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*Indicates comprehensive studies containing reviews of the literature.

AN ENCAPSULATED ORBITAL MELANOMA*

BY

J. FOSTER

LEEDS

THE patient, a woman aged 65 years, was in good health until November, 1941. In this month she developed a paresis of the right inferior rectus, constant circumorbital pain, and slight proptosis of this eye. She was treated for six weeks with eye drops elsewhere, and when brought to me was feeling very ill and losing weight.

When examined in January, 1942, the left eye was normal, but the right showed 7 mm. of exophthalmos, displacement slightly up and in, paresis of the inferior rectus, mydriasis, and vision of 6/24.

Although no tumour could be felt, a tentative diagnosis of a metastasis of the orbit was made. All general and local investigations were negative—a slight subcostal projection of the liver was attributed to visceroptosis.

* Received for publication, April 17, 1944.

At the end of a fortnight a slight increase in the pain and exophthalmos indicated orbital exploration. This was performed on January 21, 1942, by the transpalpebro-conjunctival route of Félix Lagrange. (*Tumeurs de l'oeil*, 1904; p. 503, et seq.).

An encapsulated tumour, about the size and shape of a date-stone, situated axially in the fat on the outer side of the external rectus, was removed intact by gauze dissection, except for a "tail" adherent to the orbital apex,

The patient remained well during the next year until December, 1942, and again in September, 1943, when she had two attacks of delirium and headache, lasting a week, preceded by anorexia and a feeling of falling backwards. Her family doctor attributed these to cerebral thrombosis, and the patient made a spontaneous recovery from both.

When examined in November, 1943, by Mr. D. M. MacKay, of Hull, she was in good health. The right eye had vision of 6/12, a slight sluggishness of outward movement and of the light reaction. The patient did not apparently have diplopia or vertigo.

The chief interest of the case lies in the pathology of the tumour, of which two micrographs are shown. This tumour, although melanotic, was strongly encapsulated. The original account by Dr. E. Horne, of the Leeds Infirmary Pathological

Melanotic sarcoma. $\times 150$. To show thick capsule of tumour

Melanotic sarcoma. Approx. $\times 500$. To show linear cells containing melanin.

Department is given below, but the opinions of the pathologists who have seen it since differ considerably as to its provenance and malignancy.

"Sections were taken through this tumour at two points. They showed in general the same picture. The tumour cells were of large size, with oval or rounded vesicular nuclei and abundant slightly granular cytoplasm. They were closely packed together without any definite arrangement. Large masses of them were surrounded by fibrous septa. These septa were continuous, with a moderately thick fibrous capsule. In addition to the large cells there were numbers of small cells about the size of lymphocytes. These were seen in strands between the larger polyhedral cells. Some of them were certainly lymphocytes, but others were possibly tumour cells. The other striking feature was the presence of abundant pigment, almost entirely confined to chromatophores in the fibrous septa. One or two large tumour cells themselves appeared to have pigment in their cytoplasm. The pigment, of brown tint, was probably melanin, as the reaction for iron was negative. The large tumour cells varied considerably in size and staining reaction, and scattered mitotic figures were seen among them. Although the tumour has several unusual features, it must be regarded as a variety of malignant melanoma."

"Sir John Parsons states that he considers that this tumour is not malignant, and may have originated in an orbital dermoid.

Professor Loewenstein has sent me a lengthy report, with interesting suggestions as to further investigations, which unfortunately I cannot carry out, as neither the patient nor the tumour material are now available. He regards this as a melanotic tumour, of mixed cell type, displaying both ecto- and meso-dermal features. He has not seen or read in the literature of anything quite like it. He too, would not regard it as markedly malignant."

REMOVAL OF A NON-MAGNETIC FOREIGN BODY FROM THE VITREOUS*

BY

V. O'HEA-CUSSEN

CORK

THIS case is recorded because it is felt the technique employed, being different in many details from the usual procedure, may be of assistance to others who have to treat such cases, which at the present times are all too numerous.

History. Whilst mining for phosphates, the patient was involved in an explosion. A flying particle struck his left eye, causing immediate loss of sight in that eye. He was admitted to Eye, Ear and Throat Hospital on the day following the accident, namely December 12, 1943.

Condition on admission. Vision, R.E. 6/12; L.E. hand movements at one foot. Tension, R.E. N.; L.E. -1. The eye was moderately injected. A small central, perforating, and healed wound of the cornea was present. On dilatation of the pupil a posterior synechia was seen at 12 o'clock. A stellate opacity in the posterior layers of the lens prevented examination of the fundus. The lens opacity could be seen by oblique illumination, as well as by transillumination. Application of the giant magnet yielded no result.

Treatment. Atropine, and albuclid drops; protein shock. An X-ray taken a few days later revealed the presence of a foreign body. The course it took to reach the vitreous appeared to be around the upper pole of the lens, inflicting en route a contusion on the lens capsule without perforating it.

By December 30, 1943, the lens opacity had entirely disappeared with corresponding improvement of vision to 6/60. The fundus could be seen fairly well, without trace of the foreign body. A few days later the foreign body was seen in the vitreous at 2 o'clock,

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