OBSERVATIONS ON EYE CONDITIONS MET WITH IN MALTA, 1916-1917,
Occurring among British troops in the Balkans and Malta Garrison.
The Montgomery Lecture, 1916-1917.*

BY
EUPHAN M. MAXWELL, M.B., F.R.C.S.I.

(continued)

II.—Ocular Conditions arising from Traumata.

A. Gun-shot wounds.
The immediate results of gun-shot wounds were not seen in Malta, but the cases which came to our notice were frequently of interest in showing the later stages.
The thirteen cases detailed below represent the majority of ocular and orbital wounds seen in St. George's during the period. Cases 1-5 are illustrations of penetrating wounds of the globe.


   November 28, 1916. Examined at St. George's. L.E. outer halves of eyelids cicatrized. Movements of globe perfect. V. of L.E. = hand movements. Pupil sluggish but reactive to light. Tension normal. Media—clear. Fundus—two large grey bodies visible, one at macula, the other in outer and lower quadrant.


   Autumn, 1916. Contracted malaria in the Balkans. Shortly after developed "keratitis" R.E.

* Read on November 28, 1917, in the School of Physic, Trinity College, Dublin.
X-Ray report not obtained.

These three cases illustrate the tolerance of the globe to foreign bodies posteriorly situated, a fact commented on by several ophthalmic surgeons since the commencement of the war.

4. September 7, 1916
   Beginning October, 1916
   Wound of right eye on Balkan front.

   October 12
   R.E. enucleated. Two metallic fragments just behind lens. One adherent to outer surface of globe beside optic nerve. Nothing palpable in orbit.

5. Bew.
   May 9, 1917
   Immediately blinded” by bomb explosion on Balkan front.
   May 14
   R.E. enucleated in Salonica.
   July 13
   L.E. as above.

   September 2
   Cases 6-8 demonstrate the successful extraction of foreign bodies from the orbit, in so far as the operation did not disturb the integrity of the globe. They also illustrate changes in the globe, the result of the near passage of a foreign body.

6. McC.
   September 11, 1916.
   Shrapnel wound below L.E. on Balkan front. Fragment 1 in. by 1/2 in. removed from left orbit in Salonica.
   June 26, 1917

7. D.
   September, 1916
   November 3
   Shrapnel wound below R.E. on Balkan front.
   Examined at St. George’s.
November 16. Major Kiep removed metal fragment 2 ½ cm. by 1 7 cm. Fragment was firmly imbedded in bone. Sinus extended from it into lower fornix.

December 4. Ectropion right lower lid diminished. Downward movements of globe impaired.

December 9. Lid scar excised and wound sutured vertically.


8. M.

January 19, 1917. Shrapnel wound left side of face on Balkan front. Fragment removed from left orbit in Salonica.


Cases 9-13 further illustrate changes which may occur, as a result of the near passage of a foreign body.

9. H.


February 14. L.E. marked oedema of conjunctiva with globe pulsation persisted for some days. X-ray—Foreign body behind left temporal bone, lying apparently on dura mater.


The fragment, in this case, apparently entered the right eyeball low down, grazing the left globe in its passage upwards and to the left.

10. V.

May 9, 1917. Trench mortar wound of right side of face on Balkan front. Patient reported removal of dead bone from cheek.


11. S.

May 9, 1917. Shrapnel wound of right side of face on Balkan front. Seen at St. George’s. Superficial scars above right eyebrow and on right side of chin.
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July 20


September 2

Conjunctival granulation removed. No sinus discovered. Granulation as large as before. Ptosis disappeared. Condition of R.E. as above.

12. T.

March 7, 1917


March 26


June 2

R.E.—Tension minus. Otherwise condition as above.

August 12

In this case the fragment in its passage from the right temple to within the left globe, apparently caused invagination of the lower posterior portion of the right globe into the vitreous chamber.

13. St.

April 24, 1917

Shell wound of face on Balkan front. Metallic fragment extruded later from wound just below right orbital rim.

September 4


The question as to whether any of the lesions were preventable is suggested by a survey of these cases. Goggles of various kinds have been advocated as a protection for the eyes. The steel visor, attached to the helmet, designed by Capt. Cruise, R.A.M.C., has the advantage of not adding to portable equipment. It also affords considerable lateral protection, an omission in the helmet which has been severely criticised. Any protection which does not seriously hamper visual acuity, must be strongly recommended. The personal observer in the front line should always have the last word as to the most effective method.

The injuries in cases 1, 2, 3, 4, 5, 6, 8, 11, and 13, may be classed as probably preventable. Adequate protection in cases 9 and 12 might have saved the second eye.

The lesions in cases 7 and 10 suggested considerable velocity and
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force on the part of the fragment. They must therefore be classed as non-preventable.

B. "Functional" disorders.

It is obvious in these cases that a disturbance has taken place in a nerve system; its nature and position of maximum effect in the nerve path are quite obscure. The term "commotion nerveuse," to my mind, more aptly describes the condition than the expressions in use in our Army.

The disturbing factors illustrated in the following cases may be roughly divided into:

(i) Emotional.
(ii) Physical.

In many instances both factors would appear to have played a part.

LEFT

November 1, 1916.

RIGHT

FIG. 1.

No perception for blue or green.

No perception for green.

The eighteen cases detailed below represent the majority of instances of "commotion nerveuse" seen at St. George's during the period.

An examination of the visual fields of the patients was initiated by Major Kiep. It was performed in daylight. The white and coloured mires were 10 mm. square; their distance from the eye 20 cm. A mirror served as the fixation point of the perimeter, which was held in the hand.

   October 3, 1916.

On Balkan front a bursting shell shattered bridge across which patient was marching, and he was flung into a river. Unconscious for some days. Power of speech lost, and defective vision noticed on regaining consciousness.
Power of speech regained.

Examined at St. George’s.

V. of both eyes—4/36. Refraction, emmetropia.

Right fundus, nothing to note.

Left fundus, patch of connective tissue in superior nasal quadrant extending down to disc. This doubtless due to a kick between the eyes, received three years previously, subsequent to which sight in L.E. had been somewhat defective.

See Fig. 1 for visual fields.


See Fig. 2 for visual fields.

December 12.

No perception for green.

Central perception for green.

December 3, 1916.

Green not tested.
2. G.


September 10. Struck on left side by lightning while in bed in a Salonica Hospital. Felt a tingling sensation down left side. Noticed defective vision in L.E. a few days later.


December 3. V. of both eyes as above. See Fig. 3 for visual fields. No change in general condition.

3. H., age 23.


November 14. Examined at St. George's. V. of R.E.—6/18 with +3 '5

+1 90° = 6/9.

V. of L.E.—6/24 with +3 — +0'75 90° = 6/9.

Fundi and media both eyes — normal.

L.E.—periodic concomitant convergent strabismus. This became permanent and very marked during examination. See Fig. 4 for visual fields. No change in vision.

December 31

4. P.

October 26, 1916. On Balkan front received a scalp wound caused by bullet which indented front of helmet.

Admitted to hospital with symptoms of "cerebral malaria." Blood examined—negative. Pyrexia responded to quinine.

X-ray of head negative.

Fundi examined by Major Usher—normal.
Landed in Malta. Symptoms of headache, insomnia, loss of appetite, easily acquired fatigue. Showed marked tremor of fingers. Examined at St. George's. V. of both eyes—6/6. Complained of rapid and progressive failure of accommodation when playing billiards. See Fig. 5 for visual fields. General condition somewhat better.

On Balkan front flung to ground by bursting shell. Was able to notice that several men near him were killed. Felt dazed for about 1 hour. Noticed almost at once defective vision in L.E. with flashes of light and contortion of images. The vision improved in a few days, the other ocular symptoms persisted for some weeks. Suffered from constant headaches.
February 16, 1917
Examined at St. George's. V. of R.E. with—3 Cyl.—
Right fundus—normal. Left fundus—some blurring of
inferior and nasal margin of disc. See Fig. 6 for
visual fields.
During examination patient trembled continually.

6. T.
February, 1917
In a "dug out" on Balkan front received blow on head
from falling rafter. His glasses were smashed. Began
to suffer from insomnia and found difficulty in keeping
upright. Noticed great variations in his power of sight.
Examined at St. George's. V. of R.E. with —6= 6/60, of
L.E. with = 3= 6/36. Fundi—small myopic crescents.

March 7.

LEFT

RIGHT

April 1, 1917.

FIG. 7.
No perception for green.

LEFT

RIGHT

May 6, 1917.

FIG. 8.
Central perception for green. Spiral fatigue curve.
April 1. V. of R.E. with $-7 = 6/18$, of L.E. with $-5 = 6/12$. See Fig. 7 for visual fields.

May 6. V. of R.E. with $-8 = 6/9$, of L.E. with $-6 = 6/12$. See Fig. 8 for visual fields.

General condition improved.

On Balkan front, flung to ground by bursting shell. Examined at St. George's. Complained of defective vision; general condition unknown. Diagnosis, "shell shock." V. of R.E. with $25^\circ - 3.5 = 6/9$. V. of L.E. with $-25^\circ - 3.5 = 6/18$. No pathological conditions visible in either eye. See Fig. 9 for visual fields.

Fields for green slightly enlarged, red and blue fields as before.

LEFT

March 17, 1917.

RIGHT

On Balkan front, buried by trench mortar shell. Examined at St. George's. Complained of defective vision. General condition unknown. Diagnosis "shell shock." V. of R.E. $6/12$ with $+0.25 = 6/6$, of L.E. $6/9$, with $+0.23 = 6/6$. No pathological conditions visible in either eye. See Fig. 10 for visual fields.

Shrapnel wound left side of chin on Balkan Front. Examined at St. George's. Complained of defective vision. General condition unknown. Diagnosis "shell shock." V. of R.E. with $-1 = 6/9$, of L.E. with $+3^\circ + 20^\circ = 6/24$. No pathological conditions visible in either eye. See Fig. 11 for visual fields.

Hurled through carriage window in railway accident in France. Unconscious for some hours. During subsequent service on Balkan Front suffered from insomnia—very "jumpy" at shells. Examined at St. George's. V. of R.E. $6/12$ with $+0.5 = -2/24$, of L.E. $6/9$. Refr. L.E. $-0.75$. No pathological conditions visible in either eye. See Fig. 12 for visual fields.

General condition—very little change.
Buried in "dug-out" on Balkan Front. Unconscious about half-an-hour. Subsequently suffered from insomnia and trembling fits. Air-raid while in Salonica Hospital. Was able to get under his bed—several patients in ward killed.

Examined at St. George's. V. of both eyes—6/9. Refr. +1. No pathological conditions visible in either eye. See Fig. 13 for visual fields.

Spastic gait—exaggerated plantar and knee reflexes.

**LEFT**

April 4, 1917.

**RIGHT**

**FIG. 10.**

No perception for green.

Spiral fatigue curve.

**LEFT**

April 17, 1917.

**RIGHT**

**FIG. 11.**

Green indefinite.
Gun blew up near him in France. Subsequently suffered from "nerves."


No pathological conditions visible in either eye. See Fig. 14 for visual fields. General condition improved.

Fig. 12.

Spiral fatigue curve.

Fig. 13.
Knocked down by bursting shell on Balkan Front. Remembers the stretcher bearers. On regaining complete consciousness felt pains in side and back—vomited, had dyspnoea. Orbital haemorrhages reported. "Casualty Clearing Station." No nasal or oral discharge.

Examined at St. George's. V. of both eyes = 6/9, with +0.75 cyl. 105° = 6/6. No pathological conditions visible in either eye. See Fig. 15 for visual fields. Still had pains in his side, with general feeling of fatigue.

**LEFT**

**RIGHT**

**FIG. 14.**

**LEFT**

**RIGHT**

**FIG. 15.**

Spiral fatigue curve. Blue perceived as grey.

Previous history of chorea and stammering for four months following a motor accident when 12 years of age.

June 20, 1917. Attacked by Bulgar aeroplane and forced to descend in parachute from observation balloon. On second ascent was again attacked. Descended in balloon. On reaching ground felt "nervy" and tremulous. Two days later went up again. Strong wind began to blow. He "had to crouch on the bottom of the basket" to prevent throwing himself over. Suffered from severe headache.

July 1. Admitted hospital in Salonica. Insomnia, bad appetite, pain behind eyes, difficulty in looking at near objects, trembling limbs, feeble grasp.

July 2 Periodic convergent squint noted. Knee jerks exaggerated. Ankle clonus.


August 25, Examined at St. George's. V. of R.E. = 6/24, of L.E. = 6/18. See Fig. 16 for visual fields. Patient too exhausted for examination of fundi or refraction.

I am inclined, from the history, to regard the defective vision in this case as due to hypermetropia associated with paresis of the ciliary muscle.

15. Br.

Enlisted in R.F.A. Had occasional attacks of scintillating scotoma with headache and giddiness.

February 27, 1917. Fired an anti-aircraft gun on Balkan front. Immediately after the report, "lost the target, and another man had to be put on the gun." Stated that it was the first time he had heard a gun fired since September, 1916. Began to suffer from defective vision, headaches, and giddiness.

September 4. Examined at St. George's. V. of R. E., 3/60. Emmetropia. No external congestion. Floating opacities in vitreous. Thin fibrous curtain hanging from upper portion of ciliary body, just visible. Fundus readily seen, nothing to note. V. of L. E., 3/60 Emmetropia. Lids kept tightly closed, no paresis of lid muscles. Some ciliary hyperaemia. Mild blepharo-conjunctivitis. Fundus and media, normal. See Fig. 17 for visual fields R. E. The cyclitis in R. E. may have been caused by the wound received in France; the conjunctival condition in L. E. by the "gassing." Conceivably, the gun-fire on February 27 recalled to his sub-conscious mind the train of ultimate events in France. The resulting nerve disturbance would be readily aggravated by existing pathological conditions.

September 4, 1917.

FIG. 17.

Central perception for green.


August 6, 1916. Shell burst near him on the Balkan Front. Carried on with work for some weeks, during which time he frequently saw "pink flashes." Was subsequently invalided to Salonica with a diagnosis of shell shock.

February 27, 1917. Air-raid while in hospital.


May 2. Examined at St. George's. V. of both eyes=6/6. White and colour fields—nothing to note. "Pink flashes" only very occasionally seen at this time.
17. Har.
February, 1917. Buried beneath sand-bags. Knocked over by shell on Balkan Front. Unable to speak for a week. Subsequently lost power of speech again, but quickly regained it.


+5.


No pathological conditions visible in either eye. See Fig. 18 for visual fields. Suffered at this time from insomnia and trembling fits.

June 21, 1917.

**Fig. 18.**

**Fig. 19.**
Admitted to Salonica Hospital with pain in left shoulder due to a wrench.

Air-Raid. Was able to get under his bed—several patients in ward killed. Commenced after this to suffer from headaches and dizziness.

Examined at St. George's. V. of both eyes =6/6. No pathological conditions visible in either eye. See Fig. 19 for visual fields. General conditions somewhat improved.

The patient obviously started when any attempt was made to touch the scar on his cheek, and behaved altogether in a theatrical manner.

A survey of these cases brings into prominence the following points:

1st. That defective central vision, where present, was due in the majority of instances to asthenopia of the ciliary muscle.

Only in cases 1, 6, and 15, could it not be attributed to an error of refraction.
The very prominent symptom of headache was probably largely due to the same cause.

2nd. That a concentric contraction of the white and colour fields, with a further relative contraction of blue and green as compared with red, was an outstanding feature. Fifteen cases definitely exhibited these symptoms.

Cases 16, 17, and 18, showed normal or indefinite fields. The condition was bilateral.

Cases 1, 2, 5, 8, and 10, showed a more marked deviation from the normal in the eye with the greater defect of vision: in case 11, with equal vision, there was a greater defect in the left eye.

The frequent presence of these symptoms in "functional" cases is well known. If the rods be more susceptible to disturbance than the cones, the concentric contraction for white with preservation of central vision could be thus explained. This would also help to explain the colour inversion, should Sivén's theory be correct that the rods are mainly concerned in the perception of lights of short wave lengths.

In this connection it is of interest to note that Landolt in a recent article quotes several authors who have detected red and blue inversion in night-blindness.

Colour inversion may conceivably result from a general "lowering" of the colour vision system. Red produces a greater retinal excitation than blue or green, and may therefore more readily produce an impression on the conscious mind in these cases. Edridge-Green, in the July number of the British Journal of Ophthalmology, attributes the inversion to a hyperaesthesia of the retina.

Despite the necessarily crude methods employed, I entirely agree with Major Kiep, that, taken in conjunction with other signs and symptoms, these fields were of distinct diagnostic value.

3rd. That the progress in all the cases was very slow, a fact already frequently commented on by observers of this condition.

I take the essential lines of treatment to be rest, mild occupation, good and varied diet, and abstention from smoking. Dark glasses are advisable where photophobia is present, and any existing error of refraction should be corrected.

Hypnotic suggestion has undoubtedly many brilliant results to its credit, but I think it may be regarded as a refinement of treatment, unnecessary in the majority of instances.

(To be concluded.)