Twentieth Annual Report of the Ophthalmic Section, 1932.

Department of Public Health, Egypt. Government Press, Cairo.

There are now 22 permanent ophthalmic hospitals, 14 travelling hospitals under canvas, and 16 ophthalmic departments attached to general hospitals. The total expenditure was about £77,000 during the year.

The number of new patients seen was 714,551. The number of operations was 242,365.

The percentage of blind patients, excluding cataract cases was 6.5 of all cases examined. This is a very marked reduction, since in 1909 the percentage of blind patients was 15.6. The definition of blindness is that proposed by Trousseau, that is to say, inability to count fingers held up at a distance of one metre.

The number of operations for senile cataract was 1,518, and for glaucoma 1,145. It is interesting to note that 3,392 lacrimal sacs were excised during the year, while the colossal number of operations for trichiasis-entropion was 73,340.

Great credit is due to the Department of Public Health for the provision of annual increments for ophthalmic purposes, and for continuing publication of the important statistics which are contained in this report.

CORRESPONDENCE

OCULAR TORTICOLLIS

To the Editors of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

SIR,—I have not had the advantage of reading Mr. McMullen's paper in full, but only the abstract published in the Journal of May, 1934. It contains, however, several statements which I should like to traverse. He kindly refers to my paper in the *Brit. Med. Jl.* of May 4, 1934, but does not appear to have accepted the suggestions I have made therein as to the aetiology, behaviour and course of ocular torticollis. He has "difficulty in accepting the hypothesis" that paralysis of the superior oblique is the commonest cause, as is "stated by most writers;" yet he says that "it appears to be the most reasonable explanation in a majority of cases."

It would be idle to deny that superior oblique paralysis may occur, or, indeed, paralysis of any muscle. In this case the complementary muscle is the inferior rectus of the other eye; and we should get compensatory overaction of this rectus and a downward shoot of this eye when looking away from the side of the eye

with the weak superior oblique; and tenotomy of this inferior rectus would be indicated if head tilting had arisen. I have not met with this condition, though it may occur. I am satisfied, however, from my own observation that the syndrome described by Duane in the *Arch. of Ophthalm.*, 1916, is a relatively frequent one. This is an overaction of the inferior oblique, and upshoot of the right eye when looking to the left, or vice versa, and due to an initial paresis of the superior rectus of the other eye.

Mr. McMullen says that, as it has a tendency to spontaneous improvement, it is inadvisable to operate on children. As it is a congenital condition I do not see how any spontaneous improvement can be expected to occur, nor have I seen it. And in such a complex co-ordinated movement it is difficult to see what good could be expected from exercises or prisms. The reason that not many adult head-tilters are seen, though I have met with a few (a prominent Sydney physician is a typical instance of this syndrome), is, as I pointed out in my paper, that the majority avoid the diplopia, not by inclining the head, but by developing a squint with suppression. And in any large children's eye clinic quite a fair percentage of convergent squints will be found to have overaction of the inferior oblique if this is looked for by appropriate movements; which, while it does not prove, at least supports my thesis.

Myotomy of the inferior oblique at its origin is not at all difficult, once the technique is acquired. And I can assure Mr. McMullen that his fear of the muscle slipping back too far does not seem to be justified by experience. In fact, to make sure of the effect I always excise a small piece of the muscle, which is always much more bulky than one would expect.

The issues seem to me to be simple. To ascertain which muscle is weak, in my own experience, it has almost invariably been the superior rectus; then to deal, not with this tendon, which would be futile, nor with its antagonist in the same eye, which would lead to derangements in the primary position, but with the complementary muscle in the other eye, which has developed compensatory overaction.

I am not here referring to simple cases of hyperphoria or hyperopia, in which headache, not head-tilting, has arisen. In these, where prisms are not corrective, advancement of the tendon of the offending muscle may be the correct procedure.

Yours truly,

E. TEMPLE SMITH.

SYDNEY,

May 22, 1934.