
In most cases the experiments were done on rabbits and in a few on dogs and cats. Eyes intended to be removed as a whole for examination were experimented on under ether or urethane general anaesthesia and the others under one per cent. holocaine local anaesthesia.

Steindorff’s conclusions are as follows:

1. For the quantitative determination of iodine the colorimetric method evolved by Heffter-Anten is one of the most exact.
2. Using a 2 per cent. solution of iodine and a current of 10 m. A. for 30 mins; the amount of iodine penetrating the eye is found to be 0.856-0.994 mgs.
3. With a stronger current the amount of iodine entering the eye in the same period of time increases.
4. With weak currents (2 m. A.) acting for short periods (2 mins.) the quantity of iodine entering the eye varies very greatly.
5. The same holds good of iodine introduced into the aqueous with weak and with strong currents.
6. From weak solutions less iodine enters the eye than from strong ones.
7. Iontophoresis is more effective than simple diffusion.
8. Weak currents acting for long periods conduct more iodine into the eye than strong currents acting for short periods.
9. The iodine entering the eye with 2 m. A. in 2 mins. is eliminated from the aqueous in 60 mins. and from the globe at the latest in 240 mins.
10. Strong currents carry into the vitreous about the same quantity of iodine as into the aqueous; on the contrary weak currents are ineffective.
11. The amounts found in the coat of the eye (30 m. A. 15 mins) are considerable.
12. Through ionisation iodine never enters the lens.
13. In 1 hour after intravenous injection of 1 c.c. alival, between 0.137 and 0.245 mgs. of iodine enter the globe. The
quantity remains about the same during the second hour, decreases during the third and fourth hours until at the end of the fifth hour it has disappeared.

14. After intravenous alival injection, iodine is eliminated from the aqueous at the end of 2 hours.

15. In these experiments, the iodine content of the coat of the eye and of the vitreous was very considerable; that of the lens both in man and animal zero.

16. Only the strongly irritating subconjunctival injection of alival carried iodine into the lens.

17. In the rabbit one does not succeed in introducing iodine into the eye by intra-muscular injection of iodipin.

18. The iodine therapy in commencing senile cataract is to be discarded.

19. This applies especially to Meyer-Steineg’s method, whose pharmacological promises are quite unsatisfactory and lack all scientific value.

20. All attempts to check early senile cataract by iontophoresis are fruitless and should be given up.

N.B.—For details of Heffter-Anten colorimetric method and Meyer-Steineg’s treatment of cataract, the reader is referred to the original.

D. V. Giri.

II.—LENS

Gifford, S. R., Bennett, A. E., Fairchild, Nora M. (Omaha).—
Cataract in myotonic dys 
Arch. of Ophthal., March, 1929.

Gifford, Bennett and Fairchild’s paper opens with a useful summary of the clinical features of this disease as seen in 200 cases reported to date. The age of onset is usually from 20 to 30 years, practically all the patients dying of secondary disease before 45. The myotonia is at times widespread but is most characteristically present in the hand grips, the inability to relax being greatest when the patient is cold or under emotional tension. Atrophy usually appears first in the facial and masticatory groups of muscles and next in the sterno-mastoids and forearms. Mental changes are usually present. The association between this disease and cataract has been known since 1911, and Fleischer’s classical report appeared in 1918. In this he describes finding a number of instances of myotonic dystrophy among his cases of presenile cataract. Vogt found that in the early stages the changes in the lenses were absolutely
typical of the disease. The posterior stellate opacity described by Fleischer is often seen but it may be absent at first and on the other hand may be present in other conditions. What is absolutely characteristic, is the formation of cholesterin crystals under the anterior and posterior capsules of the lens. They appear as a sharply defined layer of shining flaky white dots and fine dust-like opacities. The authors have seen four cases of myotonic dystrophy associated with lens changes. In two eyes (Cases 1 and 4) the cataract had progressed to almost complete maturity. In one case posterior star figures were present in both eyes but the anterior opacities were as described by Vogt, while in the remaining four eyes, opacities corresponding completely with his picture were alone present. The ultimate development of posterior stellate opacities is thought to be due to the posterior capsule becoming permeable to water. The paper concludes with an interesting report by Knüsel who examined three cases of post-operative cataract following thyroidectomy. The changes were so nearly identical with those developing in myotonic dystrophy that Knüsel is inclined to attribute this disease to parathyroid insufficiency.

F. A. W-N.

NOTES

Death.

As we go to press we regret to announce the recent death of Mr. A. L. Whitehead, of Leeds. We hope to publish an obituary notice in a future number.

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Honorary Degrees.

At the recent meeting in Winnipeg of the British Medical Association, the degree of Hon. LL.D. of the University of Manitoba was conferred upon Sir James W. Barrett, K.B.E., C.B., and Mr. N. Bishop Harman.

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Honour.

Dr. Emile de Grósz has been elected an Honorary Fellow of the American College of Surgeons. He is at present in the United States and is engaged in lecturing at Philadelphia, Chicago, Minneapolis, and Rochester.