over the controls. It must be emphasised that this patient has had no orthoptic training at any time, and in spite of the great displacement of his right eye, experienced only a minor degree of diplopia as a temporary phenomenon. Since then he has been proved to possess good stereoscopic vision sufficient to have adequate control of a motor cycle, a motor car, and an aeroplane in flight. The photographs show the displacement of the right eye.

We wish to record our indebtedness to Miss Bennett and Mrs. Edwards of the Orthoptic Department for their very ready assistance and co-operation in the elucidation of these two cases. In addition we wish to thank Dr. H. Black, Radiologist to the Hospital for his opinion on the X-ray appearances in Case 2. Our thanks are also due to Mr. W. E. Meggeson for kindly photographing this patient.

THE USE OF M. AND B. 693 IN POST-OPERATIVE OCULAR SEPSIS

BY

ALLISTER M. MACGILLIVRAY

DUNDEE

THE following case is of interest as illustrating the efficacy of M. and B. 693 in post-operative ocular sepsis.

The patient, a woman aged 52 years, was operated on for simple chronic glaucoma. The left eye was trephined, with a peripheral iridectomy, the conjunctival flap being stitched into position with a continuous silk suture. The suture was removed on the fourth day. On the morning of the seventh day, the conjunctival wound was found to be injected and oedematous. By 6 p.m. on the same day, flakes of pus could be seen adhering to the wound, and several small conjunctival haemorrhages had developed. The whole of the upper bulbar conjunctiva was injected and oedematous. Pus could be seen draining through the trephine opening into the anterior chamber. The aqueous was turbid, and the visual acuity reduced to 1/60. The frequent instillation of atropine sulphate 1 per cent. and argyrol 10 per cent. was ordered, and half hourly bathings with really hot boric lotion. Two tablets of M. and B. 693 were given at 6 p.m., and repeated every four hours. This treatment was carried on throughout the night. Fortunately, in spite of intense nausea, the patient was able to retain the tablets. The following morning, the wound was found to be clear of pus. The injection and chemosis of the conjunctiva had subsided, and

the aqueous was now only slightly turbid. The vision had improved to 6/24. The administration of M. and B. 693 was continued until late afternoon, when it had perforce to be stopped, as the patient could no longer retain the tablets. By evening, that is, 24 hours after the first signs of pus formation had been observed, all signs of inflammation had disappeared. Atropine and argyrol drops were continued, thrice daily, for 14 days, and recovery was uneventful. Six weeks later, the trephine opening was draining well, the tension was normal, and the vision had improved to 6/5.

I am convinced that such a highly dramatic recovery could only be attributable to the early and intensive administration of M. and B. 693. Had the drug not been employed, the eye must inevitably have been lost as the result of an acute endophthalmitis. Such a result would have been little short of tragic as the glaucoma was only in an early stage, and the vision was 6/5 before operation, the patient's other eye being an old glaucomatous one, with poor visual acuity.

HOSPITAL LIGHTING FOR PROTECTION IN WAR TIME*

BY

C. E. FERREE *and* G. RAND

PROTECTIVE war-time lighting is essentially low-brightness lighting. The light should be evenly distributed and well diffused, and all glare and high brightness should be completely eliminated from the source of light, the fixtures and every part of the illuminated field. These features are not only needed in general for protection in war-time but are essential to the comfort and welfare of the patients in hospital lighting, particularly in the lighting of hospital wards. As a special war-time protection there should be auxiliary night light of low visibility and with an adequate proportion of wave-lengths that have a low power of penetrating the external atmosphere. For convenience the provisions for attaining these objectives should all be embodied in the same lighting fixture. They are all embodied in the fixture shown in Figure 1.

This fixture was devised by us at the request of the director of one of our leading hospitals for a glareless light for use in hospital wards. Fortunately, as noted above, the principles involved in good hospital lighting are pretty much the same as are needed for protection in war-time. That is, the provisions that

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