While there are probably many exciting causes of headache, we have always considered that a change in the intra-cranial vascular conditions was the most likely origin of the pain. So frequently patients are referred for spectacles in cases of headache; and it has always seemed to us a problem as to how many are really cured by optical appliances. Of course the error of refraction or muscular imbalance is said to act as the trigger which fires the shot. If you cut out the trigger the shot will not be fired. No doubt in a very large proportion of cases this is so; but it seems a pity that, at any rate in hospital practice, many cases are sent up for headache without much attempt having been previously made to determine if the headache is really ocular.

Over thirty years ago, when the writer was a house physician, one of his colleagues gave a headache case ten grains of aspirin on his night round. When his physician saw the drug card next day, he asked the reason; and on being informed, he called for reference cards and invited the Dental Surgeon, the Ophthalmic Surgeon, and the Nose and Throat Surgeon to see the patient, remarking to the house physician "that is the way to treat headache." The case had meanwhile recovered and the only thing that saved the Obstetrician from being consulted as well was the fact that the patient was a man. This was a case of carrying references too far. The best physician is that man who makes a thorough examination of the patient in the first instance and only applies to the special departments if his general examination reveals no obvious cause for the trouble. Headache is a marked symptom of the early stages of typhoid fever; but the man who sent a patient up with the rose spots on him with a request for spectacles would look a fool. On the other hand it does not do to treat a case as functional for too long a period, especially if an organic cause be present, without applying to the eye department. These facts should be borne in mind if we ever tend to get restive over the number of headache cases referred to us.

ABSTRACTS

MISCELLANEOUS


(1) Hughes describes an ingenious plastic procedure for re-making the lower lid in cases where it has been removed for a
neoplasm or as the result of trauma. The upper lid is split along the intermarginal line and the deeper layer, comprising the tarsal cartilage and conjunctiva, is pulled down and after removal of its epithelial edge is attached to the conjunctiva of the lower fornix. The skin of the cheek is undermined and mobilised so that it can be pulled up into contact with the anterior layer of the upper lid. It is then attached to the underlying tarsal cartilage of the upper lid so that the upper border of the skin occupies a transverse position mid-way between the upper and lower borders of the tarsus. The two borders of the skin are aligned by a subcuticular stitch and the lashes held upward to the skin of the upper lid by collodion. Rubber tissue is placed over the area and kept in place by a pressure bandage which is allowed to remain for six days, subsequent dressings being applied at five day intervals for three weeks. Three weeks later a row of hair is transplanted from the opposite eyebrow to the anterior surface of the tarsus just below and parallel to the upper row of lashes. Three months after the original procedure a transverse incision is made between the two rows of lashes and a complete new lower lid is then present.

F. A. W-N.

(2) Nizetic, Zdranko (Belgrade).—The indications and difficulties of corneal grafting. *Klinika Oczna*, February, 1937.

(2) Nizetic describes his experiences of 39 cases of corneal grafting following the methods employed by Elschnig and Filatoff. The latter solved the difficulties of finding suitable donors for grafts by suggesting the use of corneal grafts from a cadaver’s cornea.

Filatoff has done 95 corneal grafts in which a cadaver’s cornea was used. In several cases the graft was obtained 24 hours after death.

In the author’s series of 39 cases 15 grafts were taken from live donors and 24 from cadavers. In 18 of those cases the graft was obtained from the corneae of children who died from acute illnesses (enteritis, pneumonia, bronchopneumonia, asphyxia, rupture of ventricle and poisoning). In the other 6 cases the graft was taken from the corneae of adults who died as a result of accidents.

The graft is removed from the dead eye into which normal saline is injected to raise the tension. The graft is placed on gauze on a Petri dish and is covered with gauze, it is not kept in any solution and is used for grafting half-an-hour to one hour afterwards.

No difference was observed in the subsequent behaviour of the cadaver’s graft when compared with the graft taken from a live donor.

The author reports improvement of vision in 10 cases out of a total series of 39. He attributes this to the fact that at first he operated on a number of unsuitable cases.
Corneal opacities following interstitial keratitis, serpiginous ulcer, eczematous keratitis are most suitable for grafting. On the other hand cases with occluded or secluded pupils, cicatrization of conjunctiva following burns and leucoma adherens are difficult and useless for grafting.

JOSEPH MINTON.


(3) Ramsey comments on the fact that until recently artificial lighting for visual purposes has been almost entirely empirical. He emphasizes the importance of an accurate measurement of light to place the subject on a scientific basis. Gradually during the past 20 years more exact information has been obtained and the advent of a convenient and reasonably accurate photometer in 1931 replaced the old and cumbersome apparatus formerly in use. Since 1931 rapid progress has been achieved in the science of lighting.

Intensity of lighting for visibility only varies widely. Daylight conditions range from several hundred to about 10,000 foot candles, yet the eye can do moderately fine work such as reading under half a foot candle. But when work is done under conditions which approach the lower threshold of visibility even healthy eyes complain.

The author discusses contrasts obtaining on different papers and inks. The average book paper reflects about 80 per cent. of the incident light, while the paper of the average telephone directory, he says, reflects only 57 per cent.

Statistics compiled by the Washington Public Health Department in the New York Post Office are quoted. The eye conditions of 2,449 employees, divided between the old, poorly lighted City Hall Post Office with the more modern, better lighted offices of the City were compared. The following table gives the results:

<table>
<thead>
<tr>
<th></th>
<th>City Hall</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal vision in both eyes with no defects</td>
<td>10.3</td>
<td>19.8</td>
</tr>
<tr>
<td>Defective vision in both eyes</td>
<td>...</td>
<td>42.5</td>
</tr>
<tr>
<td>Refractive errors</td>
<td>...</td>
<td>76.6</td>
</tr>
<tr>
<td>Inflammatory conditions</td>
<td>...</td>
<td>20.9</td>
</tr>
<tr>
<td>Muscular imbalance</td>
<td>...</td>
<td>33.4</td>
</tr>
<tr>
<td>Asthenopia</td>
<td>...</td>
<td>16.5</td>
</tr>
</tbody>
</table>

The average difference in illumination was that of 3 to 5 foot candles. These statistics are, of course, open to many errors, but the results are consistent enough to be suggestive.
Ramsey's summary, which he says is on the conservative side, is as follows:—
1. Light for reading ordinary print should be about 10 foot candles.
2. For poor print or print on paper that is not a good white 20 foot candles should be used.
3. The light should be diffused.
4. If a diffuse light is not available the intensity should be lower, about 6 foot candles, to avoid glare.
5. There should be supplementary lighting of the central field, to make it greater than the peripheral lighting.
6. No bare lights should be visible in the peripheral field.
7. Old eyes or poor eyes need more light.

R. R. J.


(4) Bhaduri is convinced, after the examination of the fundi in a series of nine hundred cases of epidemic dropsy, that papilloedema does exist in this condition. A paper of his in the Calcutta Medical Journal of August, 1935, was noticed in our columns, 1936, p. 50. In the present paper he reports another case in which it was possible to perform lumbar puncture. The patient was a woman, aged about 30 years. At her first visit the vision was R. 6/12, L. 6/18, and there was at least 2 D. of swelling of the discs. She was admitted in-patient after a fortnight’s out-patient attendance. Examination of the fundi showed 4 D. of swelling on the right side and 3 D. on the left.

Lumbar puncture was done. Crystal clear fluid came out under pressure, about 3 drops per second. Nine c.c. fluid was withdrawn. The patient obtained relief from her headaches and the papilloedema rapidly diminished. The cerebro-spinal fluid showed no cellular elements and no bacteria, while the cultures were negative. The Wassermann and Kahn tests were both negative.

The author also refers to a similar case of Dr. Bose, where lumbar puncture was done with like results. He points out that the character of the cerebro-spinal fluid excludes the possibility of intracranial inflammation, and there was no clinical evidence of neoplasm.

R. R. J.