the failing of all racks, namely that retinoscopy is performed at the distance of half a metre, and that one must be careful to have no other source of illumination behind the user, or the small lenses will be obscured by the reflex. Other users have complained that there is too much reflection from the lenses not in use. This difficulty is easily overcome by a slight movement of the hand holding the rack. The rack is so arranged in the latest models that the hand holding it can be rested against the forehead; the weaker lenses are, in consequence, at the end of the rack nearer the hand.

ANNOTATION

Surgical Narcosis

Recently there has been some discussion on the production of what has been termed surgical narcosis for major ophthalmic operations by the administration of drugs which will lessen or remove the distressing psychological effects associated with the operation. It is claimed by some that the mental shock of an ophthalmic operation to elderly persons is the cause of post-operative delirium, flatulence, abdominal pain and absence of peristalsis.
It is obviously desirable that the drugs used for the purpose of inducing narcosis should not cause restlessness, sneezing, jactitation and other disagreeable features which might jeopardise the satisfactory conduct of the operation or spoil the eye in the period immediately following it. Of the drugs used some produce a tranquil, acquiescent state with retention of consciousness and others render the patient unconscious. Some require the assistance of inhalation anaesthesia. Sedative drugs such as morphia, omnopon, scopolamine, paraldehyde and the barbiturate preparations such as sodium evipan, sodium pentothal, nembutal and avertin have been tried.

Morphia, omnopon and scopolamine given hypodermically are satisfactory in some cases in which a tranquil and passive state is induced without loss of co-operation. However, some persons have an idiosyncrasy to opium derivatives and post-operative vomiting may be a serious source of danger. Flatulence, abdominal discomfort and restlessness are other features which make these drugs undesirable for use in intra-ocular surgery. Of the drugs which produce unconsciousness paraldehyde administered by the rectum has attracted recent attention. In some cases it has caused post-operative muzziness which lasts for two days, restlessness, vomiting and delirium, complications which it is unjustifiable to risk in ophthalmic surgery.

Avertin per rectum dispenses with the patient’s co-operation; the conjunctiva becomes pale, the pupil small, the eye fixed in the middle position and the conjunctival and corneal reflexes are absent. This drug also lowers the blood pressure and intra-ocular pressure and occasionally it causes post-operative vomiting and restlessness. Another disadvantage is that it has often to be used in combination with a general anaesthetic. Sodium evipan is administered intravenous and will render the patient anaesthetic for 20 minutes or so. It is necessary to use a local anaesthetic as well, and in some cases this drug causes violent sneezing, twitchings, raising of the head and jactitation, incidents that would frustrate an ophthalmic operation or lead to disaster.

Pentothal sodium, an intravenous anaesthetic, has a narrower margin of safety than sodium evipan but it does not induce such complications as twitching, sneezing and jactitation. The induction is quick, anaesthesia is quiet and unperturbed and the administration of this drug may be used up to one hour. After operation recovery of consciousness is uneventful, there is no restlessness or other undesirable consequence. The intra-ocular pressure falls and the eye is fixed in the central position. Pentothal sodium is, we think, the best of the intra-venous anaesthetics for ophthalmic use.

Nembutal in many cases is satisfactory for preparing a patient
for operation. If the dose is too heavy the patient becomes semi-conscious, restless and unable to co-operate. Its effect is variable but when it works well it is admirable.

The Ophthalmological Society of Australia

Early in the month of April of this year the newly founded Ophthalmological Society of Australia was formally decided on in Sydney. Until now, while there have been ophthalmic sections of the British Medical Association in Queensland and Victoria and an eye and ear section in South Australia, together with an Ophthalmological Society of New South Wales, there has been no federal body to embrace the whole Commonwealth, and Western Australia and Tasmania have had no ophthalmic provision at all.

The new Society starts with a membership of 110 and its first President is Sir James Barrett. We feel confident that Australia could not have chosen better for the first of what we hope will be a long line of distinguished Presidents. Sir James Barrett was a student of Lord Lister, a fellow research worker with William Lang and he has been a member of the Ophthalmological Society of the United Kingdom for close on half a century.

Committees on various aspects of ophthalmology such as (a) literature and publications, (b) research and scientific, (c) orthoptic training, (d) industrial injuries and compensation, have been set up. Among the conveners are Mr. Bruce Hamilton and Dr. Ringland Anderson.

It is hoped to have the first general meeting in Melbourne in March, 1939. Transactions will be published and the Society hopes later to be in a position to undertake the publication of an ophthalmic journal.

It is with great pleasure that we learn of this new undertaking; nothing is more likely to stimulate research work in Australia and we wish it many years of successful enterprise.

ABSTRACTS

I.—RETINA


(1) After paying a justifiable tribute to the pioneer work of Gonin, who was "learned, sincere and good," Arruga deplores the fact that the treatment of retinal detachment is not as good as