will naturally require modification; with this in view a meeting was arranged, under the Chairmanship of the President of the Royal College of Surgeons, between four representatives each of the Faculty, the Ophthalmic Group Committee of the British Medical Association, and the Association of British Ophthalmologists. This body met on May 8 and the results of its deliberations will be published in due course.

At its first meeting the Council elected Standing Committees on Medico-politics, Education and Research, and Remuneration and Emoluments.

FRANK W. LAW,

Hon. Secretary,

Faculty of Ophthalmologists.

ABSTRACTS

MISCELLANEOUS

- (1) **Galton, E. M. G. (R.A.M.C.).—Treatment of perforating corneal ulcer.** *Lancet*, 247, p. 242, 1944.

(1) **Galton** describes his technique for treating perforating corneal ulcers in 15 Italian soldiers. The patients received pre-operative treatment for three or four days. This consisted of irrigating the conjunctival sac with either saline or hydrarg. perchloride lotion 1:10,000; sulphanilamide 8, 6, 6, 6 grammes by mouth and sulphanilamide powder dusted into the lower fornix. The diet was augmented by cod-liver oil, "marmite" and oranges.

The site of the perforating corneal ulcer was covered by a "visor" conjunctival flap. When the ulcer was central flaps were brought down from above and up from below and joined by mattress sutures. The author had no difficulty in separating iris which had been prolapsed for over seven days. He states that by bandaging both eyes the conjunctival flap remains longer in position and does not retract as early as it does when one eye only is covered. In the series both eyes were bandaged for four days. In every case the corneal ulcer healed and there were no septic complications.

H. B. STALLARD.

- (2) **Greeves, R. A. (London).—Retrobulbar optic neuritis. A pathognomonic sign.** *Lancet*, i, p. 715, 1944.

(2) **Greeves** comments that it is not commonly known that the tenderness elicited by pressure on the eyeball in cases of retrobulbar neuritis is limited to a spot in the mid-line roughly corresponding

to the site of the superior rectus insertion. He regards this as a pathognomonic sign. The patient may not be aware of the tender spot until it is discovered by pressure. This sign is more common in patients who feel pain on movement of the eye, but it may exist independently. The author has noted it in several patients whose visual acuity was not reduced below 6/9. It is present in the early stages of the disease but disappears after a few days.

H. B. STALLARD.

- (3) **de Rötth, H. (Washington).—On the morbidity of trachoma.**—*Amer. Jl. Ophthalm.*, p. 1279, November, 1944.

(3) Virus inclusion bodies (Halberstaedter-Prowaczek Körperchen) may be found in the cytoplasm of conjunctival epithelial cells in recent cases of diseases other than trachoma; these are inclusion blennorrhoea, inclusion conjunctivitis and swimming-pool conjunctivitis, all being manifestations of disease caused by the same virus though entirely different in its effects from the virus of trachoma. Inclusion blennorrhoea of the new-born cannot be confused with trachoma because the latter never occurs in the new-born; inclusion conjunctivitis of the adult is a rare disease which begins acutely in one eye, though it may spread to the other; in swimming-pool conjunctivitis, there is a history of freedom from any eye complaint until after a recent use of swimming pool.

If virus inclusions are found in the conjunctival epithelium of a patient exhibiting the lesions of chronic conjunctivitis in a country where trachoma is endemic, the disease may be considered to be trachoma, even though the clinical signs are obscure.

de Rötth states that a characteristic of every infectious disease is its morbidity, that is the sick rate or proportion of disease to health in a community in which every member has the opportunity to become infected. Quoting from Wilson's clinical research published in the Report for 1929 of the Memorial Ophthalmic Laboratory of Egypt, the author concludes that the morbidity in Egypt is 100 per cent., and from other sources that morbidity in Japan is from 30 to 60 per cent., and in Hungary 30 to 58 per cent.

A. F. MACCALLAN.

- (4) **Schorstein, J.—Compound fronto-orbital fractures.** *Brit. Jl. of Surg.*, Vol. XXXI, No. 123, January, 1944.

(4) **Schorstein** discusses the value of radical operation in those cases of frontal injuries which have open wounds and contain in their depths the broken fragments of the walls of paranasal sinuses and have dural tears. He gives detailed reports of eight of these cases and early and extensive operations were performed in six of them. All had dural tears and four had severe laceration of

the brain; five had fractures into the frontal sinuses and in four the fracture extended into the ethmoidal cells. Half the number had fractures of the roof of the orbit. All these patients recovered satisfactorily after operation.

The author describes two types of fronto-orbital fracture in his cases; one in which the fragments of the roof of the orbit are multiple, irregular and wedged and the other in which the depressed fragment is large and has the shape of a segment of a circle. He points out that in six of his eight cases which had early and radical wound debridement the result was entirely satisfactory but in the other two cases which had received only superficial attention to their wounds the recovery was slow and attended by intracranial infection.

B. W. RYCROFT

- (5) **Oldfield, Michael C.—Some experiences of reparative surgery in the Middle East.** *Brit. Jl. of Surg.*, Vol. XXXII, No. 126, October, 1944.

(5) Oldfield gives a brief review of twelve hundred cases which were treated by a Maxillo-Facial unit in the Middle East Forces.

In the section devoted to the orbit and lids he describes eleven cases of defects of the bony margins of the orbit. For repair of these defects bone grafts from the iliac crests were employed. Thirty-five cases of deficiency of the eyelids were treated by razor grafts held in position by a Stent mould which was secured by silk sutures tied over it. In this connection the author stresses the essentials of wide over-correction, tarsorrhaphy and grease massage. Eyebrow losses were repaired by Wolff grafts from the post auricular region and eye socket defects were treated by epithelium inlays buried on Stent moulds.

B. W. RYCROFT.

- (6) **Hagley, H. Gordon and Suggit, Stephen C.—Fractures of the Zygomatic tripod.** *Brit. Jl. of Surg.*, Vol. XXXII, No. 126, October, 1944.

(6) Fourteen cases are described and diplopia was a sequel in three. The authors stress the importance of backward as well as downward displacement of the orbital floor in the production of diplopia.

Prompt surgical intervention is recommended by reduction through the temporal route (Gillies 1927), or by exposure and reduction through the canine fossa (Leegaard 1939). The prognosis to diplopia after early successful reduction is good but otherwise bad since late restoration of the orbital floor rarely overcomes this distressing symptom.

B. W. RYCROFT.