fourth ventricle giving "some direct fibres to the nucleus of the sixth nerve," which lies closely mesial to it at its proximal end. He also here traces the fibres coming from the nucleus of the descending root and passing into the posterior longitudinal bundles. "In all probability this nucleus forms an important relay on the reflex path, linking up labyrinthine receipts with movements of the eyes and of the limb muscles."⁴

Duke-Elder⁵ quoting Kappers (1920) emphasises the "position of the oculo-motor nuclei, with their close anatomical relationship to the posterior longitudinal bundles and vestibular system." The slight outward movements, noted occasionally on effort, might be due to reflex action, a paralysis of movement rather than of muscle; as Gordon Holmes suggests "the lesion responsible for it must involve certain paths converging on the oculo-motor nuclei rather than these nuclei or the nerves that arise from them,"⁶ also that such movements may be elicited by labyrinthine stimulation or other means.

One is forced to recognise the outstanding importance of the posterior longitudinal bundles in all ocular palsies. Their value as central relay stations is emphasised by the authorities I have mentioned. In the present state of my knowledge I suggest the sixth nerve nucleus on the right side as the chief seat of the defect in the patient. Unfortunately for a more complete history, she left here for a distant town and, so far, attempts to trace her have failed.

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A CONJUNCTIVAL BAND SIMULATING A PERSISTENT NICTITATING MEMBRANE

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UNDER the heading conjunctival bridges and pouches Herbert describes folds of the conjunctiva in the region of the superior fornix with or without adhesion to the tarsal conjunctiva.

I have come across a few cases showing a condition which does not come under this description, nor do they resemble any of the congenital anomalies of the conjunctiva such as ankyloblepharon or acquired adhesions like symblepharon.

In the case which is pictured in the Figure it will be seen that a fold of the inferior fornix is drawn up and adherent to a small area of the upper tarsal conjunctiva. It was bluish-pink in colour, fan-shaped, with the apex at the attachment to the upper tarsal conjunctiva and the base at the inferior fornix, the borders being crescentic. A few blood vessels ran vertically on its surface like the ribs of a fan. Apart from its location on the outer side of the cornea

it simulated a persistent nictitating membrane. The eyeball was perfectly free underneath the band and rolled in and out without any impediment.

The case depicted represented the fourth of a series of five seen by me, the first, third, fourth and fifth having come directly under my notice and the second belonging to my then colleague in the eye department of the Madura Government Headquarter Hospital.

The mode of formation of this condition was at first a puzzle to me. But sometime after I saw the first case of this kind there came to the clinic a number of cases of acute mucopurulent conjunctivitis, which had been treated with irritants. These cases showed enormous swelling of the eyes with what looked like an everted upper lid in front of the swelling. Under treatment this gradually went down and in the end was seen to be a greatly chemotic lower fornix.

The country treatment for ordinary "sore eyes" ("heat" as it is popularly termed in the local vernacular) is what is called "cutting the heat," *i.e.*, the lower fornix is scarified with the very rough under surface of the pumpkin leaf. This produces the excessive swelling of the lower fornical conjunctiva just described. With a struggling child and lids already swollen as a result of the acute inflammation it can easily be imagined how, when the lower fornix is scarified, a part of the upper tarsal conjunctiva may also be injured. The two

excoriated surfaces then become adherent to each other during healing and thus the band is formed.

The treatment of the condition is, as may be seen, very simple and consists simply of cutting across at the upper tarsal attachment with a pair of scissors. The band then springs back to its original position and, in the course of a few days, smoothens itself out. A little yellow ointment into the eye every morning is all that is required by way of medication.

In conclusion I wish to record my gratitude to Major M. M. Cruickshank, I.M.S., the Superintendent of the hospital, for kindly according sanction for a photograph of the case to be taken.

A NEW ANTERIOR SYNECHIA KNIFE

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IN cases where three-quarters or more of the pupil is incarcerated in a corneal scar and, as a consequence, the anterior chamber to a corresponding extent is very shallow or practically non-existent, I have experienced a great deal of difficulty in insinuating the ordinary instruments recommended for the release operation, like a Graefe's or Herbert's knife or Ziegler's knife-needle, since the sharp point either pierces the cornea or gets entangled in the iris. To obviate this difficulty I use a special knife made for me by Messrs. Down Bros., Ltd., of London, the details of which are clearly shown in the illustration.

An ordinary keratome incision is made at a spot where the anterior chamber is deepest, and of a size slightly larger than the width of the blade of the instrument, with the usual precautions for avoiding loss of aqueous. The instrument is then introduced through the incision until the point is well past the site of adhesion. By either depressing the handle, or by a series of sawing movements, the adhesion is severed. Sometimes the iris is only partly cut through, some of the fibres simply stretching before the instrument without giving way. When this occurs, the instrument is partly withdrawn, pushed past the scar on the opposite side, and again made to cut the iris as before. Being double-edged