other typical signs of trachoma, and the presence of tuberculosis elsewhere, are sufficient grounds for the diagnosis of the miliary type of tuberculosis of the conjunctiva.

It seems justifiable, therefore, to conclude that all the pathological conditions are due to one cause, namely, tuberculosis.

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CLINICAL NOTES

THE DIAGNOSIS OF SUB-RETINAL TUMOUR

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A CASE of detachment of the retina in which there is reason to suspect the presence of a sub-retinal tumour may give one a good deal of anxiety, and one does not feel justified in proposing excision of the affected eye before having employed every method which will help to make the presence of a neoplasm reasonably certain. I have sometimes been disappointed with the results of transillumination, and in two recent cases I have tested the character of the detachment by noting the effects of puncturing it under direct ophthalmoscopic examination. I mentioned the method at the November meeting of the Scottish Ophthalmological Club, and as it seemed to be new to the members I bring it forward in the hope that it may be helpful to others.

The case in which I employed it most recently was that of a woman, 46 years of age, presenting a prominent detachment of the retina in the lower nasal part of the fundus, highly suggestive of a sub-retinal neoplasm. Tension was normal, and there had been no pain or redness of the eye. Transillumination gave a doubtful result. A scleral puncture at the supposed site of the tumour gave exit to a small quantity of yellowish glairy fluid, but made no appreciable change in the prominence of the detachment. A few days later, under a local anaesthetic, a discission needle was inserted through the sclerotic in the upper and outer segment of the globe, passed across the vitreous, and, under direct observa-

tion with the electric ophthalmoscope, passed into the elevated retina, avoiding the retinal vessels. Immediately a little blood was seen to ooze out of the puncture, and on giving the needle a quarter turn a larger jet of blood passed out into the vitreous. One also noticed that the needle point did not displace the mass, but penetrated it, and one was conscious of a certain degree of resistance. Had the detachment been due to the presence of fluid one would have expected the retina to yield before the needle, there would have been no sense of resistance, and no haemorrhage would have occurred.

In both of the cases in which the procedure was tried the eye was afterwards excised, and a choroidal sarcoma was found to be present.

While not attempting to minimize the value of other methods of diagnosis in these cases, I would suggest that we have here an additional method which is both simple and reliable.

SARCOMA OF ORBIT*

BY

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THE patient was a woman of 40 years of age, the wife of a farm labourer, and of robust appearance.

Up to November 13, 1918, she enjoyed perfect health. Late that evening she experienced severe pain in the right frontal and temporal regions which kept her awake, and which was accompanied by vomiting. During the night she experienced the sensation of something bursting over her forehead, after which all pain subsided. Next morning the eyelids were swollen to a degree which prevented the eye being opened. Her local doctor saw her and sent her to the local hospital, from whence she was sent to Cork on November 17. When I first saw her the following day the eyeball was half protruding between the lids, which were greatly swollen and intensely red. The edges of the lids, the cornea, and the exposed portion of the conjunctiva were gangrenous. Temperature and pulse were normal. Patient complained only of a dull ache. Examination of the nose for sinus disease was negative.

That evening, under general anaesthesia, the orbit was probed for pus in all directions, but none was found. The eye was then enucleated, this only requiring division of the optic nerve and a

* Case shown before the Cork Medical and Surgical Society.