History of a primary sore followed by rash fifteen years ago. For last three months has noticed an extending sore on right lower eyelid; knows no cause for it. It is painless. There are no enlarged glands. There is a crescentic ulcer with concavity upwards, extending along the outer two-thirds of the tarsal margin of the right lower lid, leaving an islet of skin between its horns. The surface of the ulcer is greyish, and yields a very scanty discharge. The adjacent skin is tumid, livid, and somewhat indurated. The margin of the ulcer is sharply cut. The tongue exhibits white plaques on the dorsum, suspiciously syphilitic. He was ordered mercury but he did not return to show the result. The appearance of the ulcer and neighbouring skin was strongly suggestive of a chancre; the history, absence of glandular enlargement, the evidence of previous syphilitic infection in the tongue, pointed to the possibility of its being a tertiary syphilitic ulcer, while the age of the patient, the surface of ulcer, and the appearance of the surrounding skin negatived the likelihood of its malignancy.

(*Card specimen. May 3rd,* 1888.)

Recurrent hysterical ptosis (right), becoming actual; removal of semilunar strip of skin; cure.

By W. J. Collins, M.D.

(With Plate IV, figs. 3 and 4).

Alice Maria L—, æt. 23, a teacher, always had good health. In 1879 suffered from a transient attack of symmetrical ptosis; treated at Moorfields; recovered rapidly. A second attack in 1880 lasted eight months, and eventuated in complete recovery. In September, 1882, she again began to suffer with ptosis of right eye, and when this was incomplete, with vertical diplopia. She is small, stunted, with misshapen head, and weak though hardly hysterical, behaviour. Was in-patient at St. Bartholomew's 1882 (vide 'St. Bart. Hosp. Rep.,' vol. xix, 1883, p. 282). When suddenly awoke from sleep on three occasions she opened both eyes equally and well, and moved them freely in all directions. There was, however, no suspicion of the genuineness of her symptoms; she was very anxious to be cured in order to resume her occupation. Galvanism, faradism, extraction of carious teeth, and many anti-hysterical remedies were tried without success. The ptosis of the R. eye became persistent and nearly complete, though the epicranius effected some elevation of the lid when it acted vigorously. In 1887 she was in the same state, and was admitted under my care at the North-West London Hospital. I removed a semilunar strip of skin from the R. upper lid, with very satisfactory cosmetic effect.

(*Card specimen. May 3rd*, 1888.)

Pseudo-ptosis from paralysis of left occipito-frontalis.

By W. J. Collins, M.D.

(With Plate IV, fig. 2.)

Louisa L—, æt. 21, married two years, never pregnant, looks delicate and fatigued. Has been subject to epileptiform seizures during last eight years; last attack six months ago; does not bite tongue in attacks. For the last four weeks has had pain at back of eyes and dimness of vision; a fortnight ago the left upper eyelid began to droop, and eye was quite closed. It is better every morning, and always gets worse towards evening. There is slight diplopia sometimes. No history of traumatism, teeth not defective nor carious; catamenia regular.

Present condition.—L. eyebrow 1·5 cm. lower than R., and less of the "bended bow," giving appearance of pseudo-ptosis; when brow is raised, however, the upper lid can be elevated quite normally. Skin of the lids dusky and pigmented. Can knit brows normally (corrugator supercilii) and furrow the forehead on the right side horizontally; not so on left. Pupils equal and active; media clear; fundi *nil* abnormal; no loss of sensation; no other palsy, though accommodation is weak, left eye 8 J. at 22 cm. $\bar{c}$ + 1·50 D. J. 1 at 22 cm.

V. R. $\frac{6}{6}$ $\bar{c}$ + 1·25 D. = $\frac{6}{6}$.
L. $\frac{6}{12}$ (letters) $\bar{c}$ + 1·25 D. = $\frac{6}{12}$.

Greatly improved by change of air and iron tonics.

This case is presumably one of peripheral neuro-muscular palsy. It is interesting as bearing upon the remedial operation for ptosis based upon the utilisation of the lid-elevating power of the frontalis in place of the levator palpebræ.

(*Card specimen. May 3rd*, 1888.)

Case of paralysis of sensory branches of right fifth nerve, with cataract, and without any corneal change.

By W. J. Collins, M.D.

John G—, æt. 58, labourer, gives the following history: Nine months ago, while digging, he was suddenly seized with sharp pain, referred to the neighbourhood of the right outer canthus. This pain, sometimes of excruciating severity, has continued with slight abatement and short remissions ever since. Before this attack his health was excellent; he had had no premonitory headache, never had a fit, denies syphilis, and inherits a gouty history.

At the present time he looks a healthy man, but in pain. He has a full pulse, no cardiac murmur, some emphysema of lungs. Urine sp. gr. 1012, acid, no albumen. He still complains of pain over the right brow, and along the right malar bone, but on testing his sensation it is found that the whole area supplied by the three sensory trunks of the right trigeminal is anæsthetic, thermanæsthetic, and analgesic. This area extends nearly, but not quite, to the middle line of the face; for 1 or 2 cm. to the right of the middle line he is uncertain and inexact in his answers as to feeling or not. On the scalp the anæsthesia extends over the summit of the cranium, nearly to the lambdoid suture; laterally it reaches the pinna, but does not invade it. The quantitative testing with compasses reveals no disagreement between the minimal distance of two points felt as two on the two ears. Vibrissæ were plucked from the right nostril without any disagreeable experience. My colleague Mr. Maggs extracted two carious stumps from the right

upper jaw with some difficulty but without the least pain. The mucous membrane of the right cheek, hard and soft palate, and tonsil, and of the right side of the tongue and lips, is entirely devoid of sensation. The right half of the tongue is smaller than the left, and is coated with a brownish-grey fur, chiefly consisting of a rich overgrowth of epithelium. He does not taste mustard, pepper, acetic acid, or quinine when applied to the right side of the tongue. He has considerable difficulty and even anxious distress in deglutition, especially with liquids; he is in constant fear of being choked, and makes powerful and eager gulping efforts in the process. By laryngoscopic examination I found an accumulation of saliva hanging about the base of the epiglottis and overflowing into the larynx, the anæsthesia of the palate, tonsils, base of tongue, and parts around apparently being responsible for the absence of the appropriate stimulus to deglutition as need and occasion arise. An œsophageal bougie encountered no obstacle in its passage. Below the lower jaw the limit of anæsthesia is sharply defined. There is apparently no motor paralysis; the action of masseters, temporal, buccinator, and pterygoids, is intact. There appears to be some palsy of the right frontalis muscle, presumably unconnected with the trigeminal lesion.

The sense of *smell* in the right nostril is not so keen as in the left.

Hearing with right ear $\frac{7}{40}$, left ear $\frac{12}{40}$.

Eye.—There is complete anæsthesia of the lids and conjunctiva; there is, I think, less lacrimal secretion on the right side than the left; there is not, and has not been, any herpes or other skin affection. There is no catarrh or hyperæmia of conjunctiva. The cornea preserves its normal pellucidity in spite of eight months' habitual exposure. The pupil is dilated, in bright diffuse daylight its diameter is to that of the other side as 9 : 5. The lens is cataractous; he noticed his vision failing since the onset of this attack; there are no distinct striæ

in cortex, but a diffuse nuclear opacity is observed. Some red reflex is obtainable; the vitreous and fundus, so far as examination is possible, appear normal. V. = hand reflex. T. – ?.

This case appears to me instructive in many ways, and by no means the least for the light it throws upon the hackneyed question of "trophic" troubles consecutive on nervous lesions. The points I would lay especial stress upon are these:

α. The non-invasion of the mesial line by absolute anæsthesia. We have evidence in other parts to show that the mesial areas of the body are supplied by filaments from both sides. An observation corollary to this is found in the respect that is paid to the macular region in cases of hemiopia.

β. The fact that although there is every reason to believe that the sensorial innervation of the ear by the auriculo-temporal was withdrawn, there was no evidence either of localised anæsthesia nor of lessened acuteness of sensation in the area to which it is usually distributed.

γ. As regards the "trophic nerve" question it appears to me this case furnishes us with evidence of the highest importance.

There can be little doubt, from the entirety with which trigeminal sensation is abolished without the smallest implication of the motor root, and from the severe referred pain complained of in anæsthetic parts, that we have here a considerable lesion of the sensory portion of the fifth somewhere between its nuclear origin in the pons on the one hand, and the eventual trifurcation of the Casserian ganglion on the other. It is equally certain that it is a pathological change, not a mechanical solution of continuity, we have to deal with. Yet here, with a profound and absorbing lesion of the fifth at its very fount, with absolute anæsthesia, there is not the slightest implication of the exposed and insensitive cornea, as the doctrines of Snellen and Büttner would lead as to expect, *but* in the lens, innocent of innervation, unexposed to the annoyance of foreign

bodies, going on as it were under a glass case, we perceive nutritive changes eventuating in opacification. I have been unable to find any report of a case similar to this, even in those mines of clinical wealth, 'Mackenzie on Diseases of the Eyes,' and the new edition of the 'Traité Complet.'

According to Charcot, while "the most advanced physiology teaches that in the normal state the nutrition of different parts of the body does not essentially depend on the influence of the nervous system," yet "there is nothing better established in pathology than the existence of trophic troubles consequent on nervous lesions." He reconciles these conclusions by opining that it is "the irritative lesion" of a nerve, not its solution, that is the one thing needful to precipitate the so-called trophic phenomena; and he quotes the experiments of Meissner, Merkel and Schiff to show that damage of certain tracts, to wit, the innermost of the trigeminal trunk, is all-sufficient, in the absence of anæsthesia, for the exhibition of corneal disorder. This case would further tend to suggest, if we admit the cataract to be of nerve origin, and it would be flying in the face of the law of parsimony to import other causation, that particular nerve lesions may determine trophic changes in non-nervous tissues like the lens, presumably through vascular disturbance, while all the time the highly innervated, yet anæsthetic, cornea is rejoicing in its normal pellucidity.

One word as to treatment. I have given iodide and bromide of potassium in increasing doses, and morphia in local subcutaneous injection to relieve pain. I shall be grateful for any suggestions as to the nature of the lesion, any criticisms as to the localisation, and explanations suggested, and should be glad to know the opinion of others as to the desirability and probable success of extracting the opaque lens.

(*June 14th*, 1888.)

Central retinal detachment in left eye, with appearances as of albuminuric retinitis in a woman suffering from chronic nephritis and fibroid of uterus.

By W. J. Collins, M.D.

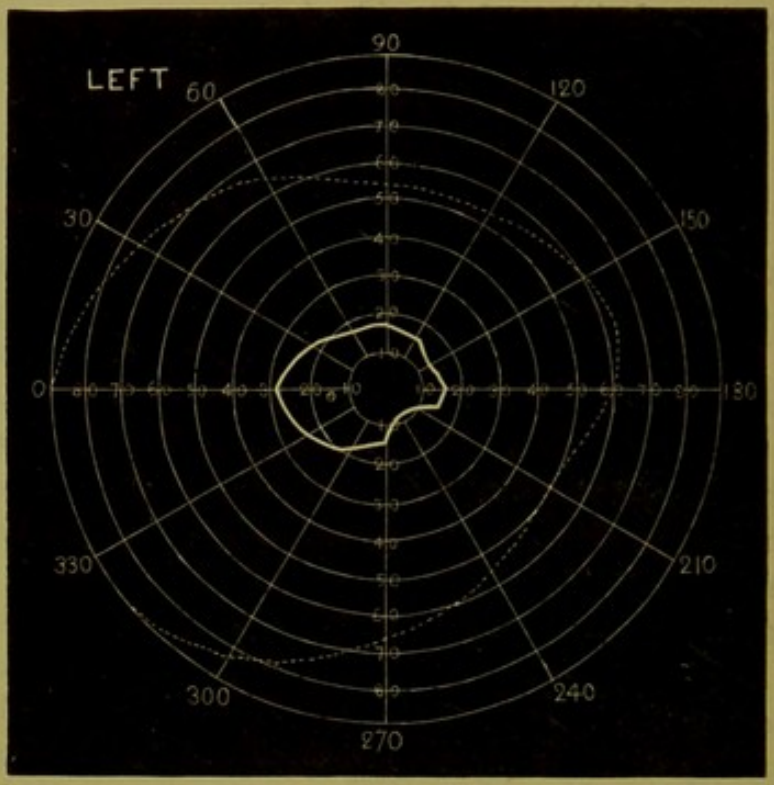
Jane P—, æt. 53, widow (seven years). Family history unimportant; one child (twenty-five years ago), one miscarriage. Is a laundress and charwoman. Always healthy until eight years ago, when she had loss of power in both lower limbs for one month. For the last seven years has had an ulcer just above left external malleolus. Six years ago she "caught a chill," and her legs swelled "like the dropsy." The ulcer and anasarca have troubled her ever since. For two years preceding the last twelve-month she had suffered from menorrhagia (in clots) and a swelling in the hypogastrium. She has severe backache, frontal headache, and occasional insuperable drowsiness.

Urine.—Sp. gr. 1020, acid; $\frac{1}{18}$th of column of albumin after boiling and HNO_3. The hypogastrium is occupied by a tumour, ovoid, mesial, the size of a six months' pregnancy; it is hard, dull, dumb; doubtless a uterine fibroid. There is a systolic, basic, cardiac murmur.

Six months ago the sight of the left eye began to fail, she thinks suddenly; no traumatism remembered. On examination with the perimeter it is found that it is central vision that is lost absolutely, peripheral perception being present but deficient. The media are clear; T. n. Occupying the site of the fovea and an area of twice its dimension around it, is a retinal detachment presenting the usual blue grey rucked appearance, with dark red tortuous vessels riding over the rugæ. This area shades off peripherally in parts to normal retina, but above

on the temporal side to a patch presenting the dead-white streaks and dots indicative of albuminuric retinitis. O. D. rosy, but no neuritis. The R. eye V. $\frac{6}{9}$, and 1 J. $\bar{c}$ + 3 D.; media clear; fundus perfectly normal.

This case is peculiar and interesting; peculiar in the fact of its strict unilaterality, and in exhibiting possibly a transitional form between that degenerative retinal



The field of V. was taken with a small candle-flame.

change with which we are familiar in chronic Bright's disease, and that larger lesion of retinal dislocation from subretinal dropsy which we associate with the graver and more acute forms of renal disease; it is interesting as raising the question of the prognosis of renal disease based upon retinal changes in their different forms.

P.S. (August 22nd, 1888).—Patient seen to-day. Scarcely any change in left fundus, no disease in right. Health much the same; still anasarca of extremities and albuminuria. (*October 20th*, 1887.)