Case 3

This case was a private patient and was interesting in that the embolism produced a sharply-defined altitudinal macular hemianopsia.

Mrs. A. H. C., aged 60 years, complains that yesterday she suddenly noted a blur over the right eye and that now the upper half of the field of vision is blind. Two years ago she suffered from a painful thrombosis of a varicose vein in the left leg.

V.R.=6/18; V.L.=6/12.

Blood pressure, 180 systolic.

The peripheral field of vision is normal and shows no trace of hemianopsia when tested with a 2 mm. object on the Lister perimeter. The central field was mapped out on the Bjerrum screen. There is a total paracentral scotoma almost semicircular in outline. It is bounded below by the horizontal diameter of the chart and above it almost accurately fills the 15 degree circle.

There is a bright embolus just beyond the first fork of the inferior temporal artery blocking the branch to the macular region. The blood column in the artery distal to the embolus is segmented and motionless. There is no retinal oedema.

Nineteen days later the acuity of the right eye had sunk to 6/60. The embolus was still visible. There was then segmentation of the blood column and the stream could be seen slowly moving on. Treatment was refused.

A CASE OF MONOCULAR DIPLOPIA

BY

T. HARRISON BUTLER

BIRMINGHAM

A. G., male, aged 54 years, came to the Coventry Hospital on August 16, 1927, complaining of double vision in the right eye.

He stated that thirty years ago a file which he was using hit the right eye and scratched the cornea. No trace of any opacity or corneal irregularity was found.

The diplopia began ten years ago. Before this time he was a marksman in the Volunteers, and had perfect acuity in the right eye as far as he knew. Great difficulty was experienced in getting an accurate retinoscopy because there was a dark band across the pupil during the movement of the shadow.

With: -1.0D. sphere and +4.0D. cylinder axis 95° V.=6/60.

A double "E" is clearly seen one exactly over the other in such-wise that the lower limb of the upper "E" and the upper limb of the lower "E" coincide.

Careful examination with Placido's rings failed to demonstrate the slightest irregularity of the cornea, which was found with the slit-lamp to be absolutely normal.

The cause of the diplopia was clearly shown by an examination of the lens with the slit-lamp. A large fluid-cleft lay in the horizontal diameter right across the lens. It occupied the whole depth of the cortex being bounded before by the subcapsular line and behind by the surface of the adult nucleus. The rest of the cortex was normal except for a few striae. This cleft formed an optical opacity dividing the lens into an upper and a lower segment. These acted independently forming an upper and a lower image upon the retina.

TSCHERNING'S PHOTOMETRICAL GLASSES*

BY

DR. W. A. WILLE

SEMARANG, JAVA

THE different methods of examination of the light-sense and of the adaptation for light, which the ophthalmologist hitherto has had at his disposal, are rather troublesome and incomplete. The most exact instrument is Förster's photometer which in its original form consists of a black, light-tight camera, in the front wall of which are made two holes, for the right and the left eyes respectively, through which the patient looks into the camera. On the inside of the opposite wall is fitted a white square, which is illuminated by the flame of a stearine candle, fixed on the outside of the front wall, and surrounded by a screen. The light enters the camera through an Aubert's diaphragm, by means of which the illumination is measured. The object of the examination is to secure the least illumination, by which the white square inside the camera can be observed. The examination must take place in a perfectly dark room. We have also other instruments constructed according to the same principles, such as the adaptometer of Nagel and Piper.

Another method is to take the patient into a perfectly dark room, in the shutter of which has been fixed a big Aubert's

*See also *Brit. Jl. of Ophthalm.*, Vol. X, p. 231, 1926.—Ed.