Two of his sons were examined. They had no defect beyond having a certain degree of refractive error. There was no history of syphilis either acquired or hereditary. It is of course impossible in these cases to be certain of the condition being congenital. But from the history and the appearances of the defect one could say that the condition was congenital or at least appeared soon after birth. There is little doubt that the case comes under the heading of so-called coloboma of the macula.

The chief points of interest in the case seem to be :

1. The size of the coloboma, it being less than half the size of the disc.
2. It was vertically oval and not horizontally oval as usual.
3. Its sharp definition.
4. The presence of round shining bodies which looked like cholesterine crystals, a degenerative product the result of an old haemorrhage or inflammation. This certainly goes in favour of the colobomata being pathological in origin.

According to Miss Ida Mann's classification this case comes under the heading of a non-pigmented coloboma.

RETINAL DETACHMENT

BY

RICHARD KERRY

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A REPORT of three cases of retinal detachment treated by the writer with iodized oil and resulting in restoration of vision was published in this journal some time ago, Vol. XII (May, 1928). Two cases treated recently by this method have not given the same happy result but as neither case was seen until the condition had been established for some months this is perhaps not surprising. There are, however, some points of interest connected with these cases which seem to be worth recording.

Of the first case, one of general detachment in the left eye of a young girl, for which no cause was established, there is little to be said, as treatment was discontinued after a few weeks. The superior temporal vein, however, which had been very dark and shrunken in appearance and with the blood column broken in many places, seemed when last seen, to be functioning well and was normal in appearance except for some displacement due to slight retinal oedema.

The second case, an over-stout, rheumatic woman of sixty odd, wearing - 8 D.sph. for the right eye and with the sight of the left

eye less than 6/60 from injury in childhood, presented an unusual condition. She complained of complete loss of sight in the right eye, coming on suddenly two days previously. Enquiry, however, as well as examination of the eye, showed that detachment must have been present for some months and that the sudden loss of sight must have been due to acute exacerbation.

On examining the fundus, one seemed to be looking into a truncated cone with the apex at the posterior pole of the eye, rather than into a globe. The retina was completely detached and of a translucent grey colour very slightly tinged with pink. There were no details of any sort visible, except that to the temporal side there was a strip of retina, running from the posterior pole to near the ora serrata, just below the horizontal meridian and about as wide as the disc, which was opaque and not oedematous. On this strip was a leash of dark shrunken vessels which seemed to spring from the posterior pole of the eye directly at the observer, although somewhat to the temporal side. Vision, practically *nil*.

Ten days later the fundus reflex was a much deeper red, the retina in more normal position, except below, although still oedematous. Neither disc nor vessels were visible, except the leash of vessels above referred to, which were now more to the temporal side, curved outwards and apparently carrying blood. Vision, fingers in the upper temporal field.

Two weeks later the position of the disc was indicated by the larger vessels which had become in part visible. The retina along the course of the vessels was in many places greyish-yellow with normal reflex in between. The opaque detachment had cleared in part and was broken by transparent sections. Vision, sees most of a white object in the central field, fingers in the temporal field and in the lower part of the nasal field.

Two months later the retina was apparently in normal position above and to well below the horizontal meridian on the nasal side, but on the temporal side the opaque strip and the retina below it was still detached. Below there was extensive detachment, bilowed here and there by contracted exudate running along the course of the vessels. The patient has at times been able to make out half inch letters at ten inches, but central vision varies greatly, and, as the old detachment almost involves the macula, the outlook for permanent restoration of central vision is not hopeful.

When last seen, eight months after her first visit, there was no material change. On one occasion the disc was seen by the indirect method but the condition varies from day to day as does the patient's central vision which at times shows great improvement, but lasting for a few hours only.

The question of origin of the relatively massive exudate in this case raises an interesting problem. As there was no hypertension,

evident at any time and as the capacity of the suspensory ligament to transmit excess fluid is very limited, I incline to the view that the sub-retinal fluid was, in part at least, derived from the vitreous humour. The vitreous colloids being saturated with water are iso-electric with their surroundings and exert no colloid or onkotic pull, but an active inflammatory exudate, derived from the uveal vessels and situated between the cerebral and epithelial layers of the retina, would exert a decided pull upon the vitreous fluid, especially if the inner layer of the retina were damaged by inflammatory or traumatic insult. As the conditions present are compatible with displacement of fluid from the vitreous chamber either through the suspensory ligament or through the inner layer of the retina, further study will be necessary to enable an intelligent estimate of the degree in which each of these factors is active, to be formed.

NOTE ON CONCRETIONS IN THE LACRYMAL CANALICULI

BY

R. R. JAMES

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THOUGH concretions in the canaliculi are not very frequently seen, they are perfectly well known to all ophthalmic surgeons as a cause of intractable conjunctivitis. I recently had such a case in a young man where the concretion was lodged in the upper canaliculus. The lower canaliculus was quite free and there was no interference with the passage of fluid on syringing the tear sac. It was not until a purulent secretion was observed flowing from the upper punctum on pressure over the inner canthus that the correct diagnosis was made. On slitting up the upper canaliculus the fragments of the concretion were easily expressed. The improvement was immediate, the patient announcing, when I saw him a fortnight later, that for the first time for 18 months the eye had been free from discharge and stickiness. The débris examined by the pathologist showed a profuse streptothrix growth.

It is easy to understand how, in the pressure of out-patient ophthalmic work, such a case can be overlooked. The conjunctival condition improves up to a point with the usual local treatment, but never gets quite well, and it is easy to see why. I would plead that in such cases the surgeon should not be content with investigating the state of the lower canaliculus only: he must remember that the upper canaliculus may be, after all, the site of the trouble.