UVEAL TRACT

apparatus and is most comprehensive. When filled in it would seem to give valuable information to those who by training and experience are in a position to make use of it.

Briefly the results shown by the nine tests are said to indicate that each eye has an acuity of 6/12 or better and that the binocular acuity is 6/9 or better; a vertical imbalance of 1° or less; an astigmatic error of 0.5 D. cyl. or less; 35 per cent. or more of stereopsis; orthophoria for near; J.6 at 33 cms. and recognition of colours. We confess that we were not impressed over strongly by the stereogram for colour testing and it appeared to be easy to induce an artificial hyperphoria if our eyes were not properly centred on the instrument. It would be absurd to expect that an instrument, which is intended for use by the laity who have no technical knowledge of the basic principles underlying the various tests, could offer more than a comparatively rough test. We would point out that there is no royal road to the diagnosis of eye diseases, errors of refraction and muscle balance, other than expert examination. We can conceive certain cases such as papilloedema and some cases of glaucoma which might easily escape detection as well as certain defects in the field of vision. High or even moderate degrees of hypermetropia in young employees, which might give rise to eye strain in many specialised branches of industry, would most certainly escape detection. At the same time we can also conceive quite a number of cases in which its use as a layman’s test would be helpful. Failure to pass the tests does not mean that the candidate should be discharged from his employment, but that he should be sent to an ophthalmic surgeon. As long as the possession of such an instrument by any factory or other employer of labour does not lead to a false feeling of security as to the ophthalmic health of the staff no harm will accrue.

ABSTRACTS

I.—UVEAL TRACT


(1) Hudelo and Voisin report the case of a man, aged 36 years, who was admitted to the Hôtel Dieu with clinical signs of hepatitis. His temperature was raised, he was an alcoholic and blood cultures were negative. Later septicaemia occurred, the patient became
delirious and unconscious, the meninges and lungs became involved but the diagnosis remained in doubt until an ophthalmoscopic examination revealed miliary tubercles in the choroid in the vicinity of the optic disc. The patient died and at autopsy miliary tubercles were found in the meninges, the choroid and the lungs. The liver was fatty and congested. Tuberculous follicles were seen between the dilated vessels in the choroid. These follicles had the cellular arrangement characteristic of tuberculous granulation tissue and showed some tubercle bacilli.

The authors stress the importance of an ophthalmoscopic examination in a case of septicaemia in which the blood culture may be negative and no definite focus of infection has been found. In the particular case they have reported the diagnosis was obscure until an ophthalmoscopic examination was made.

H. B. Stallard.


(2) Velhagen describes a case of iridocyclitis in a woman, which rapidly progressed to hypopyon, and purulent choroiditis, so that the eye had to be excised. On section, groups of Gram-negative cocci were visible in the exudates anterior and posterior to the lens, but there were no bacteria in the iris or ciliary body. At the onset this case had the clinical signs of gonococcal iritis but there were no other signs of infection elsewhere in the body. No gonococci could be found in the urethral or vaginal secretions, and the complement fixation test was negative. It is unusual to have no other focus of infection, and the author does not know of a panophthalmitis which had no obvious septic cause or focus elsewhere.

D. R. Campbell.


(3) Kraupa recalling the relative infrequency of central lesions in syphilitic disseminated choroiditis, records two cases of severe central involvement. In addition to the characteristic peripheral changes there were central pigmented lesions 4-8 D.D. The largest of these gave the picture of a relatively non-pigmented macular coloboma surrounded by pigmentary disturbances, and was probably the result of a local gumma of the choroid. Similar cases from the literature are discussed, and the differential diagnosis from tuberculous lesions and the macular colobomata is indicated.

Arnold Sorsby.

(4) May Vianna gives a detailed description of a case of striate choroiditis which he observed in the left eye of a healthy young woman. The ocular trouble had started two years before in the fourth month of pregnancy. The visual acuity of the left eye was only 1/50, while the right eye was normal. The author observed the development of a temporal detachment which disappeared again within three months. There was no sign of a tear, of haemorrhagic or pigmented changes.

The orange-yellow streaks are probably in front of Bruch’s membrane. The appearance differs from the picture of angioid streaks by the colour, by the absence of a peripapillary network sending rays to the periphery and by the unilateral course. Further, there is no relation to elastic pseudo-xanthoma of the skin. Angioid streaks are of a purely degenerative nature, striate choroiditis is an exudative process which may be related to tuberculosis, though no positive statement can be made in this regard.

HUMPHREY NEAME.


(5) Bücklers applied the methods introduced by Stock who believes that salicylates are useful in sympathetic ophthalmitis. Atophanyl (= sodium atophan + sodium salicylate) and cyclotrophin (= 40 per cent. urotropin + 16 per cent. sodium salicylate + 4 per cent. caffeinum natrio-salicylate) were given intravenously, atophanyl 10 c.c. daily, sometimes for weeks, and cyclotrophin up to 10 c.c. twice weekly. Ten cases of sympathetic ophthalmitis were treated; eight were completely cured, in the two remaining only mild reactions occurred. (Of the eight cured cases, seven had the exciting eye removed; in the two unsuccessful cases the exciting eyes had not been removed.) The author could find no evidence of tuberculosis in his cases.

ARNOLD SORSBY.


(6) Meller discusses the reasons why tubercle bacilli are not demonstrable in sympathetic ophthalmitis and but rarely in tuberculous iridocyclitis. It would appear that the organisms are destroyed
in the tissue, and it is only in exceptional circumstances that they can be seen. In spontaneous uveitis, organisms have been previously demonstrated in necrotic pigment epithelium. In the present case, too, they could be seen in the pigment epithelium with a few outlying colonies in the inner layers of the retina. The author concludes that for the successful tissue culture of tubercle bacilli in uveitis it is therefore necessary to use the greater part of the eye; choroid by itself is not enough.

ARNOLD SORSBY.


(7) Melanowski reports the case of a girl, aged 12 years, suffering from melanotic sarcoma of the choroid. Permission to excise the eye was refused; iridectomy was performed for secondary glaucoma. Three-and-a-half weeks later sympathetic ophthalmitis developed, and subsided after removal of the exciting eye and general treatment. The author dismisses the iridectomy as the cause of the sympathetic inflammation. He holds the tumour and the tuberculous family history responsible.

ARNOLD SORSBY.

II.—MISCELLANEOUS


(1) In this long and interesting paper the authors discuss the various affections of the intracranial optic paths and show to what lengths cranial surgery has gone, in the endeavour of relieving some of them. The first portion of the paper is taken up with an account of the anatomy of the parts concerned and of the neighbouring vessels. The authors agree with the more recent anatomical views which dispense with a separate arachnoid membrane, but consider the pia and arachnoid as part of a single structure “Inside the dura and separated from this by the intradural space, there is a thin membrane made up of fibrils which are more densely arranged externally, forming the arachnoid, and internally around the central nervous mass, forming the pia mater; between the two layers
run scattered fibres forming the intra-arachnoid of the classical description." This thin meningeal coat, in the meshes of which is the cerebro-spinal fluid, is made up chiefly of fibrocytes. The authors from their own observations, doubt the existence of endothelial cells covering the intra-arachnoid spaces. Embryologically this account seems to agree with modern ideas. It cannot be said that the question is settled. The anatomy of the subarachnoid spaces has considerable importance in relation to certain pathological conditions of the nervous structures. A number of spaces (cisterns) lie in relation to the chiasma and may in certain circumstances, become cut off from the others, forming small reservoirs, in which the fluid can collect and compress the nerves in relation with them, even to a dangerous extent.

It is these cases of "perineuritis" which have been proved to be accessible to modern surgery; in a number of cases the region of the optic chiasma has been explored, and when it has been found that the membranes are interfering with the functions of the nerves, either by pressure from the formation of a local cistern or by constriction from the formation of tight bands, it has been possible to free the nerve and restore the function, or at least to prevent further loss.

The authors make the interesting suggestion that the "primary tabetic atrophy" of the optic nerve, may really be secondary to changes in the arachnoid and pial sheaths; if this is so, it may be possible in the future to treat this fatal condition surgically with hope of success.

HAROLD GRIMSDALE.


(2) Fischer studied a large number of cases of pituitary tumour devoid of papilloedema. A normal fundus appearance when changes in the fields were present was not so common as is generally accepted, though much more common than in tabes in which fundus changes always precede functional disturbances. In tabetic optic atrophy temporal pallor may be present for a short time but is soon followed by generalised pallor; in pituitary lesions temporal pallor is a striking feature; it was present in 32 out of 59 cases. In contrast to the temporal pallor of retrobulbar neuritis, that seen in pituitary lesions is not clearly confined to the temporal half of the disc; it overflows to some extent into the nasal half, which, though not white, is palely red. Even in fully established optic atrophy this difference can be detected. A point of importance is that with successful operation the progressive atrophy is not brought to a standstill, though function may improve. The question why
temporal pallor develops in spite of non-involvement of the papillo-macular bundle (as shown by detached central vision) is left unanswered.

Arnold Sorsby.


(3) In this case the patient, a shepherd, aged 13 years, had noticed severe pain in the right eye for some three weeks. The eye was very red, the pupil dilated, aqueous muddy and tension 54 mm. Hg. A whitish mass could be seen in the lower part of the anterior chamber. After the use of pilocarpine, the tension fell and the mass could be seen more distinctly. It was diagnosed from its appearance, to be the larva of a fly. It was removed with a part of the iris, to which it adhered.

Harold Grimsdale.


(4) Déver describes a case of this rare disease in a child. The eye was acutely inflamed, with a raised intra-ocular tension. A mobile larva was observed in the anterior chamber. The latter was removed under a local anaesthetic. The eye showed an immediate improvement but the vitreous was cloudy for some time. The lens was dislocated and developed a secondary cataract. Although the retina was not detached, the vessels were small and the disc atrophic. Subsequent vision of the eye was perception of light only with poor projection. The larva was that of the fly Wohlfartia magnifica, which rarely occurs in Germany and Austria, and only flourishes in the height of the summer. The evidence in this case suggested that the larva entered the eye via the blood stream and passed forwards from the retina to the anterior chamber, dislocating the lens en route. Such cases are only known to affect children.

D. R. Campbell.


(5) Buschke describes an unusual case of metastasis in the eye. The primary growth was in the wall of the small intestine and invaded the mesentery. The striking feature of the secondary growth was that it invaded almost all the vessels of the eye—the
iris, uvea and choroid and even the posterior ciliary vessels. It caused a secondary detachment of the choroid and retina and had the microscopic features of a reticulo-endothelial sarcoma.

D. R. Campbell.


(6) Georgariou describes a case of congenital sympathetic stimulation which showed in one eye a wider interpalpebral fissure and lagophthalmos on looking down. Other symptoms, such as, dilatation of the pupil or secretory disturbances, were absent. The retinal vessels were perhaps a little narrower than normal. There was a family history of four other cases. The author considers the probable explanation is a slight malformation of tissues or blood vessels causing irritation at one point of the cervical sympathetic.

D. R. Campbell.


(7) Karsch describes the case of a father who had lobster hand on the right side and syndactyly of the third and fourth toe on the left; his daughter showed the complete picture of lobster hand and foot. Ocular malformations were present in both: divergent squint, nystagmus, cataract and fundus lesions described as tapeto-retinal degeneration.

Arnold Sorsby.


(8) Wittels determined the tension of eyes enucleated for absolute glaucoma, and confirms the common experience that such eyes remain hard after excision, though, like normal eyes, they lose some two-thirds of their tension. That the excised eyes still kept about one-third of their original tension would indicate, according to the author, that there is an increased intra-ocular content in glaucoma.

Arnold Sorsby.