ABSTRACTS

MISCELLANEOUS


(1) Meller, in the opening paper at the Oxford Ophthalmological Congress, 1929, discussed the methods of treating diseases of the lacrymal apparatus, and in particular, chronic dacryocystitis. He described the treatment of introducing into the lacrymal sac such medicaments as silver nitrate 0.25 per cent., albargin 0.25-0.75 per cent., optochin 1 per cent., and oxycyanate salve. Silver nitrate is contra-indicated when ulceration, obstruction of the lacrymal duct, and inadequate drainage are present. Optochin salve is of value in pneumococcal infections of the lacrymal sac. When iodine injections are used the sac is first cleansed by saline irrigations. Potassium iodide 10 per cent. is introduced into the sac and followed by a very small quantity of hydrogen peroxide. Swabs are placed over the puncta to prevent regurgitation, and finally the sac is syringed through with distilled water. Meller states that these methods afford no certain cure.

Hetero- and autogenous vaccines injected into and around the sac are unsatisfactory. He describes the destruction of the mucous membrane of the sac by zinc chloride, chromic acid, ammonium trichloride and other chemicals as being primitive.

Meller gives an account of three methods of surgical treatment of chronic dacryocystitis. He recommends extirpation of the lacrymal sac when pus is present; when an intra-ocular operation is to take place; and when the lacrymal sac is tuberculous.

He gives a detailed account of dacryo-cysto-rhinostomy and its modifications as practised by Toti, Dupuy Dutemps, and Marquez. The maxilla in the vicinity of the lacrymal crest is thick and in the process of chiselling, an opening is accidentally made into the anterior ethmoidal air cells on some occasions. Concussion has followed upon violent chiselling. Later complications are suppuration in the canaliculi; granulation tissue and cicatrization blocking the site of anastomosis between the nasal mucosa and lacrymal sac; erysipelas in and around the wound; surgical emphysema; granulations and cicatrization.

The treatment of acute purulent dacryocystitis must be governed by the condition of the tissues in the vicinity of the lacrymal sac. When there is no clinical evidence of softening or infection of the
tissues around the sac then conservative measures are indicated. Hot, damp, antiseptic compresses are applied over the sac; a tampon soaked in 5 per cent. solution of cocaine and adrenalin is inserted into the nose on the affected side; the canaliculi are dilated and aspiration of the pus is attempted.

When the surrounding tissues are infected Meller advises incision and drainage followed later by radical dacryocystectomy and excision of a fistula if such is present.

The indications and technique for other methods of treatment such as slitting the canaliculi, probing, pressure syringing, forced dilatation, and stricturotomy are also discussed in this paper.

Meller describes the value of radiographic examination after injection of lipiodol 40 per cent. He emphasizes the importance of a thorough investigation of the nose for lesions that may cause epiphora by reflex irritation.

By instilling Rose-bengale solution at the palpebral margin the puncta lacrymalia and the posterior margin of the lid are stained selectively. Normally, the puncta lie within the stained line.

H. B. StAllard.


(2) Zentmayer's case of primary sarcoma of the iris was a boy, aged 10 years, who for four months had noticed a "small pinkish coloured swelling on the coloured part of the left eye." This swelling had gradually increased in size.

Clinical examination of the left eye revealed a swelling 3 by 5 mm. situated in the lower temporal quadrant and on the pupillary margin of the iris. Some fine blood vessels ramified on the anterior surface of the growth. The neoplasm was translucent on slit-lamp examination. The iris reacted to light except in the sector where the growth was situated.

The neoplasm was removed by wide iridectomy, and during the operation bleeding was free. Hyphaema and detritus were present in the anterior chamber after operation, and owing to the doubtful nature of this debris the posterior aspect of the cornea and the lips of the wound were curetted.

Later, five X-ray treatments were given, in all, 175 per cent. of an erythema dose. Details of this treatment are given in the original paper. Pathological investigation revealed a spindle celled sarcoma with no definite intercellular substance, and having blood vessels lined by endothelium only. Three and a half years later, the patient was examined and found to be in good health.
The vision in the affected eye was 6/20 with correction. There was a triangular opacity in the deeper layers of the cornea and an irregular shaped opacity in the lens capsule at the site of the neoplasm. Diffuse granular opacities were present throughout the posterior cortex of the lens.

H. B. Stallard.


(3) Knapp describes a case of sarcoma of the iris occurring in a male, aged 30 years, who six weeks before examination had noticed that his right vision was defective. For nine years the patient had noticed a "brown spot" on the iris between 3 and 5 o'clock.

On clinical examination a brown mass was seen on the iris at the site described by the patient. The surface was flat and it was thickened at the periphery. The anterior chamber was deep; the pupil 8 mm. in diameter and immobile; the intra-ocular pressure was 42 mm. of mercury; the visual field concentrically contracted and the optic disc cupped. The left eye was normal.

A trephine operation was performed. One year later the intra-ocular pressure was normal but the brown mass on the iris had increased in size. A diagnosis of malignant neoplasm was made and the eye removed. At the end of this paper there is a discussion on the relationship between melanoma and sarcoma of the iris.

H. B. Stallard.


(4) In ten years and out of 213 cases of migraine under treatment, Sédillot has collected six undoubted examples of ophthalmic migraine. According to Charcot and Féré, who first pointed out the clinical entity of this syndrome, ophthalmic migraine is nothing more than common migraine characterized by the severity of symptoms and especially by peculiar ocular phenomena at the onset of the attack. Sédillot adds: it is characterized by its abrupt onset occurring at any hour, whereas ordinary migraine develops gradually and often during sleeping hours, manifesting itself on
exposure to light, whether natural or artificial. Proof that ophthalmic migraine is not a special type is found in the fact that from time to time the subjects of common migraine have an attack of clearly marked ophthalmic migraine.

What is the cause (mechanism is the term Sédillot employs) of the special ocular symptoms of ophthalmic migraine? The author discusses briefly various explanations brought forward at congresses of neurology and ophthalmology, and concludes that none of them is wholly acceptable.

It seems obvious, he writes, that either the scintillating scotoma is a phenomenon of hyperaemia, and hemianopia one of ischaemia, or that the scotoma is a phenomenon induced by irritation of a conductor nerve and hemianopia a phenomenon of inhibition of the same nerve. Whether their origin lie in a vascular disturbance or in an interference with nerve conduction, these are in all cases two inverse phenomena. He is of opinion that the two successive ocular phenomena of the onset of ophthalmic migraine, the scintillating scotoma (indicative of nerve irritation) and homonymous hemianopia (indicative of nerve inhibition) are both due to a sudden compression of the optic tract by the hypophysis in a pathological erectile condition (poussée erectile).*

The hypophysis in enlargement of any kind can extend only laterally and upwards. Lateral enlargement must lead to pressure on the optic tract. In rapid swelling there are two stages of pressure, one of irritative compression, during which abnormal luminous sensations are experienced; in the other and later stage the pressure inhibits or suppresses conductivity in the nerve and homonymous hemianopia results, with the special feature of a transitory negative scotoma.

In support of his contention that the scintillating scotoma is due to irritative compression of the tract, Sédillot quotes the case of Plateau, a medical man, who suffered all his life from ophthalmic migraine: he became blind from choroido-retinitis, but continued to be troubled by the sensations of a scintillating scotoma. Sédillot expresses the opinion that compression of the optic tract by a suddenly or rapidly congested hypophysis will suffice to explain the following features of ophthalmic migraine, logically and simply: —the bilateral and hemianopic character of visual disturbance; the persistence of a scotoma scintillans in the case of Dr. Plateau; the appearance of normality, or at most of a slight arterial spasm in the fundus oculi, during the hemianopia; and even such symptoms as anosmia, agraphia, etc.

* In the Monde Médical, December, 1929, Sédillot offers some explanation of the pathogenesis of these congestive states of the hypophysis and the reasons for thinking that they are generally limited to one half of the gland.
Ophthalmoplegic Migraine.—Sédillot suggests that the same compression theory may be applied to ophthalmoplegic migraine, the position of the third nerve in the wall of the cavernous sinus, which is the lateral boundary of the sella turcica, rendering it liable to pressure. His views in this relation, however, are less crystallized.

His belief is that the anatomical substratum of all forms of migraine is a congested condition of the hypophysis, and that this erectile expansion of the hypophysis may exert fairly distant repercussions on pre-existing weak points in the brain.

The author’s hypothesis of a pituitary origin of migraine resembles closely that suggested by J. H. Fisher, in 1918. (vide Proc. Roy. Soc. of Medicine, Section of Ophthal., Vol. XII.)

J. B. Lawford.


(5) In the first article Odell gives a valuable survey, together with references, of recent work on migraine and analyses the 91 utilizable replies received in answer to a questionnaire sent out to 177 patients with migraine whom he had treated, and in all of whom examination for physical causes was disappointing. The commonest physical condition was constipation (in 44 out of 177 cases); 13 only “had refractive errors of sufficient importance to be mentioned”; focal sepsis was likewise of no great significance. Of the 91 replies 76 were by women and 15 by men. From these replies it appears that in about half of the women who had passed the menopause, migraine had become less troublesome. As regards heredity, children of a migrainous mother have a much smaller chance of escaping migraine than those of a migrainous father, and daughters are more apt than sons to inherit the condition. In the vast majority of cases treatment is disappointing; this applies to luminal as well as to the older drugs and attempts at eliminating peripheral irritation. Dietary treatment has been of benefit in only a few carefully selected cases, the best results coming from carbohydrate restrictions. Lyon’s method of washing out the duodenum, on the supposition that migraine has a biliary basis, gives unconvincing results. “Rest, freedom from strain . . . an abundance of sleep, moderation and not prohibition in all things seem at present the best line of attack on this problem.”

In the later contribution the author analyzes the case histories of 376 patients with migraine seen at his clinic during the past 21
years. In this series there were 82 men and 294 women; the percentage of those following a profession was higher in the case of the men, who as a group also showed a higher incidence of professionally employed, when compared to a group of patients treated for other conditions. Yet when all migrainous patients are studied as one group, a greater incidence of the affection amongst professional people is not found: in fact the reverse is the case. "This study would seem to indicate that one does not have to be a 'brain worker' to be a fit subject for migraine." The seemingly greater frequency of migraine among professional men is due to the fact that the nature of their work compels them to seek relief from this condition.

ARNOLD SORSBY.

OBITUARY

Mr. F. RICHARDSON CROSS, M.B., F.R.C.S., LL.D.

It is a trite saying "that manners make the man," but it was well exemplified in the late Mr. Richardson Cross who died after an exceedingly full and busy life on July 12 last, in his 84th year, following an attack of influenza. Possessed of striking and handsome features, a tall well-knit athletic figure, his open and charming manners secured for him a host of friends and admirers in various walks of life: in his consulting room, in the hospitals with which he was connected, at the University, at scientific societies, in the Civic chamber, on the Bench, and in the hunting field.

The son of the Rev. Joseph Cross, he was born at Merriott Vicarage, Somerset, and educated at Crewkerne Grammar School and King's College Hospital, London, where he served as House Surgeon and came under the influence of Sir William Fergusson. Qualifying as M.R.C.S. in 1871, he held at King's College the posts of Medical Tutor, Sub-Dean, and Assistant Demonstrator of Anatomy. He served also as a Clinical Assistant at the Royal London Ophthalmic Hospital in the days of Bowman and Critchett. He became F.R.C.S. in 1878 and shortly after M.B. of the London University. In 1878 he left London in order to take a teaching post in anatomy at the Bristol Medical School, and continued to reside at Bristol for the remainder of his life. He joined the staff of the Bristol Royal Infirmary first as a General Surgeon, and practised as such in association with ophthalmology for six years. He was one of the first to introduce Listerian