Optic neuritis following measles

Dr. T. C. Meurer (New South Wales) dealt with optic neuritis and post-neuritic optic atrophy following measles. He said that the condition was a result of an encephalomyelitis which occurred late in the course of measles usually when the rash was beginning to fade. The resulting optic atrophy did not appear to have any relation to the severity of the encephalomyelitis or the severity of the attack of measles. Three cases were reported and a review of the literature presented.

Social

The annual dinner was held at the Royal Automobile Club of Australia and was attended by forty-two members and guests.

On the evening of the opening day a cocktail party was given at the Wentworth Hotel by the Ophthalmological Society of New South Wales to members and their ladies.

The President offered the congratulations of the Society to Dr. J. Bruce Hamilton who had been appointed President of the Section of Ophthalmology of the British Medical Association Congress, Sixth Session, Perth.

Dr. Hamilton was also congratulated on his election as President of the British Medical Association, Tasmanian Branch.

Annual General Meeting

The annual general meeting dealt with general business. Dr. Claude Morlet was elected President for the ensuing year, and Dr. Arthur H. Joyce, Vice-President.

It is proposed to hold the eighth annual general and scientific meeting at Perth in conjunction with the British Medical Association Congress Sixth Session, August 15 to 21, 1948.

CORRESPONDENCE

COLOUR VISION IN THE CONSULTING ROOM

To the Editors of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

DEAR SIRS,—It is not important to argue further on the differing incidence of defective colour vision in the normal male population and in the series examined by Dr. Neubert. All I wished to do in this connection was to suggest an alternative explanation to that offered by the original author. This can hardly be classed as illogical.

The matter of fundamental importance is the interpretation of the data obtained from a completely unstandardised lantern. If one compares the results obtained with a single light lantern, and a lantern with three lights, the most obvious difference is the introduction of simultaneous contrast. If, in addition, one adds the variability of a rheostat control of illumination then without examining a single patient it is reasonable to suppose that the results obtained with the two types of lantern would differ. This is the conclusion one can reach while seated in an armchair by the fire and the results given by Dr. Neubert add nothing of value to this theoretical deduction so long as no attempt to standardise the lantern is made.

Yours sincerely,

JOHN GRIEVE.

MEDICAL SCHOOL, DUNDEE,

November 10, 1947.

[Dr. F. R. Neubert does not consider a reply is necessary.]

This correspondence is now closed.—Editors.

POST-OPERATIVE SECURITY IN CATARACT CASES

To the Editors of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

DEAR SIRs,—With reference to Mr. A. J. Boase's letter in your December issue: I quite agree that a hyphaema may possibly form and be absorbed before the conjunctiva retracts and so escape notice. I have a feeling that the well-being of the patient should take a second place to statistics.

On the point that Mr. Boase raises regarding the possible failure to observe a hypopyon early, I can only say that I have had no infection in any of my cases as yet, but should it occur I would expect to observe the usual accompanying symptoms of pain or discomfort, chemosis, etc. These would be definite indications for cutting the purse-string suture in order to examine the anterior chamber.

A further point with regard to the purse-string suture which appears to be worth mentioning is that, if silk or nylon is used the suture has to be cut—at whatever day the surgeon decides—whereas with the original catgut suture, nature will do her own work.

Yours faithfully,

T. G. WYNNE PARRY.

69, HIGH STREET,

BANGOR, N. WALES

December 15, 1947.