investigated in the supporting treatment of retinopathy secondary to choroidal and ciliary body melanomas.

A part of this study has been presented at the meeting of the Ophthalmic Oncology Group of the European Organisation for the Research and Treatment of Cancer (December 1992, Amsterdam).

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History of ophthalmology

Ophthalmologists at war 1914–1918

At the beginning of this troubled period, a committee of eminent ophthalmologists was urgently summoned by the War Office to consider soldiers' standards of vision. Up until then, those wearing glasses were rejected, but with the number of recruits needed, this rule was speedily revoked. (Rightly so; ophthalmologists at the front line later correlated the number of injuries from broken glasses with the number of glasses worn, and felt they presented no increased risk of injury.) This left them to revise the 'basic standard of vision.' One continental army was using the 1877 criterion of 'ability to detect another person at ten paces,' and clearly this was inadequate.

Unfortunately, the ophthalmologists' recommendations were never carried out, owing to lack of time. Wirgman served in Egypt and reported that visual defects of patients sent for his opinion from convalescent hospitals were 'so gross it was a matter of surprise that they had been passed at all.'

The primary presenting feature at the front was traumatic injury, and the subject of exenteration in front line hospitals was furiously debated. Many ophthalmologists felt that no eye should be removed without their specialist opinion, and bilateral removal only after at least two doctors agreed. Undoubtedly eyes which could have been saved *were* enthusiastically removed by non-ophthalmic surgeons, though at least the cases combining orbital wounds with gross skin lacerations were treated further back down the line.

It was realised that many of the eyes which were grossly mutilated had not been injured directly – Barrett notes cases where the projectile passed at least one inch away, yet the eye was destroyed, presumably by pressure waves from the blast. One eyed soldiers were invalided out, although some disagreed with this, saying that the chances of a second eye injury were minute. This did not hold true for one Australian who eluded the authorities to rejoin his regiment, and by great mischance was re-injured and had his other eye removed.

Barrett was perturbed on considering the number of foreign bodies seen, and was extremely grateful when the large magnet at Mensoureh was put at their disposal, where he sent his patients by the truckload. He noted with interest that the number of malingerers fell off when the specialist ophthalmic team arrived, presumably to put their pleas to some other specialty.

The great ophthalmological mystery of the war was night blindness. One officer noted that in the desert, his men were persistently tripping over the tent ropes at night, to his great annoyance, and he initially suspected malingering. However, it became clear that the phenomenon was widespread, and whereas Birch Hirschfeld blamed 'general debility and perhaps alcohol,' Weekers felt the monotonous diet and overtiredness were to blame.

Arriving in Palestine, officers were infuriated by the hosts of native children who were persistently selling fruit to men while they were engaged in shelling the Turks. However, all the men who bought fruit recovered normal night vision and the cause, by implication, finally became clear.

Many agreed that patients with hysterical symptoms, as opposed to malingering, presented the greatest challenge. One soldier was completely blind for six months after shelling, with no apparent physical injury. Deviously, his specialist (who was, unsurprisingly, French) explained that a truly enormous operation was needed – the suturing of the optic nerves to the brain with silver wire. The patient was anaesthetised for an hour, then told that the operation had been performed. The 'placebo' procedure was successful: on removing the bandages, his sight returned.

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