
(1) Gordon's paper is based on a study of 1,339 patients. He has drawn certain conclusions which he hopes will help to clear up some of the confusion at present existing with regard to ocular headaches. As evidence of this confusion, the author quotes from the literature many and various hypotheses as to the cause of headache, beginning with the Babylonians, Persians and Hebrews, who ascribed it to the activities of a specific demon known in the Talmud as Tsihatho. His own view is that the site of ocular pain is in the muscles of the head, the pain reaching this area, in a reflex manner analogous to that in which reflex pain is caused elsewhere. The most important factor "is the presence of an abnormal condition of the nerves in the eye itself due to abnormalities in its make up, such as the presence of ametropia or heterophoria. The more pronounced the instability of the ocular nerve supply, the more painful is the headache."

Among predisposing causes, heredity, age and occupation are of importance, also impaired health, particularly a broken-down nervous system. Taking headache as a whole, about 50 per cent. of cases are due to ocular causes, though some authorities would put the figure very much lower ascribing the majority to a psychoneurosis. The association of headache with low errors of refraction and of muscle balance is due to the attempts made by the ocular muscles to overcome these defects. When the errors are of high degree compensation is not attempted and so no strain results. The attempt to use the two eyes together is also a fertile cause of headache as is shown by its relative absence in those who are organically or functionally monocular.

F. A. W-N.


(2) Poos describes nine cases of migraine with ocular complications:—

1. A patient, subject to typical migraine with scintillating scotoma between the ages of 13 to 35 years, developed at 53 years, a persistent, complete, right-sided hemianopia, the maculae being
spared. There was return of the migraine and there was no change for three years.

2. Transient right-sided external rectus palsy followed later by cerebral vascular crisis. These developed and regressed independently of attacks of migraine with scintillating scotoma.

3. Recurrent right-sided external rectus palsy associated with palsy of the inferior rectus.

4. and 5. Paralysis of inferior rectus.


8. and 9. In one there was an isolated reflex rigidity of the pupil; in the other left-sided iridoplegia with right-sided reflex rigidity.

The author's impression would seem to be that the cases cannot be regarded as of the same class as uncomplicated migraine. An extensive bibliography is given.

ARNOLD SORSBY.

(3) de Andrade, C. (Bahia, Brazil).—Two cases of hemicraniosis with atrophy of the optic nerve. (Dos casos de Hemicraneose com atrophia de nervo optico). Rev. d'Ophthal. de S. Paulo., Vol. CXI, p. 225, 1934.

(3) One of the most rare of the craniostoses is hemicraniosis, which is a bony tumour of congenital origin, occupying one side of the head, chiefly in the region of the trigeminal nerve.

The first case was described by Brissaud and Lereboullet in 1903. These authors showed that such tumours gave rise to a necrosis of bone and of dura similar to a psammoma. Then later Duvigneaud and Marigot de Treigney demonstrated a case with an accompanying atrophy of the face on one side and an intermittent paralysis of the external rectus muscle. There was no optic atrophy in these cases. There was never any history of trauma.

M. Lery described a similar tumour, again of congenital origin, in a boy, aged 11 years. It was entirely painless; smell and hearing were diminished on the side of the tumour, and there was a convergent strabismus with manifest diplopia. In de Andrade's two cases, X-rays showed a marked thickening of the skull, with necrosis similar to that of a sarcomatous growth of meningeal origin invading the skull. The first case had marked facial asymmetry which was accentuated by the presence of a large fibroma at the level of the zygoma. The eye on the side of the growth was proptosed. There was a paresis of the external rectus and some manifest diplopia. The left eye (i.e., the eye on the affected side) was 8 mm. lower than the right. The right vision was normal, but the left slightly defective. There was an atrophy of the left optic nerve which progressed slowly, and after three
years the left eye was completely blind. The Wassermann reaction was positive. The atrophy of the optic nerve was due to the pressure of the bony tumour. The differential diagnosis is discussed. In the second case there was again a bony enlargement of the face on the left side. There was complete atrophy of the optic nerve. There was no alteration in the external muscles of the eye. The Wassermann reaction in this case was positive.

E. E. Cass.


(4) Pavia stresses the importance of the examination of the fundi in cases of general diseases. Minute lesions in the choroid and retina may be amongst the earliest symptoms of some diseases. The depth at which these lesions are situated can be determined with the aid of a binocular ophthalmoscope. When these lesions are very minute, they cannot be seen with the ordinary ophthalmoscopic methods, and are only discovered by means of the binocular ophthalmoscope. The author quotes Bailliart's paper on capillaritis and the necessity of thorough general investigation to determine the significance of early fundus lesions.

The author here describes a case seen in his own clinic. The patient was aged 46 years, and was suffering from iridocyclitis in the right eye. The pupil was dilated, and a minute fundus examination revealed the existence of a doubtful capillaritis. The patient never returned to the clinic, but two years later was examined by someone else and was diagnosed as subacute conjunctivitis. A month later he was seen by Pavia, as the vision in both eyes had suddenly failed and he had bare perception of light.

Both discs showed atrophy, exudates, and changes in the macular region. The urine contained 3.5 grs. of glucose per cubic centimetre. The vision had begun to fail six months previously, that is to say, 18 months after the author had first discovered the fundus lesions.

In conclusion, the author stresses the importance of laboratory tests in cases with early retinal changes.

E. E. Cass.


(5) Pavia refers to a previous paper of his regarding the significance of a "green coloured" lesion in the fundus. In the present paper he describes 25 cases, with chronic diseases and retinal
lesions, showing green spots recorded by coloured photographs. All cases showing this green colour have some oedematous condition of the retina.

The author describes the case of a diabetic, aged 69 years, who had very fine points of exudate in both eyes; his blood sugar was 0.220 per cent. In the right eye there were some white patches at the macula, situated behind the retinal vessels and scattered all over the posterior pole.

A coloured photograph was taken and a green spot was seen to be situated above the inferior macular vein. The ordinary black and white photograph showed no difference in this region, nor did examination with red-free light. The author points out that in a previous paper he says that a retinal photograph in black and white shows retinal changes whereas a colour photograph shows choroidal changes.

The green spot corresponded with the spots of choroidal capillaritis.

Confirming the situation of the lesion (i.e., in the choroid and not in the retina) no scotoma for white or colours could be found, and colour vision and dark adaptation were normal. The patient was given general treatment for his diabetes and when the blood sugar was only 0.142 per cent. no green spot was seen at the macula. When, however, he stopped his treatment and the blood sugar rose, the green spot was again seen and the white spots of exudate were more accentuated.

On treatment this lesion again disappeared. The patient was not seen for three months and then came up again complaining that he could not see so well with his right eye. The blood sugar was 0.230 per cent. There was now a superficial exudate at the macula and a small haemorrhage. The green spot was not so obvious as in the first examination. In the colour photograph the choroid could be seen much more distinctly in the region of the lesion and the author thinks there was some retinal degeneration.

Pavia thinks that the green spot is caused by the presence of serum in abnormal quantities in the tissues (retina or choroid). The bilirubin of the serum is acted upon by the oxidases present in the tissues; forming biliverdin.

E. E. Cass.


(6) Pavia and Dusseldorf say that alterations at the macula have been very rarely observed in cases of pigmentary degeneration of the retina. One case has been described with an "orange
coloured focus," with pigmented borders, five with clear areas with spots of pigment, and one with a brownish area. There have been some doubtful cases where there were some pigmentary spots in the macular region. Attempts have been made to classify infantile and juvenile degenerations with pigmentary degeneration of the retina.

The authors describe a case of a Russian, aged 55 years. Night-blindness started in childhood, there was no family history; in the right eye the disc was a good colour, and had well-defined margins, the veins were normal and the arteries narrowed. At the macula was a polygonal area of half a disc diameter and darkish red in colour. Below this were two spots of black pigment. Round the central zone was a pale rose ring about half to three-quarters of a disc's diameter, whose irregular borders were defined by pigment; its limits were most marked on the temporal side. The other changes were peripheral, they consisted of numerous scattered pigmented spots, of irregular size and shape, many of them following and enveloping the vessels.

In the region of the papilla many choroidal vessels showed sclerosis. The spaces between the choroidal vessels instead of containing normal pigment contained a substance which was greyish-green in colour.

In the left eye at the macula there was a central zone in the form of an X, the two arms directed towards the disc, which was dark red. Surrounding this zone was another with the characteristics as described in the right eye. The other peripheral lesions were similar.

"Coloured retinographs" were taken, and showed that behind the spot at the macula there was an irregular accumulation of pigment.

There was evidently a deficiency in the layers of the retina at this point. The greyish-green substance previously mentioned appeared to be green. This substance was deep to the pigment deposits.

The visual fields showed annular scotomata in the periphery, and small central scotomata. The vision was—Right eye: finger-counting only, and left eye: 7/10. Dark adaptation, nil in the right, and diminished in the left.

The patient was treated with injections of liver extract for six months. In March, 1934, with red-free light, the right and left fundi showed a localized yellow-spot. The visual fields were the same as before. The vision was—Right eye 3/10; Left eye 8/10. The colour vision showed many abnormalities. The dark adaptation had improved.

(Note:—Dr. Pavia uses a Zeiss - Gullstrand binocular ophthalmoscope.)

E. E. Cass.

(7) Pavia describes a case of a diabetic with a high glycaemia, in which one eye had been blind for two years, and the other had choroido-retinitis. Three months before he was seen by the author he was knocked on the head and the vision of the left eye was appreciably diminished and only a very small sector of the field was left. There was a large retinal detachment, corresponding roughly to the diminished field. Although little hope of any improvement was given to the patient, he wished for an operation, which was accordingly performed.

A big conjunctival flap, extending from "1 o'clock" to "5 o'clock," 7 mm. from the limbus, was dissected up and the external rectus was cut. Dugast's diathermy apparatus was used and two punctures were made. The patient was kept flat on his back for five days after the operation. Twenty-nine days after the operation the vision was 1/16 (Wecke) and the visual field was markedly improved.

Retinal photographs taken before and after the operation are shown, demonstrating that the detachment was considerably less after the operation, but the astonishing thing was that a large number of the exudates rapidly disappeared after diathermy and the vessels, which were hidden by the intense infiltration of the choroid and retina, came into view.

E. E. Cass.


(8) Orzalesi has had the opportunity of examining an eye which was removed on account of the mistaken diagnosis of glioma. The lesion was in reality Coats's disease in various stages. From the microscopical anatomy of the specimen he concludes that the first change is an affection of the pigment epithelium which produces a secretion between the layers of the retina; the nature of this secretion is not ascertained, but the author thinks it is probably viscous and colloid. In it are found a number of cells derived from the pigment epithelium and some red corpuscles derived by diapedesis from the engorged choroidal vessels. This exudate is not absorbed, but seems to interfere with the proper nutrition of the retina and this also undergoes degeneration.

_Harold Grimsdale._

Malkin recalls division of the optic nerve as a procedure which aimed at retaining a blind painful eye. He finds alcohol injection, first advocated by Grüter in 1918, a superior method. Of 26 cases thus treated, 23 were glaucomatous; in 22 cases the procedure had to repeated, and in most cases antiglaucomatous measures, such as trephining and the use of miotics, had to be carried out in addition.

**Technique:** Cocainize the eye. Inject 1 c.c. of 2 per cent. novocain-adrenalin, using a needle 4 cm. long, and injecting backwards within the orbit at the lower and outer angle. Leave needle *in situ* and inject, 8 to 10 minutes later, 1 to 3 c.c. of 80 per cent. alcohol (40 per cent. if eye still retains useful vision). Subcutaneous injection of morphia to control pain which generally lasts for one to two hours.

Complications: Oedema of lids and conjunctiva. Transient ocular palsies (ptosis lasting several months has been observed). Headaches lasting as long as 5 to 12 days or even longer.

**Arnold Sorsby.**

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**BOOK NOTICES**


That this little book has attained its 8th edition is testimony to its popularity and usefulness to the student who wishes to learn the essentials of practical ophthalmology in a concise and direct form. The author has emphasized the relation of general medicine to a number of ophthalmic diseases and injuries. He has included a chapter on 'Standards of Vision' for official and other appointments for the convenience of reference. The 7 chapters on refraction are based on sound teaching and should form a concise guide to the practitioner who may wish to begin this branch of work after qualifying.

The whole book has been corrected, revised and brought up to date, and 38 new illustrations included. At the end there are 22 examination questions such as might be asked in any final qualifying examination. It is a valuable book for the student on the eve of examination and for the busy general practitioner who wishes to revise important and essential facts in the practice of ophthalmology.
ABSTRACTS

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