that he did not know how leprosy was communicated; to which my comment was that I did not know how trachoma arose. In all three diseases there is an unknown factor (as in so many biological problems) which renders their spread possible. Yet we do know that true trachomatous material grafted into the conjunctiva will produce trachoma, and we have always assumed that gonorrhoeal pus would produce gonorrhoeal ophthalmia. At all events whatever be the explanation there is no doubt that trachoma is disappearing in Australia, to my own knowledge in Victoria and from the reports of oculists in other States.

I am, etc.,

JAMES W. BARRETT.

MELBOURNE,
December 27, 1934.

CONJUNCTIVOPLASTY

To the Editors of The British Journal of Ophthalmology.

Sirs,—This very brief communication refers to a small but important point in effecting a satisfactory conjunctival support to clean corneal wounds, corneal fistulae, etc., which I do not think is generally known or practised and which I have for a considerable time found most efficacious.

The object of placing a conjunctival flap over a wound of the cornea is, of course, to support by means of a natural bandage the edges of the wound until coapted there is a sealed junction, though not necessarily a firmly healed wound. Now ordinarily the conjunctival flap dissected from the limbus and undermined is brought up or down as the case may require, and its lateral margins are sutured to the conjunctiva which has not been separated from the subjacent tissue. The result is that the friable conjunctival membrane allows the stitches to cut through sometimes in 24 hours causing the flap or apron to recede and the wound is no longer sealed or supported. Should this occur the primary object is not achieved. The proper procedure is to incise and slightly undermine the bulbar conjunctiva at the sites where it is desired to attach the free edges of the flap, these are then drawn under and anchored by suture in precisely the same way that the apex of a pterygium is anchored in a transplantation operation.
By this means the conjunctival adhesions maintain the flap in place for a considerably longer time than the usual method. Should the flap not recede after some days (it usually does recede), a snip of the scissors on each side releases it.

Yours faithfully,

W. Wallis Hoare.

Brisbane,
January 18, 1935.

NOTES

The generosity of Mr. William Henry Ross of Stanmore, Davidsons Mains, has made it possible to establish in Edinburgh an organization with the object of investigating the origin and causes of blindness and utilising the results of such investigation towards its prevention and cure.

Mr. Ross is well known as one of the most successful and most highly esteemed business men in Scotland. A few years ago he lost the sight of both eyes—the one through a comparatively simple accident and the other subsequently through a serious illness. He is now totally blind. Thinking over this experience, he has come to believe that more might be done to preserve the world from the affliction of blindness. Total blindness is seldom curable. When once darkness has descended upon the eyes of the blind, they know that in all but a very few cases it is a darkness that will be with them till the end of their lives; they will never see again. But if the causes of blindness can be discovered and made known there is every hope that it will be possible in the future to check the development at its inception and in many instances prevent the occurrence of one of the greatest afflictions that can well be imagined.

This is the aim of the W. H. Ross Foundation. Mr. Ross has placed in the hands of Trustees a fund of £40,000, the income of which will be applied partly to research work into the causes of blindness and partly to practical measures for its prevention and for the preservation of sight. The Trustees are authorised to confer and co-operate with all bodies and persons engaged in similar work and may delegate their work in whole or in part to a Committee of persons having special knowledge of the problems to