On three occasions in the past twelve months, the bony window has opened into ethmoid cells. Whilst this complication had made the operation technically more difficult, the end results have been satisfactory.

**Summary**

(1) The results of sixty cases of external dacryocystorhinostomy operation performed in the Leeds General Infirmary are reviewed.

(2) Consideration of the figures show little difference in the results:

(a) Of the two different methods employed, or
(b) The experience of the operators.

I wish to thank both Mr. J. Foster and Mr. G. W. Black for permission to carry out this review, and for their helpful criticism.

**References**

4. ———— (1941).—*Arch. of Ophthal.*, 26, 165.

**Visits to Continental Ophthalmic Clinics, 1948**

Under the auspices of the Faculty of Ophthalmologists three parties, each of some twenty ophthalmologists, visited clinics on the Continent in the summer of 1948. A debt is owing to the Professors and their assistants at the several clinics visited, and they will be interested to hear of the eulogy with which their efforts are related, and the gratitude with which they are remembered.

The Holland visit was organised by John Foster (Leeds), who reports that at Leiden the party was received by Professor van der Hoeve, the doyen of Dutch ophthalmology. A series of papers was read by the Professor and his assistants. Dr. Copper has modified and developed the Piezometric device of Guttman.
(Zeitschr. f. Augenheilk., 1914, 31, 4), and produced new figures of orbital impressibility for a variety of conditions. Dr. Binckhorst gave an account of twelve cases of toxoplasmosis hominis, in which organic disturbance of the central nervous system was associated with choroidal lesions. Mrs. Dr. Kok advocated square keratoplasty for adherent leucoma of irregular thickness, and round grafts where operation was expected to be simple, or good appearance essential. Dr. Pieck performed one round and one square keratoplasty, the first by the technique of Franceschetti, the second by that of Castroviejo. Professor van der Hoeve read a paper on lipoidosis, including: (a) Niemann-Pick disease and amaurotic idiocy (lecithin), (b) Gaucher's splenomegaly (cerebrosin), (c) Schilder's disease and xanthomatosis (cholesterin).

UTRECHT. Professor Weve received us at a conversazione at which he showed films of intracapsular extraction and Toti's operation. Dr. Fischer gave demonstrations of Goldmann's method of gonioscopy, the reflectograph which shows minute corneal irregularities, and the cobalt lamp for refraction invented by Russler in 1930. In-breeding in the nearby villages of Walcheren and Spakenburg has produced widespread familial keratoconus, and a special contact-lens clinic is run by Mrs. Dr. Fischer to meet this problem. The lenses are made by fusing old X-ray plates by blowpipe on to plaster casts of corneal moulds.

Black caps, walls and gowns, and grey masks attached to a special operating spectacle, make Professor Weve's theatre an unusual sight. Intracapsular extraction is performed conventionally except for pre-operative tonometry and retraction sutures held by an assistant. In detachment operations the tear is localised on the sclera by the glow point of indirect ophthalmoscopy. The diathermy is directed exclusively against the hole. Over a thousand dacryo-cystorhinostomies were carried out between 1917 and 1937, partly by Toti's and partly by Dupuy-Dutemps' method.

GRÖNINGEN. Professor Rochat (now Emeritus) demonstrated the auto-refractometer with which he has established the occurrence of diurnal variations in astigmatism, up to 1 D. A film of cyclodialysis inversa (Blaskovics), and gonioscopic appearances of successful cases was demonstrated by Professor Dekking. A case of retinitis pigmentosa was treated by 'ktanotherapy.' (Six c.c. of fresh iced placenta were dipped in penicillin and buried under the conjunctiva. A big reaction often follows.) Models of a dark-adaptation test, a binocular ophthalmoscope, and a hand slit-lamp (designed by Professor Dekking and made in the University workshop) were demonstrated.

At AMSTERDAM Professor Hagedoorn demonstrated intracapsular extractions, needling, and squint operations, a device
for measurement of orbital impressibility, cases of fascia lata graft, of resection of the ciliary ganglion for pain, and of tetanic cataract following irradiation of the thyroid. Papers were read by Dr. Adema on "Reefing as treatment of squint," and "Total corneal transplant" by Winckelmann.

Mr. Foster adds, "I would like to offer our thanks once again to our hosts, for (to paraphrase a current advertisement) "Wat der Nederland doet, doet der Nederland goed."

PARIS. The visit was arranged by R. J. Buxton (Yeovil), who sends the following report:—

After a clinical meeting at the Hôpital Quinze-Vingt, Dr. Hartmann showed cases at the Hôpital Lariboisière, and held a demonstration in the use of the tonometer. The diastolic pressure was useful in diagnosing cases of early cerebral tumour and concussion. Dr. Hartmann further discussed corneal graft technique, and showed patients with very satisfactory results. On the next day (Tuesday) we saw Dr. Schiff-Wertheimer and Dr. Dollfuss operate. One retinal detachment was treated by surface coagulation and perforations, and another by the actual cautery; intra-capsular operations were performed. Dr. Monbrun showed cases of tuberculous choroiditis, many of which had been successfully treated with streptomycin. He identified three types of fundus lesion in tuberculosis: (1) disseminated choroiditis, (2) tuberculoma (single large lesion) (3) optic disc lesions. Streptomycin was apparently not toxic to the optic nerve, but the latter might be compressed by organisation of exudate.

Dr. Favory demonstrated two intra-capsular extractions with forceps, and later we were shown round the dermatological museum by Dr. Reynard. We saw a case of leprosy with pathognomonic granules on the iris, and paintings of retinal angioid streaks associated with pseudo-xanthoma. Placental grafts were being tried for retinitis pigmentosa.

Dr. Hartmann demonstrated cataract extractions. Atropine, cocaine and adrenalin drops were used, no suture was inserted in the lower lid, and no speculum was employed. After dissecting the conjunctiva from 3 to 9 o'clock, the incision was made with a keratome and enlarged with scissors; two iridotomies were made, and three corneoscleral sutures inserted. In a corneal graft operation by Dr. Offret a Franceschetti’s trephine (made by Grieshaber) of 5 mm. diameter was used, and then a graft cut without shelving the edges. The graft was kept in place by standard criss-cross sutures. Dr. Offret also gave a lecture at the Hôtel Dieu dealing with reticulo-sarcoma. He also spoke of
familial keratitis; there are two dominant types, (a) Groenouw, and (b) grillagée (lattice), and one recessive-tâchée (dotted). The differentiation is important, as the Groenouw type can be treated by lamellar rather than whole-thickness grafts of the cornea.

We returned full of memories of a most enjoyable week, much impressed by the tempo of Paris life. We owe our most sincere thanks to our French colleagues for the organisation of the visit.

SWITZERLAND. Tour organised by W. M. Muirhead and A. B. Nutt (Sheffield).

GENEVA. J. H. Doggart (London) reports as follows:—

Professor Franceschetti and his two Chief Assistants, Dr. Bischler and Dr. Blum, demonstrated cases, performed operations and reviewed the effects of certain new drugs. Dr. Bourquin’s laboratory display of familial and hereditary degeneration of the cornea, neatly classified and vividly described, was a privilege to attend. Another particularly fascinating item was Dr. Klein’s work on inherited ocular disease.

An eminent gynaecologist, Professor H. de Watteville, reminded us that the influence of the sex-hormones far transcends their effect upon the sexual functions. Various disorders of the pituitary gland, including the Laurence-Moon-Biedl syndrome, were also reviewed in so far as gonadotrophic hormones offer a clue to the diagnoses. Professor de Watteville’s teaching, supported by a number of specimens and microscopical slides, opened up an endless vista of the influence that may be exerted upon general metabolism by the sexual hormones.

Many of Professor Franceschetti’s clinical investigations have been pursued jointly with Dr. F. Bamatter, who reviewed the literature on toxoplasmosis, and went on to describe the clinical and pathological phenomena observed in the victims of this protozoal infection. He stressed the importance of identifying protozoa in stained tissue sections or discharge obtained from the host, or else indirectly by means of animal inoculation. We were shown old fundus lesions in a number of cases. The typical disturbance consists of a large irregularly shaped, craggy-looking area of old choroido-retinitis. Treatment mainly consists of sulphonamides parenterally administered. Rabbits, guinea-pigs, dogs, cats, sheep and rats have all been shown capable of harbouring and transmitting the parasites.

Professor Franceschetti, who is a dexterous and experienced corneal gratter, reviewed the various types of graft, including the total superficial variety favoured by Sourdille, and the rectangular...
section adopted by Castroviejo. Professor Franceschetti himself uses a circular whole-thickness graft of 3 to 8 mm. in diameter, and regards 5-1 mm. as the optimum. This last-mentioned size is placed into a slightly smaller (5 mm.) gap in the recipient cornea. Many technical details were subsequently demonstrated on the operating-table by Professor Franceschetti and Dr. Blum. One aspect of grafting stressed by Professor Franceschetti was the differential prognosis. Some of the most successful results have been obtained in various forms of corneal dystrophy.

The Professor is a great host, an inspiring teacher, and a guest who will always be welcome in Great Britain.

Zü richness. Lectures and demonstrations by Doctors Huber and Verrey were devoted to the work on changes in the aqueous humour and blood-aqueous barrier studied by chamber puncture, and observations on the Tindall phenomenon and fluorescein test investigated at Zü rich for the past nine or ten years. This has already been described by Professor Amsler in the Bowman lecture to the Ophthalmological Society of the United Kingdom in 1948.

Professor Amsler gave four lectures. The first was on "Keratoconus; diagnosis of formes frustes." By "Keratoconus fruste" is meant the slight, often abortive, type of conical cornea which was not recognised until it was demonstrated by Amsler, and since the cornea is not obviously conical even when superficially examined with Placido’s disc, it is apt to be missed unless one is aware of its existence. It accounts for at least some cases of unexplained irregular astigmatism. It is spotted most easily in routine refraction work when the Javal-Schiotz ophthalmometer is used, and in retinoscopy is suggested by the presence of a central "shadow" which rotates around a central point as the mirror is moved to and fro. The diagnosis is confirmed by means of the special Placido’s disc designed by Amsler. In addition to the black and white rings, it has white cross markings, is self-luminous, and is combined with a camera which photographs the corneal Placido image. The advantage of the camera is that in very slight keratoconus the small distortion of the Placido image can best be noted by studying photographs thereof. By this means it is observed not only that the rings are narrower in one quadrant (lower temporal) than in the opposite quadrant (upper nasal), but that the horizontal limbs of the cross are at an angle to each other. Amsler measures the degree of keratoconus by reference to this angle between the horizontal white lines. He has thus divided keratoconus into four stages: K. I, when the angle is less than 5 deg.; K. II, when the angle is 5 to
10 deg.; K. III, over 10 deg. \( (i.e., \) macroscopic conical cornea, but without central opacity); K. IV, conical cornea with central opacity.

As a result of these observations several facts have come to light: (1) Mild degrees of keratoconus which may or may not progress are more common than has hitherto been thought. (2) Keratoconus is more commonly bilateral than has been realised hitherto. (3) It is more commonly familial than is realised. (4) It has been confirmed that the distortion of the cornea is always in the same direction—the apex of the cone is displaced downwards and outwards.

For treatment of keratoconus Amsler recommends: (1) For K. I, cylindrical correction decided by subjective means. (2) For K. II, the same or a contact lens. (3) For K. III, a contact lens. (4) For K. IV, keratoplasty is preferred to Sato’s operation.

Professor Amsler’s other lectures were upon detachment of the retina, tests for macular function, and the technique of corneal grafting. The enthusiasm and hospitality of the professor and his assistants were greatly appreciated and will not be forgotten.

BERNE. P. McG. Moffatt and C. Dee Shapland (London) report that the party met Professor Goldmann at the University Eye Clinic. His first lecture was on gonioscopy, and was followed by a demonstration of cases showing normal and pathological filtration angles. The Haag-Streit slit-lamp with the Goldmann deviation prism and gonioscopy contact lens were used for these cases, and an opportunity given to each member to become acquainted with their use.

The main value of gonioscopy is to determine pre-operatively which type of glaucoma operation to perform. For the narrow angles which accompany the shallow anterior chamber of congestive glaucoma, and in which the obstruction would appear to be between the root of the iris and the back of the cornea, Goldmann advises iridectomy, preferably by Dieter’s method. For the wide angle type, in which the anterior chamber is often deep, and in which the obstruction would appear to be in the trabeculae, cyclodialysis by a slight modification of Blaskovics’ method is the operation of choice.

On the next day Professor Goldmann lectured to us on (1) the slit-lamp examination of the fundus oculi with a contact glass, and (2) the localisation of non-magnetic intra-ocular foreign bodies. Retinal biomicroscopy, besides affording a much enlarged and stereoscopic view of the fundus oculi, is of definite value in the differential diagnosis of obscure macular conditions, \( e.g., \) holes,
EYEBALL ROTATING FORCEPS

Eyeball rotating forceps, cysts or oedema, and should prove of great value in research, as in detachment of the retina. Professor Goldmann also gave a short talk and demonstration on the aqueous veins which he had discovered shortly after, but independently of, Ascher.

We left with the happiest memories of the quiet courtesy of Professor Goldmann, and with great respect for his ingenuity in diagnostic instrument design.

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EYEBALL ROTATING FORCEPS

BY

R. LINDSAY-REA

LONDON

Every ophthalmic surgeon is aware of the difficulty of rotating the eyeball downwards without obscuring his view. Whether he himself or his assistant holds the conjunctival forceps, the hand holding the instrument comes up and gets in the way.

The idea occurred to me to make a forceps as illustrated. Each blade terminates with a bent arm which is toothed for catching the conjunctiva. The conjunctiva is seized at 6 o’clock and the spring clip fastened. The forceps then lies on the sterile towel on the patient’s cheek. By simply pulling the forceps down, the eyeball can be rotated downwards, the view being uninterrupted. Many uses will be found for this instrument. With it, a muscle suture is unnecessary. It always occupies a place on my operating table.

The illustration was kindly provided by Messrs. Down Bros., who made the forceps. It is also manufactured by Messrs. Weiss and Son.