Army Pensions. Old Age Pensions for the Blind.—The Committee finds that the authorities have made arrangements for the examination of the eyes of army pensioners, and of blind claimants for the Old Age Pensions. In consequence, it is now outside the duties of the medical officers of any hospital to make examination or report for either of these purposes.

ABSTRACTS

I—TUMOUR OF THE FRONTAL LOBE OF THE BRAIN WITH OCULAR SYMPTOMS


Knapp's patient, a man of 36 years, suffered from atrophy of the discs, a central scotoma in each eye, and defective sight (R.V. 20/50; L.V. 2/200). Wassermann reaction positive. The condition failed to improve under treatment, and the man became apathetic and mentally slow, and numbness of the right side of the face developed. Examination by X-rays, which showed excavation and bone rarefaction in the anterior and the middle cranial fossa, suggested pressure by an unusual mass in the sellar region. The patient succumbed to haemorrhage after an exploratory operation on the skull.

At the autopsy a firm tumour, measuring 2 by 2½ inches, was found in the right frontal lobe, springing from the dura on the convexity and from the adjoining part of the falx. The right frontal lobe was greatly enlarged at the expense of the left, so that the median line ran obliquely in the left half of the skull. The cortex of the right lobe was much reduced in size. The bone covering the ethmoidal and sphenoidal cells was very thin. The optic nerves were flattened. Posterior to the chiasma there was a rounded, bulging mass, a distended tuber cinereum, which had crowded the optic tracts apart and had hidden the mammillary bodies. The walls of this distended area were so thin as to be translucent. The dilatation of the third ventricle was limited to its lowest part, forming a sacculated diverticulum. The hypophysis was enlarged and displaced backwards. The dural covering of the pituitary fossa was intact, and the infundibular opening was not enlarged. The tumour was an endothelioma.

Briefly, the brain showed a frontal tumour in an enormously enlarged right lobe which had produced a sacculated distension of the third ventricle and pressure atrophy of the underlying bone in
AETIOLOGY OF CHRONIC MEIBOMITIS

Gifford, R. Sanford (Omaha, Nebraska).—The Etiology of chronic Meibomitis. Amer. Jl. of Ophth., August, 1921, pp. 566-570.

Gifford investigated the bacteriology of the Meibomian secretion in 65 cases. His method of obtaining the secretion of the glands without contamination from the lids or lashes, was to wipe the margins of the lids with a slightly moist sterile sponge, then to squeeze both lids together and rub the loop along the mouths of the glands. Moist Loeffler's blood-serum, or cooked-meat broth, gave the best results for culture of the pneumococcus, streptococcus, Morax-Axenfeld bacillus, and B. xerosis.

He tabulates his results as follows: Table I. Simple Meibomitis; Table II. Meibomitis with Hypertrophy; Table III, Meibomitis with Chalazia; Table IV. Normal Lids—Medical Students; and Table V. Normal Lids—Old Men at County Hospital. The findings for smear and culture are given, the former being considered the more valuable evidence when organisms are present.

The first two tables comprise the results of twenty cases.

The B. xerosis was found in rather less than 50 per cent. of these cases, staphylococcus being present in almost every case. In the five cases given under Table III, B. xerosis was found twice, and staphylococcus four times. The pneumococcus was very rarely met with in any of the 65 cases.

In the normal lids of the younger age group (Table IV) B. xerosis was found three times, and staphylococcus fifteen times; in the older men (Table V) B. xerosis occurred in fourteen cases, and staphylococcus in seventeen.

The term B. xerosis was employed to include various strains of apparently cognate organisms. Gifford describes the organism as "pyophilic" to distinguish it from pyogenic or pus-forming organisms. He finds it in large numbers in the smears of old persons—whether suffering from chronic Meibomitis or not—than in those of young persons. The senile changes which take place in the lids (as the result of increased connective-tissue formation, presbyopic spasm, etc.), favour the growth of this organism, thus
giving rise to hypersecretion and Meibomitis. When the ducts of
the glands become occluded, chalazia develop. He holds that in
younger persons staphylococci produce a sharper reaction, which
leads to occlusion of the glands and consequently to chalazium
formation; whereas in the old the B. xerosis prevalent in the glands,
produces a sluggish reaction which manifests itself as chronic
Meibomitis.

A short review is given of the literature of the bacteriology of
Meibomitis. The author refers to a previous communication of his
own on the subject, but omits to give the reference.

J. HAMILTON McILROY.

III—THE TARSUS MADE Pliable AS A CURE FOR
GLAUCOMA

Dimitry, Theodore, J. (New Orleans, La.).—The tarsus made
pliable as a cure for trachoma. Amer. Jl. of Ophthal., Feb.,
1921, p. 107.

Dimitry describes a simple procedure which he has devised for
the expulsion of the contents of the follicles in trachoma, claiming
that his method is unattended by the disadvantages of the ordinary
operative methods in giving rise to no increase of scar-tissue; and
in addition is valuable in that the manipulation involved softens the
infiltrated tarsus, and stimulates healthy cell reaction.

The technique is as follows: a piece of stout copper wire eight
inches in length, bent slightly at about two inches from one end, is
wrapped in a thin covering of cotton wool at the bent portion.
The eye is carefully prepared for surgical operation (the author lays
stress upon this), and the wool-wrapped probe, dipped in sterile
water, is taken in one hand and inserted under the everted lid, the
latter being supported by the thumb of the other hand. The probe
is rotated upwards over the lid, steady pressure being kept up
against the thumb opposed behind the lid. The tarsus is manipu-
lated and softened by this combined action, and ischaemia alternates
with hyperaemia; at the same time the contents of the follicles
become expelled. When treatment is given only once, and is of
necessity more drastic, general anaesthesia is required; but good
results are obtained from repeated applications of a more gentle
nature, local anaesthesia being sufficient. Several text illustrations
are given.

J. HAMILTON McILROY.

*The paper referred to is probably the following:—"Fusiform Bacilli on Conjunctiva
and in Meibomian Glands." S. R. GIFFORD. Arch. of Ophth. Vol. XLIX, pp. 477-
484, 1920.
IV.—MISCELLANEOUS


(1) Black had for several years met with cases in which female patients presented the signs of a troublesome and intractable conjunctivitis, which he was eventually able to trace to the use of a face powder containing rice powder; the suggestion appears to be that the cells from the hard exterior of the rice grains were to blame.

R. H. Elliot.


(2) Cozzoli records a case of partial thrombosis of the central vein of the retina in a man of 26 years, which came on immediately after a blow on the head in the left parietal region. He noticed that the vision of the left eye was affected on the following day. Cozzoli found that the left pupil did not react directly to light nor transmit a consensual reflex to the other eye, but itself reacted consensually. Ophthalmoscopically there were numerous haemorrhages, principally in the neighbourhood of the maxillo-nasal branch of the central vein, and the arteries were much reduced in size. Vision was reduced to 1/10th. The second pulmonary heart sound was accentuated, the superficial arteries were sclerotic, and the urine contained a trace of albumen. Treatment had no effect, and the vision sank to 1/20th, and that only in the superior-external quadrant of the field. There was no history of venereal disease, and the Wassermann reaction was negative. A coloured plate accompanies the paper.

E. E. H.

(3) Suker, George Francis (Chicago).—Optic neuritis (unilateral) resulting from a tonsillar infection. Ophthal. Record, June, 1917.

(3) Suker reports a case of left-sided optic neuritis with blurring of the macular area, but no retinal haemorrhages, ascribed to infection from septic tonsils. Vision was 20/60 (R. V. = 20/16), the field was constricted for form and colours, and the blind spot was a trifle enlarged downwards. Within 36 hours after enucleation of the tonsils vision rose to 20/40, and within 72 hours to 20/20.

J. Jameson Evans.


(4) During thirty-three years of eye work Gifford has met with
five cases in which an eye has been injured by a broken spectacle lens. In none of these was the eye lost, and in at least two of them it is probable, the author thinks, that if glasses had not been worn a worse injury would have occurred. To this Gifford opposes the fact that during the same length of time he has seen some 2,300 cases of serious traumatic injury to the eye, at least 90 per cent. of which would probably not have occurred if glasses had been habitually worn. "The protection which spectacles afford is so much greater than the risk which they involve, that every person with only one good eye should habitually wear them."

S. S.


(5) Hirsch's case was that of a woman aged 43 who consulted him on account of sudden diminution of vision which came on after a long walk of about 25 km. in one day with very little nourishment. On examination V. in right eye with —1.5 was 5/7, and in left eye with —2 was 5/10. Both lenses showed numerous fine radial refractive sectors. The correcting glasses were ordered and the case was diagnosed as early senile cataract. The patient returned within the week and said that four days later the sight suddenly improved and she could see better without the glasses. V. was now 5/5 in both eyes and the lenses were perfectly clear. There was no history of the use of any drug or exposure to any poison, such as naphthol, and the urine was normal.

E. E. H.


(6) Leavitt describes a rare case of recurrent paralysis of the right sixth nerve, which first appeared after an attack of measles in a girl who was then one and a half year of age. At first the intervals between the attacks lasted six to thirteen months, but for the last four and a half years the normal intervals became shortened to from two days to four months, and the period of paralysis became extended from five or six weeks to seven weeks.

Before the eye became paralysed she had severe headache, chills, and fever, sometimes nausea and vomiting for two days, and she was obliged to stay in bed and was unable to eat anything. When the eye was getting better she experienced a sort of pressing sensation in the eye and head and a feeling as if the eye was turning back to its normal position.

The last attack lasted two months before the paralysis began to
disappear, and it was another month before the movement was completely restored.

After having twenty-five to thirty attacks the muscle, when not paralysed, seemed as good as ever.

The aetiology by analogy with oculo-motor paralysis of the same type is probably inflammatory or oedematous changes involving the nerve root.

J. Jameson Evans.


(7) In Killian's operation on the frontal sinus the trochlea was originally respected carefully from fear of paralysis of the oblique muscle. Later experience showed that even if the trochlea was removed, the resulting diplopia soon disappeared. Hajeh even claims that this is always so. Doesschate and de Kleijn, however, observed a case in which, after removal of the trochlea, diplopia was so disturbing that the eye on the operated side had to be constantly occluded by a ground glass, even a year after the operation.

G. F. Rochat.


(8) Walker and Cushing give the following as the conclusions, drawn from their studies of optic nerve atrophy in association with chiasmal lesions:

1. Despite the so-called atrophic pallor of the disc in patients having visual field defects resulting from lesions in the chiasmal regions, the histological examination of the nerve fails to show the expected degree of fibre degeneration, unless the process has been of long duration.

2. The atrophy in the tracts considerably antedates that in the nerves, where the fibres may be preserved by their retinal ganglion cells for several years after complete functional blindness has occurred.

3. Their cases serve to illustrate the fact that in the presence of chiasmal pressure of known long duration associated with sharply cut hemianopsia, even when to the ophthalmoscope the nerve shows the pallor of presumed atrophy, there may be no corresponding sharp delimitation of the areas of atrophy in the cross-sections of the nerve.

4. This would at first sight seem to be an inconsistency, but more accurate perimetric findings with graded discs show that, after
all, the boundaries of the seeing areas are less sharply cut than had
been previously supposed, and perhaps really correspond with the
diffuse picture of the nerves.

R. H. ELLIOT.

(9) Lemierre, A.—Amaurosis followed by a transitory hemianopia
in the course of an acute nephritis; part played by cerebral
oedema. (Amaurose suivie d'hémianopsie transitoire au
cours d'une néphrite aiguë; rôle de l'oedème cérébrale.)

(9) Lemierre's case was that of a man aged 29 in whom an
angina was followed by an acute nephritis marked by oedema,
especially about the face, extreme scantiness of urine, vomiting,
eclampsia, torpor, and by an absolute amaurosis lasting twenty-four
hours, followed by a transitory right homonymous hemianopia.
On the fourth day the symptoms vanished with the installation
of a copious polyuria. The blindness in this case was obviously
cortical in type, as shown by the integrity of the ocular fundus and
the preservation of the pupillary reflex. The transformation of the
complete amaurosis into a hemianopia also supports this view.
Although there was a marked increase of urea in the blood, which
disappeared on recovery, Lemierre does not consider that this had
anything to do with the blindness. Azotaemia is the active agent
in the production of retinitis (Widal, Morax, Weill, and de Rochon-
Duvigneaud), but this was absent in this case. He attributes the
condition to chloride retention, and refers to a case published by
himself in collaboration with Widal, in which oedema was produced
by sodium chloride in a case of kidney disease in which that organ
was impermeable to chlorides (*Bull. et mém. de la Soc. méd. des
hôpitaux*, 1903, p. 678). On this hypothesis the visual troubles
would be due to cerebral oedema with hypertension of cerebro-spinal
fluid. The prognosis of such cases, in spite of the severity of the
symptoms, is not bad, provided the polyuria comes to the rescue in
time, and that a rapid increase of the azotaemia does not lead to
retinal changes. Treatment is of considerable value. Bleeding
to the extent of 600 ccm., and wet cupping in the lumbar region
with drastic purgation are the measures recommended by the
author.

E. E. H.

(10) Babonneix, M. L.—Specificity or non-specificity of the Argyll
Robertson sign. (Spécificité ou non-spécificité du signe
d'Argyll Robertson.) *Gazette des Hôpitaux*, March 26, 1921.

(10) Babonneix discusses in this paper the question of how far
the Argyll Robertson pupil may be taken as conclusive evidence of
the existence of syphilis. He gives no new facts, but merely
discusses the conclusions of other observers, as well as some of his
own previously published cases. After a careful analysis of all apparent exceptions, he expresses the opinion, "that there exist in the literature some cases of the Argyll Robertson sign which seem independent of all syphilis, latent or patent. These cases are, however, so exceptional that, in practice, the recognition of this symptom signifies nerve syphilis, and should in the immense majority of cases, direct the treatment."

E. E. H.

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**BOOK NOTICES**


This well-illustrated volume of 450 pages contains much interesting matter. From it we learn for the first time of the deaths of Samuel Doty Riseley, of Philadelphia, and of Robert Lee Randolph, of Baltimore. The Minutes of Proceedings include reports on standardisation of the illumination of test cards and perimeters, and of an International Congress of Ophthalmology. It was resolved that the name of any member absent without valid excuse for three consecutive years, or who shall have failed to contribute to the scientific proceedings of the Society by proffer of a paper or by participation in its discussions shall be expunged from its list of members. Certain exceptions are made; these include honorary members or members of twenty years' standing, or those then serving in the army or navy. A further exception is made in the case of any member living more than one thousand miles from the place of meeting.

Those scientific communications contained in the *Transactions* likely to interest our readers will be published in abstract form at a later date in the columns of this Journal.

S. S.


This slim volume of 77 pages represents the Proceedings of the Annual Meeting of the Society, held on March 5, 1920, in the Pathological Museum of Kasr el Ainy Medical School, when sixty members were present. The volume contains sixteen communications, of which four have been already published in *Transactions*.