The Annual Congress of the Ophthalmological Society of the United Kingdom was held at the Royal Society of Medicine, London, on Thursday, Friday and Saturday, April 20, 21 and 22, 1939.

The President, Mr. T. Harrison Butler, D.M., was in the Chair and gave an address of welcome to the visitors and members of the Society. He read an admirable Presidential address on the "Anterior capsule," dealing with its development, anatomy, physiology, slit-lamp appearances and pathology.

The Bowman Lecture was given by Professor Weve on "Diathermy in ophthalmic practice." The lecturer gave a most comprehensive review of his subject fully illustrated by some excellent coloured lantern slides and a coloured film showing the methods of investigation and the operative technique for retinal detachment.

The discussion on "The problems of refraction" covered a large field including a description of general principles, methods of estimation, description of various forms of apparatus and the clinical aspects of this subject. An item of considerable interest was Dr. Bedell's lucid demonstration of his excellent coloured fundus photographs.

Below is published an abstract of the papers.

**DR. T. HARRISON BUTLER,**

"The Anterior Capsule."

*The anterior capsule* will be held to include the capsule proper; the zonular lamella with the insertions of the fibres of the suspensory ligament; and the epithelial lining.

*The anatomy and physiology of the capsule.*—Its thickness in different zones and the influence of this inequality on accommodation. Does the elasticity diminish with age, and has this any influence upon the onset of presbyopia? The tendency of the hyaline capsule to split into layers under the influence of disease and maceration.

*The zonular lamella* has a loose attachment to the hyaline capsule, and does not require maceration to make it separate. It probably has a different origin from that of the hyaline capsule. The attachments of the fibres of the suspensory ligament to the zonular lamella were demonstrated. The epithelial cells are the oldest part of the lens, older even than the central lucid interval. They are the original cells that formed the lens-plate, and have not altered in any way since they formed the anterior part of the invaginated lens capsule. They have nothing to do with lens
growth, but have a purely nutritional function. This is a vital and not a purely physical process. The anatomy of the cell layer was described.

Development.—The embryology of the epithelium and of the capsule was discussed. The various theories of the origin of the suspensory ligament were touched upon.

The slit-lamp appearance of the anterior capsule.—The lens-shagreen and its cause were described, with the epithelial cells and Vogt's shagreen spheres.

The pathology of the anterior capsule.—Vestiges of the tunica vasculosa anterior, pigment stars, Ernest Thomson's disease. Anterior polar and pyramidal cataract. The imprint and its cause.

Injuries to the capsule.—Vossius' ring. Effect of lightning. The capsule after cataract operations. Prolapse of vitreous through holes in the capsule. Proliferation of capsule leading to thickening with the formation of Elschnig's pearls. Incarceration of capsule in wounds, with cell proliferation and subsequent glaucoma.

Separation of the zonular lamella due to age; to shrinking of the lens after irido-cyclitis; to accident, dislocation of the lens, etc.; and to radiant energy. The so-called capsular glaucoma.

DR. W. J. B. Riddell,

"Multiple Factors in Hereditary Eye Disease."

From time to time pedigrees have been published which contained two or more hereditary conditions. In some the conditions appear to be inherited independently and are the result of chance matings. In others a closer relationship appears to exist and they become identifiable syndromes. Parallel with these pathological conditions there has grown knowledge of inherited conditions which do not cause serious disability. Examples of these are the various serological reactions which identify agglutinins in the blood and in the saliva, and the phenyl-thio-carbamide reaction for taste. The theoretical possibility of constructing human chromosome maps was shown a few years ago and this led to the deliberate search for multiple factor pedigrees with the object of establishing genetic linkages. Such linkage has been established in the case of colour-blindness and haemophilia. A pedigree containing colour-blindness, blue sclerotics, deafness and fragilitas ossium has been investigated serologically and chemically. A summary of this work was given in the paper.

DR. M. Klein,

"A Survey of Different Methods of Wound Closure after Cataract Extraction."

The different methods of closing the wound after cataract extraction were considered under the following headings:—
1. Conjunctival flap.
2. Kuhnt's conjunctival apron.
3. Liegard suture.

Statistics were given and the relative merits of the various methods discussed.

NOTE.—In the Trade Exhibition (on the stall of Messrs. Davis Keeler) Dr. 'Klein demonstrated a new lamp for ophthalmic operations.

DR. W. J. W. FERGUSON,

"Bipolar Electrolysis in the Treatment of Detachment of the Retina."

Description and demonstration of instruments used, which are those of von Szily.
Methods of anaesthesia and approach, and dosage used.
Post-operative treatment.
Short notes of a few cases, with special reference to the types of cases suitable for treatment.
The advantages of the treatment appear to be: ease of access, absence of adhesions (which simplifies further operation if this is necessary), easy and accurate estimation of dosage, relative absence of post-operative reaction and pain, and relatively slight visible scarring of the retina.

MR. F. A. JULER,

"Hypotony after Sclero-Corneal Trephining."

Occasional cases of persistent hypotony occur and cause anxiety. The clinical accompaniments are choroidal detachment, pupillary exudate and lens opacity. Cases were related and appropriate treatments suggested. A readjustment of the conjunctiva over the hole seems sometimes to be of value, and a fresh flap rotated from the temporal side is suggested as being the most suitable method.

PROF. DR. HANS LAUBER,

"Pallor of the Disc."

The author discusses the different causes of discolouration of the disc: anaemia, lipaemia and ischaemia, which latter is the most important cause. Ischaemia can be the consequence of different conditions: glaucoma, quinine poisoning, retrobulbar neuritis and optic atrophy. In many cases of this affection, the pallor of the disc is the expression of disappearance of nerve fibres and their substitution by glial or even connective tissue; also simultaneous disappearance of capillaries. In tabes, the mechanism is to a certain degree
different. The pallor is partly due to ischaemia, caused by disproportion between (normal) intra-ocular tension and diminished arterial pressure in the vessels of the disc and the retina. This is proved by reappearance of pink colouring of the disc in cases where one succeeds in raising arterial pressure and in lowering intra-ocular tension. The reappearance of pink colour of the disc is one of the symptoms of improvement of the eye condition. Pallor of the disc is consequently not synonymous with atrophy of nerve fibres.

**DR. HARALD GJESSING,**

*On Holth's Iridencleisis Anti-Glaucomatosa.*

*Post examination of 198 iridencleises ad modum Holth in chronic glaucoma—6 to 280 months after the operation.*

The author has from August, 1911, to December, 1938, performed iridencleisis anti-glaucomatosa ad modum Holth as his "method of choice" in 252 cases of chronic glaucoma. 198 of the cases were re-examined 6 to 280 months after the operation. Of these 24 were operated on either with total iridectomy or a peripheral iris inclusion. The others are, as far as the author has noted in his journals, operated on with a meridional iridotomy.

No second operation has been performed after an iridencleisis save in one single case, where a cyclodialysis of Heine had to be done to lower sufficiently the tension of a still painful, blind eye. But iridencleisis has been done in 3 cases where other operations had been tried before without result.

The iridencleisis has as a rule been performed with the 6 mm. bent stop keratome, designed by Holth. Only in a few cases the subconjunctival tunnel has been made by a pair of scissors. The author thinks that the first mentioned technique is of the greatest importance for producing a subconjunctival fistula. It also appears that the meridional iridotomy is the superior method regarding the decrease of tension. None of the fistula-forming material is lost, the pupil is but slightly dislocated and dazzling of the eye is avoided.

Directly following the operation the author has to note two cases of traumatic cataract and one case of blindness due to an intra-ocular haemorrhage.

In 144 (72.2 per cent.) of all the re-examined eyes, the intra-ocular tension was found normalized without pilocarpine and in a further 36 this was obtained by using pilocarpine 2-4 times a day, which before the operation had not been able to bring the tension down to normal. Thus: *tension was normalized in 90.9 per cent. of all the re-examined cases by the iridencleisis.*

*Visus was unaltered or even bettered in 80.3 per cent. of the followed-up cases.* The younger the patient was when operated on
the better he seems to stand the operation as regards the visus—and also the campus.

*The field of vision was kept or even bettered in 170 (85.9 per cent.)* of the iridencleises.

*The average result* of the three above mentioned factors—tension, vision, and field of vision, gives 85.7 per cent. apparent cures. No more than any other glaucoma operation, however, does iridencleisis yield any absolute security for a lasting good result. The author thinks, however, that *if the progress of the glaucoma is stopped for 36 months after the iridencleisis, there is a fair hope of a lasting cure.*

Just as in other glaucoma operations, the best results are obtained when early operation is performed. The author thus thinks:

*The iridencleisis by Holth, especially combined with meridional iridotomY, gives a relatively certain and lasting result without exposing the eye to any considerable risk later on of cataract, late infection, or sympathetic ophthalmitis.*

**Mr. H. B. Stallard,**

*A coloured cinematograph film of certain ophthalmic operations, prepared for the instruction of students.*

This film has been designed with the object of instructing students in the main principles and steps of certain ophthalmic operations. Whilst this method of teaching is not altogether ideal for the needs of post-graduate students, it serves a purpose for the instruction of large numbers of undergraduates in the general teaching hospitals by presenting to them in a short period of time the main features of certain common ophthalmic operations, thus saving them from spending in the ophthalmic operating theatre some hours which they can ill afford from an overcrowded curriculum.

**THE BOWMAN LECTURE**

**Professor Weve,**

*"Diathermy in Ophthalmic Practice."*

After a short introduction some historical notes were given on the invention of diathermy and its applications in medicine, followed by a chapter on physics concerning diathermy and a description of the apparatus used nowadays, including the electrodes.

The foregoing permits us to understand that diathermy has a wide field of application in ophthalmology, chiefly by some qualities that are characteristic of it—as, for instance, the possibility of getting strictly limited effects with accurate dosage, the fact that it
does not cause shrinking scars but gives very soft and flexible ones, that it stops haemorrhages and acts antiseptically, and above all that it may be applied to the interior of the eye without opening the bulbus.

After showing that the only really reliable method of measuring the energy required for surgical purposes is a biological control with help of the ophthalmoscope, a number of applications is studied.

After a short review of the applications on the eyelids and the outer eye—among which epibulbar sarcomata and carcinomata are specially referred to—the applications in intra-ocular tumours was described, followed by the use of diathermy in glaucoma. Another wide field of application is the modified sclerotomy with removal of fluid in cases of vitreous opacities in chronic inflammation and intra-ocular haemorrhages. Trans-sclerotic extraction of foreign bodies from the interior of the eye is much facilitated by diathermy.

The next addition to our list is the active combating of some forms of intra-ocular tuberculosis. Here the course of the disease may be considerably shortened and eyes may be saved that without intervention would in all probability have been lost.

The greatest successes of diathermic surgery are gained in the treatment of detachment. The technique used by the author is demonstrated by a colour film made in his clinic by Messrs. Keeler.

DISCUSSION

"The Problems of Refraction."

MR. C. B. GOULDEN (General Principles).

Visual acuity.

(a) Light sense.
(b) Form sense.
   i. Grating acuity.
   ii. Contour acuity.
   iii. Letter acuity.
(c) Colour sense.

Snellen's test types (1842).

Founded on Hooke's observations of minimum angle of visual acuity (1645).

Distant types.

To be used at least at 6 metres distance.
Illumination necessary, 10-ft. candles.

Near types.

Used at 30—40 cms.
Test lenses.
Variety of lenses needed:
- Spherical.
- Cylindrical.
- Prismatic.

*Note.*—Advantage of plano-spherical lenses.

Lenses to be mounted in discs and not rims.

Test frames.
Three cells near together.
Adjustable for:
- i. Separation of right and left cells, either singly or together.
- ii. Height and projection of bridge.
- iii. Angle of front.

They should be engraved with "standard notation" of inclination of cylinder.

Retinoscopy.

Source of light.
Diaphragm lamp of Gullstrand on the slit-lamp plan.
Advantage of plane transparent mirror.

Measurement of punctum proximum.
- i. Measurement of amplitude of accommodation.
- ii. Check on correcting lenses in the test frames.

Muscle balance.

Method of Maddox (1890).
- i. In the distance.
- ii. At the reading distance.

Measurement of amplitude of convergence.

Mr. A. H. Levy (*Methods of Estimation*).

In addition to the minimum requirements as enunciated previously there are many other instruments and apparatus available for what might be termed refinements in refraction or attempts to obtain more accurate results.

First among these aids is the ophthalmometer or keratometer. This is an instrument which affords the observer an exact measure of the refractive power of the anterior surface of the cornea—in any or all of its meridians. Principles of construction—method of use—considerations in applying results.

Refractionometers—various types, with a description of the Zeiss parallax instrument—its principles of construction—methods of use and difficulties.
Duochrome test—principle and method of use.
Astigmatic fans.
Maddox rods and other tests for heterophoria.

**MR. R. AFFLECK GREEVES (Clinical Aspects).**
Consideration of the purposes for which glasses are prescribed. Types of headache, caused by errors of refraction. Should migraine be included? Other symptoms attributable to refractive errors. The use of mydriatics. Difficulties arising in subjective testing. Senile cataract, vitreous opacities, etc. Special problems involved in the correction of hypermetropia, myopia and presbyopia, including associated errors of balance. Points in the correction of errors of balance. Ocular paresis. The correction of amblyopia, anisometropia and aphakia. Glasses for different occupations.

**MR. W. H. MCMLLEN (Anisometropia).**
Some observations with regard to its relation to amblyopia and defective binocular vision. Discussion of causes of discomfort often felt when unequal glasses are worn.

**PROF. TERRIEN and DR. RENÉ ONFRAY (Use and Value of the Diploscope in Routine Refractions).**
After prescribing glasses, the diploscope gives an easy way of quickly and accurately testing:
(a) The visual acuity of each eye.
(b) The binocular vision.
(c) The compared size of the images of each eye.
(d) The rate of accommodation.
(e) The muscular imbalance of the corrected eyes.

When glasses are chosen by the ordinary method it is advisable:
1. To use the three letter test with the smallest letters which may be seen at 1m.20, 0m.50, and 0m.33. You have then (a) a verification of the visual acuity tested with the ordinary test types and (b) a testing of binocular vision. If the patient does not succeed in the three letters test you have to seek other correcting glasses.
2. You must ask the patient if the three letters look the same size, above all if the letter on the left (seen by the right eye) has the same height and width as the right letter (seen by the left eye), if not you must change the glasses; try a stronger convex lens to magnify a letter, or a weaker concave lens to diminish the other letter. The recent work on aniseikonia shows the importance of this test.
3. Suppose the three letters test is successfully read at all distances and the three letters look of equal size, you have to try the four letters test.
(a) If the four letters are seen in proper position, you may conclude that the muscular imbalance is not unpoised by the correcting lenses and that there is no strain of accommodation; if the letters get slightly crossed, the letters seen by the right eye moving to the left and the letters seen by the left eye moving to the right, there is a slight divergence, which is a normal position of rest in simultaneous vision; you have not to change the glasses. But if the letters uncross one another, the two letters seen by the right eye moving to the right and the two letters seen by the left eye moving to the left, there is convergence and, according to Donders’ law, you may conclude that it proves an effort of accommodation; the eyes would probably get strained by the glasses and you have to try stronger convex or weaker concave lenses.

(b) The same test shows if the four letters are on the same horizontal line; if not, the eyes are not on the same level and one must add prisms correcting the hyperphoria.

So simple and cheap an instrument as the diploscope gives an accurate answer to the usual question: “Will the patient sustain his spectacles without strain?”

Wing-Commander P. C. Livingston (Refraction in its Relationship to Latent Deviations).

Is a refraction to be graded difficult because it is objectively so or because subjective reactions within the patient make it difficult? Certain ocular muscle defects are described and the assistance to be obtained through the use of correction with or without the added aid of prisms is discussed.

Three cases are mentioned as being typical of the problems involved.

Dr. Victor Purvis (Estimation of Astigmatism).

1. The use of crossed cylinders in the subjective estimation of cylindrical strength and axis.
2. The use of the streak retinoscope.
3. A cinema film to show the contrast between ordinary mirror and streak retinoscopy.

Mr. J. P. F. Lloyd,

“The Treatment of Increased Ocular Tension with Diathermy.”

This is not a new treatment, but an excellent and effective one which is often neglected.

Possible reasons for this neglect.
The nature of long-wave diathermy current and methods of producing it.
The effect of the current on living tissues in general and the eye in particular.
Apparatus and technique of application.
Some important practical points.
Summary of personal cases: successful, partially successful, failures.
The response which may be expected in various types of case.
Can this form of treatment cause damage?

**Conclusion.** This form of treatment is frequently successful as a primary measure in cases of acute and sub-acute glaucoma of every type, and can often at least defer operation on an acutely inflamed eye.

**MR. J. MINTON,**

"**The One-Eyed Worker in Industry.**"

The one-eyed worker is at present employed in all branches of industry. Such men are to be found in the building trades, working on ladders, roofs, scaffolding, etc.; in the heavy engineering trades, working on every type of machine and in the engine rooms; and in tool-making where great precision is needed.

One-eyed people can be divided into two groups. 1. Those who have had an amblyopic eye from birth or childhood. 2. Those who have lost an eye in the course of employment in adult life. The first group suffers from few handicaps in daily life and at work; they enter most trades or professions. The second group, after a period of visual readjustment, often returns to its pre-accident employment. It develops reasonably quickly some perception of depth. The degree of such depth perception acquired depends on such factors as (1) age, (2) intelligence and previous experience, (3) sex and (4) the loss of the dominant eye.

A questionnaire was sent to a great number of industrial establishments in this country by the courtesy of the Industrial Welfare Society. The replies received point to the fact that pre-employment visual examination is being carried out by many firms and that one-eyed men are being refused employment. The visual standards required from employees by a great number of firms are 6/6 or 6/9 in each eye. The certifying factory surgeon and the industrial medical officer should be advised by the ophthalmic profession as to the visual standards required in various occupations. Arbitrary visual standards set by employers and medical officers, such as 6/6 and 6/9 in each eye, are unnecessarily high for a great number of occupations.

A list of visual requirements in industry might be usefully drawn up and would act as a guide in the selection of suitable candidates
for employment. With the increased scope of industrial medical service and the more frequent pre-employment visual examination the one-eyed men will more often be refused employment.

The Declaration of Liability offers the workmen a safeguard for the loss of earning power in the future and should be made compulsory in all cases of the loss of an eye.

MR. G. T. W. CASHELL and DR. S. K. KON,

"Studies in Lactose and Galactose Cataracts in Rats."

Mitchell and her collaborators in America observed the development of nutritional cataract in the rat by using high concentrations of lactose and galactose in the diet.

As whole milk, which contains 40 per cent. of lactose on a dry basis, had never been reported to produce any toxic changes in the lens of the rat, it was of interest to find out whether the lactose as present in milk differed in toxicity from isolated lactose in conventional diets.

Groups of rats were fed on various diets containing lactose and galactose and the eyes of each rat were examined weekly with an ophthalmoscope, the pupils being dilated with guttae atropinae, 1 per cent. Slit-lamp examination was made in many cases.

The stages of development of the cataract in each rat were plotted graphically against the time taken and the differences between the effect of various diets were noted.

The first experiment (Diets 1 to 6) was to compare the toxicity of lactose present in dried and natural skim milk with that in artificially prepared diets. No difference was found in this respect between a synthetic diet of the same composition as dried skim milk and the natural product itself. Diets containing less protein were more toxic. Likewise fresh liquid skim milk was more toxic than the dried product.

The second experiment, in which a dried milk powder was fed as such or reconstituted with water, confirmed the finding that greater liquid intake increased the toxicity. In the third experiment galactose was used to ascertain whether the cataracts regressed after discontinuation of the toxic agent; and whether high percentages of protein tended to protect the lens. These suppositions were confirmed.

MR. E. WOLFF,

"Some Aspects of the Blood Supply of the Optic Nerve and Retina."

The arteries which supply the optic nerve do so through a rich pial network which acts as a distributing and regulating centre.

The vascular supply to the nerve can be accurately studied by
the position and size of the septa. The centre of the cross-section of the intra-cranial portion, where the papillo-macular bundle runs, is relatively poorly supplied with blood and this may, according to Behr, be responsible for the retro-bulbar neuritis (central scotoma) seen in toxic amblyopia, multiple sclerosis, and the Foster-Kennedy syndrome.

The arteria centralis makes five bends from its position under the nerve till it reaches the retina.

While branches from the central artery, before it reaches the optic nerve, take a very important part in its blood supply, from its point of penetration to its bifurcation the arteria centralis probably has nothing to do with the nutrition of the nerve. In this connection special emphasis is laid on the collateral vessels which enter the nerve with the central artery.

The central retinal vein, as opposed to the artery, anastomoses freely with the choroidal veins and the veins corresponding to the circle of Zinn; it also receives numerous tributaries in the nerve.

MR. LINDSAY REA,

"Further Uses of the Curved Retrobulbar Needle."

The needle, made of platinum, has a gentle curve with a broad flange: this flange is held between the thumb and forefinger. If the patient directs his eye upwards and inwards the space between the external and inferior recti comes into view and it is here that the needle is introduced. The eye is cocaïnised in the ordinary way, then by means of a short, straight needle a bleb is raised just at the junction of the bulbar conjunctiva and Tenon's capsule. The needle is gently pushed round in Tenon's space until the point touches the short ciliary nerve, the patient usually indicating this by an exclamation. One or two c.c. of 2 per cent. procaine and 1/30,000 adrenalin in saline are introduced. The fluid should not appear round the corneal limbus; if it does, the needle has been allowed to turn in the fingers. In dealing with a case of acute glaucoma I used 4 minims of 1/1,000 adrenalin added to 1·5 c.c. of 4 per cent. procaine and adrenalin in order not only to render the eye anaesthetic for operation but also to reduce the tension. With such anaesthesia it is not necessary to use a general anaesthetic when operating for acute glaucoma as was so commonly taught at one time.

Perhaps the greatest use that can be made of this retrobulbar needle is in the operation for cataract. The strength of the solution is 2 per cent. procaine, adrenalin 1/3000 in saline, one or two c.c. being injected according to the size of the eyeball. In a few moments such anaesthesia can be produced that the corneo-scleral suture can be introduced or an iridectomy done if considered
necessary. Frequently there is no pain at all during the first 24 hours after the operation.

One need not inject the skin around the orbit; the pricks of the needle often upset nervous patients, but when the eye is cocainised the introduction of the retrobulbar needle is a painless matter. In my experience patients do not squeeze after eye operations if they do not suffer pain, and so with retrobulbar anaesthesia from this standpoint there is a good chance of the wound being allowed to heal well and rapidly. In conjunction with scopolamine and morphine medication the most nervous patient can have a cataract operation performed. Only once did I have to use evipan as well.

Another most useful occasion for the use of the retrobulbar needle is the repair of a prolapsed iris. When an eye has to be removed (as in the case of an elderly patient) or when a patient is suffering from cardiac disease the retrobulbar needle stands us in good stead. When an eye is removed under retrobulbar anaesthesia a glass or metal globe can be inserted.

This needle enables us to make intra-ocular surgery painless. The more one uses this method of anaesthesia, the more one is convinced of its extreme usefulness.

Mr. J. Adamson and E. F. Fincham,

"The Effect of Lenses and Convergence upon the State of Accommodation of the Eye."

Changes in the state of accommodation cannot be determined by the usual retinoscopic method because the lenses which must be used to bring the focus of the emerging light to the plane of the mirror influence also the vergence of the light entering the eye and thus may cause a change in accommodation. In this investigation the light from a fixation object was reflected into the eye by a transparent plane mirror, and the refraction was measured by means of the coincidence optometer operating through the mirror. The lenses which were used to induce changes in the state of accommodation were placed in the path of the light from the object but out of the path of the optometer. It was found that accommodation remained unaltered within certain limits, with the maintenance of best vision, while the vergence of the light entering the eye was modified by positive and negative lenses. In addition, the effect of the state of convergence of the eyes upon the state of accommodation was also investigated. It was found that changes in convergence influence the state of accommodation; that the accommodation in binocular vision differed from the monocular state by amounts dependent on the presence and magnitude of horizontal muscle imbalance. In all cases measurements were made only while the subject maintained clearest vision of fine detail.
MR. W. O. GIBSON TAYLOR,

"The Effect of Enucleation of one Eye on the Growth of the Face."

Fifty cases were investigated at intervals of from two to ten years following removal of an eye in childhood. External measurements, confirmed by X-ray examination, indicate that enucleation, before the age of seven years, results in an aberration of development in both size and shape of the orbit. This abnormal development affects in some part the surrounding air sinuses.

PROF. DR. HANS LAUBER,

"Combined Operations for Glaucoma."

In cases of glaucoma, refractory to applied single operations, the author combined iridectomy with cycloidalysis, either performing the latter from the iridectomy incision after iridectomy had been completed, or performing cycloidalysis on the temporal inferior quadrant of the globe and iridectomy above. For another group of glaucoma cases, posterior sclerotomy was selected immediately preceding iridectomy. The combined operations have proved efficacious in the majority of cases.

DR. T. J. PHILLIPS,

"The Therapeutic Use of Short-wave Diathermy in Ophthalmology."

Diathermy as the best method of applying heat to the eye has been used for a long time. About two years ago short-wave diathermy took its place for the following reasons:

1. Portability of the machine.
2. Less risk of burns to the patient.
3. May be safely used on an eye after trauma or operation.
4. The depth at which the heat is produced is controllable.
5. Results show that its effect on the eye are obtained in a shorter space of time.

Comparison of different types of machine and in particular the comparison of the bi-polar electrode and the cable electrode. Method of carrying out the treatment.

Conditions in which the treatment is used. Comparison of results.

MR. L. P. JAMESON EVANS,

"Tobacco Amblyopia: Pathology and Treatment."

Clinical features: the scotoma: value of scotometry, variations of position and of density: changes during treatment. Relation

The Annual Dinner was held on Thursday, April 20, at the Langham Hotel and was well attended. The President's invitation to members of the Society to bring ladies to the dinner received a favourable response.

Mr. Charles Goulden proposed the toast of the guests to which responses were made by Mr. Hugh Lett and Air Vice-Marshal Sir Alfred W. Iredell. Mr. Foster Moore proposed the toast of the President.

In connection with the Congress a trade exhibition of instruments and apparatus was held in the College of Nursing.

On Saturday afternoon members of the Congress were conducted over the Middlesex Hospital and shown there cinematograph films of ophthalmic operations and treatment by Professor Lindner (Vienna) and a film by Davis Keeler on the methods of making and fitting contact glasses.

---

ABSTRACTS

I.—MISCELLANEOUS


(1) Glees describes three cases showing the Foster Kennedy syndrome (optic atrophy in one eye, with papilloedema in the other), which were due to arteriosclerosis of the carotids and not to a neoplasm. There was a binasal loss of field but the usual central scotoma was absent.

D. R. Campbell.