The number of School Clinics provided by Local Education Authorities for the treatment of Defective Vision and Squint during the last ten years is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Clinics</th>
<th>Year</th>
<th>Number of Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>-</td>
<td>1932</td>
<td>-</td>
</tr>
<tr>
<td>1928</td>
<td>-</td>
<td>1933</td>
<td>-</td>
</tr>
<tr>
<td>1929</td>
<td>-</td>
<td>1934</td>
<td>-</td>
</tr>
<tr>
<td>1930</td>
<td>-</td>
<td>1935</td>
<td>-</td>
</tr>
<tr>
<td>1931</td>
<td>-</td>
<td>1936</td>
<td>-</td>
</tr>
</tbody>
</table>

569 660
593 673
606 670
633 694
644 718

Number of Hospitals with which Local Education Authorities have made arrangements for the treatment of defects of vision, year 1936.

<table>
<thead>
<tr>
<th>Visual Defects</th>
<th>Other Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refraction</td>
<td>Non-Operative</td>
</tr>
<tr>
<td></td>
<td>Operative</td>
</tr>
<tr>
<td>Number of Hospitals</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>42</td>
</tr>
</tbody>
</table>

ANNOTATION

Ophthalmic Casualties in Air Raids

It seems that in the event of air raids the special hospitals in the London area and other large centres will be commandeered for the treatment of casualties of all kinds and that their rôle will be similar to the general hospitals.

It is desirable that ophthalmic casualties should be dealt with by units trained for this work and that they should be evacuated from the theatre of air raids at the earliest opportunity after appropriate treatment has been applied. There is no need for any ophthalmic case to remain in the danger zone. Gas cases and minor injuries
LINES OF EVACUATION
(i) Bye roads
(ii) Railways
(iii) River

FIG. 1.
could be evacuated by underground railways, in cars or by river transport, leaving ambulances for the stretchers of those who have sustained perforating wounds of the eye and disabling injuries to other parts of the body.

Some of the burden of casualty work in the hospitals could be relieved by treating minor cases at first aid posts and the evacuation of such directly from this source. A mobile ophthalmic unit in a motor ambulance equipped for ophthalmic operating would also lessen the strain on the hospitals by touring the first aid posts in a given area when summoned for help.

Evacuation could be made directly to general or special hospitals situated 20 or more miles outside the theatre of aerial attack and at a safe distance from main roads, rail heads and rivers.

It would be more desirable to have an ophthalmic unit in a general hospital or if necessary near a general hospital. Patients could be discharged from these hospitals to convalescent homes or occupational training centres before returning to their place in military or civil life.

Fig. 1 is a rough plan showing the principles of evacuation of ophthalmic cases and Fig. 2 is a suggested plan for the reception of ophthalmic cases at a general hospital within the zone of aerial operations. This reception station should be situated underground and adequate provision made for possible failure in the main electric light and water supply. The entrance and exit should be rendered gas proof. Stores of food, drinking water, cylinders of oxygen, pick axes, ropes, electric torches, fire extinguishers and sand should be in readiness for emergency measures.

Gas cases would have to be segregated from the others and enter a decontamination room where clothing was removed and placed in bins and the patients have shower baths before entering the treatment room for irrigation of the eyes. Large irrigators holding several pints of lotion should be mounted on stands near each treatment chair. The personnel administering this treatment should be protected against gas.

In the other part of the ophthalmic clinic, minor injuries, extraction of intra-ocular foreign bodies, repair suturing of wounds of the eye would be carried out in the operating theatre for that purpose.
Ophthalmic Casualties in Air Raids

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