chamber. This experiment to my mind still shows very clearly that in its circulation the intra-ocular fluid (which I have never considered to be stagnant), but to circulate owing to factors other than those governing the process of its formation (see this Journal, Vol. XI, p. 388; Jl. of Physiol., Vol. LXXI, p. 1, and elsewhere) finds an exit more readily by way of the canal of Schlemm than through the corneal tissues into the conjunctival sac.

Yours etc.,

W. S. DUKE-ELDER.

London,
February 7, 1931.

TREPHINING FOR GLAUCOMA

To the Editors of The British Journal of Ophthalmology.

Sirs,—In his article on page 34 of your January number, Mr. George Brookes makes the following statement:—"Elliot (Glaucoma, page 536) instructs that the flap be made as thick as possible at its base. This in my opinion is wrong. A plane of tissue dissected by a metal instrument is more likely to heal down again; it is artificial, and resented by Nature."

I cannot find the instruction to which he refers on that page though there are four other references in the index to "Flap to be made thick." I am, therefore, a little uncertain of his exact meaning. There is, however, one point which I consider, and always have considered, essential to the success of the operation; it is that the flap should be made thick in order to protect the eye from the possible ingress of infection from without. The stress I lay on this is clear from the fact that I devoted nearly seven pages of my book to the subject, pages 535 to 541, besides making a number of further references to it on other pages. I will not, therefore, weary your readers by going over the ground again, but as there appears to be still a possibility of a misunderstanding, I would like, in the interests of the many surgeons who are using the method to-day, to lay stress on two points:—

(1) The technique I have advocated rests throughout on following the normal planes of the conjunctival and corneal structures and in avoiding cutting across them.

(2) When I have spoken of making the base of the flap thick I have meant—and have endeavoured to make my meaning clear—that as the cornea is approached, the whole of the episcleral tissue should be taken up and the flap should be continued along the
same plane into the cornea, as microscopical sections of trephined eyes have shown that it can be.

The procedure I make use of at the present time is exactly that laid down in the pages of my book above referred to. With it I am able to obtain excellent flat, thick, filtering scars. In addition to this, I see a great number of cases which have been operated on by other surgeons who have followed my technique with equally good results. I look upon thin flaps as provocative of late infection, and believe that many of the failures to obtain good results are to be attributed to want of care in securing thick flaps.

Colonel Kirkpatrick and I have tried the distension of the conjunctiva with fluid before making the incision, but we both gave it up as a needless procedure that introduced decided disadvantages of its own. We think that it is quite unnecessary in the hands of any skilful surgeon.

Yours truly,

R. H. Elliot.

London,
January 28, 1931.

NOTES

The following appointments have recently been made at St. George's Hospital, London. Consulting Ophthalmic Surgeon, Mr. R. R. James; Ophthalmic Surgeon, Mr. W. Stewart Duke-Elder; Assistant Ophthalmic Surgeon, Mr. J. H. Doggart.

Lieut.-Col. E. O'G. Kirwan, I.M.S., has been appointed Professor of Ophthalmology and Superintendent of the Eye Infirmary, Medical College, Calcutta, vice Lieut.-Col. W. V. Coppinger, C.I.E., I.M.S.

Dr. T. K. Uttam Singh has been appointed Hon. Ophthalmic Surgeon to the Civil Hospital, Karachi.

The International Organisation for the Campaign against Trachoma wishes to create on the largest possible scale a library concerning trachoma.

Therefore all those who are publishing articles on trachoma are earnestly requested to reserve one or, if possible, two copies for