the recent developments of this type are, of course, familiar to all ophthalmologists.

This brief review of the evolution of the ophthalmoscope is necessarily incomplete. Time will not permit of any description of many interesting types, such as various forms of autophthalmoscope, nor of the recent developments in reflexless ophthalmoscopy, in which Gullstrand's work is pre-eminent.

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A CASE SHOWING THE EVIDENCES OF RAISED INTRACRANIAL PRESSURE IN SUCCESSIVE PREGNANCIES, AND ATTRIBUTED TO EXAGGERATION OF THE ENLARGEMENT OF THE PITUITARY BODY, NORMAL TO PREGNANCY.

BY

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MRS. ANNIE L——, 30 years of age, saw me at the Royal London Ophthalmic Hospital on January 25, 1916, complaining of misty vision, variable, but the left eye was considered to be the worst. For about four months she had experienced double vision and had been having very severe headache for three months. At this date she was five months advanced in pregnancy, and had up to that time suffered from much vomiting, but it was not so bad as it had been. She had suffered from vomiting in two previous pregnancies, but the symptom did not persist so long as it had done on the present occasion. It was found that she had paralysis of the left external rectus, and that the sight of this eye was 6/18, three letters. With the right eye the vision was 6/6: pupils were normal. There was

slight nystagmic jerking recognisable when the eyes were examined with the ophthalmoscope. Knee-jerks not exaggerated. It was found that each optic disc had an atrophic appearance, and that the atrophy in each had undoubtedly followed a papillitis. The right disc was paler than the left, but the left was the more blurred

and indistinct in surface and in outline. There were white lines traceable along the vessels, particularly in the left eye. At the outer and upper quadrant of the left disc one or two spots of ? faint hæmorrhage, and a small group of gleaming dots adjoining the outer edge, of hæmorrhagic origin, were noticed. The urine was normal. Fields

of vision were charted, but I would not be too confident that the patient very accurately comprehended what was required of her, and too much stress should not be laid upon them, although they are probably approximately correct. She was seen by Dr. James Taylor, who was unable to offer any explanation, except the suggestion that she had suffered from intra-cranial tumour, which had become quiescent. She attended only on one or two occasions at this date, but returned on June 27, 1916, when she reported that confinement occurred on May 26, 1916, and that she felt quite well. The child born was well and healthy.

Paralysis of the left external rectus muscle was still present. The right eye read four letters of 6/6, and the left eye read three letters of 6/12. The optic discs presented the same appearance as before, but there was no evidence of any active mischief in progress.

I did not see the patient again until March 13, 1917, when her doctor wrote me a letter which she brought to the hospital. He reported that when the child was born, but not before, she completely lost all pain in the head, and since then was quite free from it until she became pregnant again some four months ago, when all the head pains returned within a month of the onset of pregnancy. This pregnancy terminated spontaneously at three months, and since then she has been quite relieved of her headaches. I found on March 13, 1917, that the right eye read 6/6, the left eye 6/9 pretty fully, and some letters of 6/6. The left sixth nerve paralysis was still as before, but she was not very much bothered by her diplopia.

The appearances of the discs were as on the previous occasion, with the exception of the fact that there was nothing in the way of hæmorrhage or exudative spots: they were pale and atrophic, the left showing more change than the right, and while the right, as before, showed evidence of antecedent papillitis, these evidences were more decided in the left eye. Perimeter charts at this date revealed a partial right hemianopia, the lower right quadrant being lost in each field with a slight peripheral loss in the upper right quadrant. The blind sector in the lower quadrant approached much nearer to the fixation point in the left than in the right eye.

Summarising the case, we have an example of a woman who had suffered from double papillitis and symptoms of vomiting, which may probably have been of cerebral origin, associated with pregnancy, severe headache coming on a few weeks after the onset of pregnancy and accompanied by a paralysis of the left external rectus muscle, complete recovery as regards pain after confinement. A few weeks after again becoming pregnant, the headache returned as before; this pregnancy terminated at three months spontaneously. The sixth nerve paralysis persisted on the left side and she developed a partial but quite definite hemianopia, indicative of pressure on the left optic tract.

In a former paper dealing with the cause of Leber's disease, I pointed out that the pituitary body is known to enlarge to two or three times its normal dimensions in association with pregnancy, and that it fills with a milky juice which can be pressed from it.

The hypophysis is known to be larger in a woman who has borne children than in a nullipara. The explanation in this case seems to me to be that the enlargement of the pituitary body associated with pregnancy exceeded the limits of the normal, and sufficiently so to cause pathological increase of intra-cranial pressure in two successive pregnancies; the enlargement extended particularly to the left side of the sella Turcica, and thus involved the left sixth nerve in the floor of the cavernous sinus groove, and to some extent the left optic tract.

The X-ray picture reveals a sella Turcica of rather unusual depth and with the anterior and posterior clinoid processes closer together than usual. In such a fossa any unusual and rapid swelling of the pituitary body would probably find its path of least resistance to be in the lateral directions, and in this case the swelling gland expanded particularly towards the left side.

A CASE OF DETACHMENT OF THE RETINA AT THE ORA SERRATA*

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CLINICAL reports of detachment at the ora serrata must be very rare. In my somewhat hasty search through ophthalmic records I have not managed to find a single case and certainly I have never seen one similar to this. As a pathological specimen the condition, though rare, may occur if there is a great shrinkage of inflammatory vitreous exudates, but in such cases the eye must generally be blind before the occurrence, or at any rate so nearly so that a detachment at the ora serrata could not be seen. In the case I am about to relate, the diagnosis was made clinically by ophthalmoscopic examination and subsequently confirmed by pathological investigation.

The patient was a lieutenant of 23 years, who came to see me first at the latter end of October, 1915. He had been wounded at the Dardanelles in the previous May. A bomb burst near him wounding him in the right groin, and almost simultaneously he was struck on the left leg by two bullets, one of which killed his

* A communication to the 1917 meeting of the Ophthalmological Society of the United Kingdom. The full text will appear in the Society's *Transactions*.