

CLINICAL REMARKS ON CATARACT AT THE TORONTO GENERAL HOSPITAL.

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(Continued.)

SOFT CATARACT—(*Keratonyxis*).—Here is a child, *æt.* two and a-half years, the pupil of whose right eye has appeared milky at least one and a-half years, the mother says; and you see that there is also a slight squint. The right pupil is but little larger than the left, and nearly as active, and the opacity seems in contact with its posterior edge. The anterior chambers are of equal depth, and the tension of both eyes is alike, the globes dimpling under very slight pressure. Having dilated the right pupil, we find that the normal reddish reflex from the fundus cannot be seen with the ophthalmoscope, and the lens appears uniformly opaque; and there is no shadow cast by the iris into the lens under oblique illumination, shewing that it is involved up to the anterior capsule.

Since the crystalline lens is quite soft during adolescence, and comparatively so, indeed, up to the age of thirty or thirty-five, this case should be termed *soft* cataract. The cause cannot be determined in this instance, but the affection is probably congenital, although not hereditary. Congenital cataract, which is generally double, is not unfrequently hereditary; and I have seen a mother and three of her children apply together for the treatment of cataract. In some of the cases developed *in utero*, the lenticular opacity occurs with changes in the deeper tissues, and the sight is very defective or but little better after the removal of the cataract. But it is not advisable to wait until a child is intelligent before deciding to operate, for more or less amblyopia or defective sight may result from prolonged functional disuse of the retina, especially where owing to the opacity of the lens and the want of the proper visual impulse, a secondary squint develops. On the other hand, be certain before operating that the lens is diffusely cloudy and all its tissue involved, the eye otherwise appearing normal; for there is one form of congenital

cataract in which the lens itself should be left intact.

And, again, glioma of the retina, a malignant disease, sometimes simulates cataract. Glioma may be distinguished, however, by the bright yellow-white reflex from the depths of the eye, the pupil being more or less enlarged and sluggish or fixed, the anterior chamber possibly shallow, and the tension, as a rule, increased.

[*Double Glioma of Retina.*—Boy, *æt.* three, well-nourished, but uneasy and fretful for the past year without apparent cause; left pupil "got larger than ordinary, one year ago," after inflammatory symptoms, and six months ago, "quite large, and eye looked hollow. You would fancy you could see the back or bottom of the eye, which looked as the right does now, yellowish-gray, with red veins on it." Six weeks ago the right pupil first shewed the peculiar appearance of the left; and the child has since stumbled, the sight being much worse. Right eye—externally normal, but with glistening "creamy" reflex from a large part of the fundus, the retinal vessels being well seen on the pale, raised background by means of the ophthalmoscopic mirror alone. Left eye—episcleral vessels enlarged; pupil widely dilated and fixed; anterior chamber, shallow; lens, transparent, or only slightly hazy, but seemingly opaque, the anterior part of the vitreous having a gray look with a brighter, yellowish appearance shewing through; eye glaucomatous, dimpling only on *firm* pressure; motion of eyes perfect. No family history of cancer.]

You need hardly be reminded that the term "cataract" as popularly given to opacity of the cornea from old ulceration,—leucoma, when dense; nebula, when merely hazy, is a misnomer; though, of course, cataract may accompany or complicate this condition.

We shall treat this case as soft cataract is usually treated, viz., by *keratonyxis* or needling; (formerly, *scleroticonyxis*, because sclerotic was pierced); also styled *discission*; and *solution*, advantage being taken of the fact that the aqueous humor will attack and dissolve the lens when it is unprotected by its capsule. Several operations are necessary; and on the first occasion it is well simply to prick the lens at its centre. In the second needling the capsule may be torn a little and some of the lens broken up; and in the succeeding ones a freer division of the capsule and lens should be made. From three to six needlings may be