TRYPANOSOME KERATITIS

BY

C. W. DANIELS, M.B., F.R.C.P.

LONDON SCHOOL OF TROPICAL MEDICINE.

THE interesting article on "Trypanosome Keratitis," by George E. de Schweinitz, M.D., and A. C. Woods, M.D., in the *Transactions of the American Ophthalmological Society*, Vol. XV, p. 106, (for abstract see the BRITISH JOURNAL OF OPHTHALMOLOGY, December 1917, p. 774) recalls to me a similar result of infecting a dog, reported in the *Journal of Tropical Medicine*, 1911, Vol. XIV, p. 161, the main point being the rapid recovery under treatment with arsenical preparations.

A subsequent statement by E. Treacher Collins, in the course of a discussion on a human case, shown for me by Mr. L. Paton at the Section of Ophthalmology (*Ophthalmoscope*, Vol. XIII, p. 595), shows that the lesions were identical with those described.

Interested mainly in the eye lesions in man in these infections, and their use in aiding the diagnosis of this rather difficult disease, I publish here a list of cases seen in England by myself. These do not complete the list, but there are only some 5 other certain cases, and 2 so doubtful that, as they lack confirmation, I do not include them in my list. The list includes Rhodesian cases, all but one, so far, fatal; 16 cases from Nigeria, but whether these are from infection with *T. gambiensi*, or that described as *T. nigeriensi*, is uncertain; and others, Uganda and the Congo, from *T. gambiensi* infection.

	Cases.	Deaths.	Eye lesions.
Rhodesian ...	8	7	6 (75 per cent.)
Nigerian ...	16	3	6 (37 "
Uganda and Congo	18	3	3 (16 "
Total ...	42	13	15 (35·7 ")

The eye lesions are similar to those described in dogs, but milder: no visible haemorrhages in the anterior chamber. Keratitis and iritis not severe, and in some cases only congestion of the periciliary ring, and these cases yield more slowly to treatment.

It is difficult to state how long after infection the eye lesions manifest themselves. In some cases they have been the first definite lesion noted by the patients, but the other signs may have been overlooked by the patients and their medical attendant; and there is proof of this in some cases. The onset of eye lesions in two cases was definite, three months after infection; in two, four months; and in one remarkable case, the eye had been removed for neglected irido-cyclitis before the discovery of trypanosomes over

sixteen years ago (probably infected 1900 to 1901), and the lady, although she has had slight trouble with the other eye at times, has now developed severe irido-cyclitis, notwithstanding that she has been living for many years in Canada, and could not have been re-infected.

We generally consider the eye lesions as a toxic phenomenon, and they bear no relation to the number of parasites present in the blood, or the severity of other symptoms. In the human cases recovery rapidly follows treatment by soamin in all but Rhodesian cases. There have been no post-mortem examinations at a time when any eye symptoms were present.

ON CLOSE VERSUS DISTANT ILLUMINATION FOR OPERATIONS

BY

ERNEST E. MADDOX, M.D., F.R.C.S. Ed.

BOURNEMOUTH.

A LITTLE addition which I have made to conjunctival forceps for operations on "after cataract," as well as for emergency night operations, has proved so successful that its description may be of interest to those who have not yet solved their illumination difficulties. It consists in attaching a tiny screened electric lamp to one limb of the forceps, half an inch from the gripping end. This attachment can be made with adhesive strapping, or, better still, by a very light metal clip or steel wire, into the curl of which an ordinary bulb from a child's flashlamp is so screwed as to illuminate the iris brilliantly, when the forceps are gripping the limbal conjunctiva. The connecting cord must be of a featherweight character, and it is a great convenience that the ordinary flash-lamp, sold in so many shops, will provide the electricity required. The grip of the forceps ensures a perfectly steady light, and maintains its distance from the cornea constant. This is better than the plan which has been tried hitherto, and rightly abandoned, of attaching an electric lamp to a dissection needle. Is it not a mistake to attach a lamp to any cutting instrument held by the working hand, since the light not only moves with the instrument, but makes manipulation more cumbrous? When, however, the lamp is borne, as I recommend, by fixation forceps, none of these disadvantages apply, and, like the mouse which released the lion, this small expedient is able to solve all difficulties of illumination arising through the absence of an assistant.

It is for "needling" operations that the method is ideal, although it also greatly facilitates the removal of foreign bodies from the