MISCELLANEOUS

This scene came into our mind when we went to the chemist to order some morphia in view of the possibility of being called upon to render first aid to air-raid casualties. We were surprised when we were told that to those retired from active practice morphia could not be supplied on their own prescriptions. It is apparently a punishable offence for a chemist to supply morphia, cocaine, or any other "dangerous drug" to a qualified medical man or woman if he or she has retired from practice. In our opinion it is high time, in the present emergency, that this embargo on the provision of drugs should be lifted. Ophthalmic surgeons do not often have to prescribe morphia for their patients, but cocaine is one of our sheet anchors, and it is a monstrous interference with professional liberty that, because we happen to be no longer competing with other physicians and surgeons, we should be debarred from obtaining the drugs that we may need in an emergency. And as morphia is more often than not urgently needed in the severe types of injury inflicted, no restrictions should be placed in the way of its provision to qualified persons.

ABSTRACTS

MISCELLANEOUS


(1) A series of cases, in which bilateral papilloedema with raised intracranial pressure and yet no brain tumour was present, was published by Dandy in the Annals of Surgery in 1937 and abstracted in our pages, Vol. XXII, p. 244. The present paper deals with another, even larger, group of cases having papilloedema, usually bilateral, but occasionally unilateral, frequently fundus haemorrhages with mild degree of headache and varying degrees of visual loss. The present group differs from the former in the absence of increased intra-cranial pressure.

Forty-four cases are included in this report and the end-results of 31; from the remaining 13 cases no answer has been received to inquiries by letter. The cases are spread over the past 15 years. Females were almost three times as frequently affected as males and cases occurred in every decade of life up to the 70th year.

The following are the author's conclusions:
(1) The underlying aetiologal or pathological lesion is unknown, except that two cases of multiple sclerosis and two of encephalitis are included. No evidence of either of these lesions can be found in the remaining cases. A few of the cases appear to follow a mild non-specific inflammatory process in the eye or lids, but these cases are distinctly in the minority.

(2) Although there is evidence of some intracranial involvement in some cases, in others there is none. Moreover, the papilloedema may be unilateral, although more commonly bilateral. On the whole, the pathological process is decidedly local and any intracranial extension and its effects are usually mild and of little concern. Exceptions to this statement are, of course, the examples of encephalitis and multiple sclerosis.

(3) The condition carries no danger to life, and heals spontaneously in the course of a few weeks or months. No form of treatment is known to be effective. Certainly, all forms of operative intervention are contraindicated.

(4) Women are affected nearly three times as frequently as men. It occurs in all decades of life in about equal frequency, except the second, where it is two and a half times as common.

(5) The outstanding symptom is loss of vision—usually a blurring at first. Scotoma, field defects and blindness may develop with great rapidity, and may or may not remain. Great defects of vision and visual acuity, even blindness, may disappear and even normal vision may return. Permanent blindness resulted in only one case. Haemorrhages in the eye grounds occur with great frequency.

(6) There are no changes in the cerebro-spinal fluid; the pressure is not increased. Ventriculograms are always normal.

(7) In only one case did the papilloedema recur. This was three years after the initial attack and three years ago. On each occasion the vision was seriously defective, but returned almost to normal. The eye grounds show only slight pallor of the discs. In another case, a dense scar fills the disc and obliterates all its landmarks.

The cases are shown in tabular form and a bibliography of 13 items is appended.

R. R. J.


(2) Miss Maxwell's Presidential address to the Irish Ophthalmological Society is here printed in full. It appears that the National Council for the Blind in Ireland was founded in 1921; and five years later the Council formed a Prevention of Blindness Committee which
has already done good work in bringing to the notice of Government problems associated with ophthalmia neonatorum, trachoma and protection in industry.

Her address is printed under five headings, "four age-groups," and certain aspects of Public Health administration.

The first age-group; the pre-school age. In this connexion the Maternity and Child Welfare Act was passed in 1918, and "slowly but surely beneficial schemes in Eire have been, or are being, developed around this central idea." Clinics for mothers in Dublin are becoming more extensively used, for in 1938 there were about 25,000 attendances contrasted with about 3,000 in 1928. Ophthalmia neonatorum was made a notifiable disease in the City of Dublin in 1924 and it is hoped to extend this order throughout the country at an early date. The order appears to have been more honoured in the breach than the observance, for in the period 1936-1938, thirty-one cases from the City were treated in the Dublin Eye Hospital, but for this period the M.O.H. was notified of only three cases.

In Eire there is still widespread ignorance as to the nutritive properties of fish, cheese, fruit and many vegetables. The author states that much of the malnutrition in the country is the result of "a poverty of the intelligence rather than of the purse."

Her second age-group deals with the school age. The importance of lighting and educational hygiene are here emphasized. She holds strongly that in schools where there are a number of "partially-sighted children" special classes for oral instruction in certain schools might be organized. Children leave school in Eire at the age of 14 years. She thinks that it might be possible to allow a child with progressive myopia to continue attending the medical inspections of his previous school until he has reached the more stable age of 16 years.

In this age-group the trachoma problem is in intimate association. Government have under consideration "regulations which, if promulgated, will make trachoma notifiable all over Eire." This, however, will prove valueless in the absence of definite arrangements for segregation and treatment.

In 1939 a "Public Health" nurse was appointed in Clare for the treatment of trachoma patients under the supervision of the County Ophthalmologist. "It must be admitted that trachoma is in essence a social evil rather than a medical problem." If hygiene were introduced as a compulsory subject in all schools and means found for the prevention of the overcrowding so prevalent to-day in institutions and in the houses of the poor, succeeding generations would know it no more."

In the third age-group the question mainly arises of prevention of eye accidents in industry. Miss Maxwell gives figures from an
Miss Maxwell urges that relevant data should accompany all patients on their admission to hospital.
An "organized social service in hospital administration in Eire would seem to be conspicuous by its almost complete absence." When these words were written only five out of 64 hospitals in Eire had an almoner. There has been some improvement in this matter since 1933-1934, but there is still room for more.

Miss Maxwell's final remarks concern the position of the optician in the state. At present there are three centres of the National Eye Service functioning in Dublin, and the ophthalmic group of the Irish Free State Medical Union have formed a committee to deal with difficulties that may arise in regard to local administration. In Miss Maxwell's opinion "State registration for opticians would not only secure a universally high standard of efficiency, but would serve to maintain the honour and dignity of a body which forms one of medicine's most highly valued ancillary services." She thinks that the Pharmacy Act (Ireland) of 1875, with the Amendment Act of 1890, might serve as a model for any such legislation. Any pass examination "shall not include the theory and practice of medicine or surgery; no person may assume the title of registered druggist or chemist, unless registered."

It will be realised that this Presidential address is of a very high standard. We congratulate Miss Maxwell on her very able paper.

R. R. J.

(3) **Yanes, Dr. Tomás R.**—Paradoxical monocular ptosis. *Arch. of Ophthal.*, Vol. XXIII, p. 1169, June, 1940.

(3) **Yanes** deals with an interesting case of monocular ptosis of which no other similar case has been met with in the bibliography, which in many respects resembles a case published by Dr. Gifford in the *Arch. of Ophthal.*, Vol. XXII, p. 252, August, 1939.

He speaks of an adult who in 1933 began to have some difficulty of vision in the left eye, without diplopia, giddiness, or any other change, who previously had had no ocular disturbance. His troubles began with a deviation of the left eye outwards and, at the same time, the upper lid drooped until it almost completely covered the eye.

On examining the patient in 1938, an incomplete paralysis of the third nerve was found, only the extrinsic muscles being affected and the pupillary movements being preserved, the position of the left eye being one of abduction, due to the action of the rectus externus. Of special interest was the fact that the ptosis would disappear completely when the right eye (which was not affected) was occluded and when this eye looked inwards or outwards. The media and fundi of both eyes were normal. The vision in the right eye was 1 and that of the left eye from 1/10 to 1/20, although no lesion existed to justify this. There was a history of a primary syphilitic lesion at the age of 20.
The condition of the patient improved with the recession of the external rectus and advancement of the internal and with a shortening of the levator palpebrae superioris. Although the ptosis is not so marked as before these operations, it can still be observed, but disappears completely, not only when the patient shuts his right eye, but also when the vision of this eye is interfered with by means of a disc and when the patient looks inwards or outwards with the right eye.

The author deals with various considerations to eliminate the possibility that it was caused by the aberrant regeneration of nerve fibres or a defensive phenomenon to prevent diplopia and comes to the conclusion that, although the interpretation of this phenomenon accounted for on any fundamental anatomical basis would be doubtful and false, he believes that his case, associated with those of Drs. Gifford and Pacetti (cited by Bielschowsky) form a strong diagnostical basis, capable of being used in the study of the whole condition of the functional paralysis of the ocular movements.

E. E. Cass.


(4) The aetiology of chronic glaucoma being still an unsolved problem, it may be of interest to outline Fortin's theory as quoted by Denig. According to the former, the ciliary muscle plays an important part in the regulation of intra-ocular pressure. The long posterior ciliary and other arteries pass through the substance of the muscle, whereas the veins remain outside it. When the muscle contracts therefore, the arteries are compressed, thus diminishing the flow of blood through them, whereas the veins are opened up, thus tending to lower the intra-ocular pressure. At the same time contraction of the muscle opens up the sclero-corneal interstices round Schlemm's canal and the subscleral spaces, via which transudate is being eliminated. The observations explain the actions of miotics and mydriatics on intra-ocular pressure and form a basis for the author's operation of iridotorsion. This consists in excising an elliptical piece of sclera under a conjunctival flap and drawing into the hole thus made one of the pillars left after meridional division of the iris. The portion of iris drawn into the wound is twisted round a fine dental probe, thus forming a tunnel lined by pigment and connecting the interior of the eyeball with the subconjunctival space.

F. A. W-N.

Elwyn's patient was a man aged 72 years who had bilateral cataract extraction performed. Vision, with adequate correction after operation was R.E. 20/50, L.E. 20/30. Each disc was pale and showed a shallow excavation extending to the margin, with a halo of choroidal atrophy around it, the appearances being similar to those seen in a case of advanced simple glaucoma. The fields showed a nasal defect and some temporal loss in each eye. The intra-ocular pressure, measured with a Schiotz tonometer, on many occasions, was only 16 mm. Hg. An X-ray examination of the skull revealed “deposits of calcium in the carotid artery” and the author suggests that the optic atrophy was due, either to pressure on the nerves by the calcified artery, or to loss of nutrient vessels. A. Knapp has reported a series of similar cases, from which he concluded that “atheromatous carotid arteries cannot alone cause this descending atrophy, but the conditions must be caused by simultaneous circulatory disturbances in the optic nerve from arteriosclerotic vascular changes.”

F. A. W.-N.


Van der Hoeve recalls the classical signs of supra-sellar tumours, stressing the presence of choked disc on one side and optic atrophy or papillo-macular atrophy on the other side. From a description of four personally observed cases he emphasises the value of radiography of the optic canal; all his cases showed erosion of the roof of the canal.

ARNOLD SORSBY.

Rochat, C. F. (Groningen).—Calcified aneurysm of the internal carotid artery. (Anevrysme à pario calcifié de la carotide interne). Ophthalmologica, Vol. XCIX, p. 265, 1940

Rochat gives the case history of a man aged 47 years who had been under his observation for 12 years, suffering from indefinite and intermittent ocular symptoms mainly in the nature of recurrent ocular palsies. The cause of these symptoms is now seen to be an aneurysm of the internal carotid artery shown up radiographically owing to calcification.

ARNOLD SORSBY.

(8) Mulock Houwer, drawing on his experience in Java, strongly advocates extraction of the opaque lens in both eyes at the same sitting. Out of 117 cataract patients operated on bilaterally, both operations taking place at the same time, 99 had good results in both eyes; 15 had good results in at least one eye; 4 lost one eye; one lost both eyes (a diabetic case): and one died shortly after the operation. The necessity of bandaging both eyes is no objection to the double operation, since after a unilateral operation both eyes are usually bandaged for some time and in a double operation the bandage may be replaced by a "Gitter" bandage very shortly after the operation. There is no tendency for accidents to occur in both eyes; even infections of one eye do not tend to spread to the other. There is a very small chance that both eyes may be lost. This chance is, however, much smaller than the chance that, the operation on the first eye being a failure, no operation can be performed on the second eye owing to lack of courage on the part either of the doctor or the patient. In cases where the chance of success is subnormal the double operation should not be performed. The advantages of the double operation are: it is less expensive, since it requires a shorter stay in hospital and consumes less of the eye-surgeons' time; it gives less discomfort to the patient.

Arnold Sorsby.


(9) Recalling the classical description of true diabetic cataract given by Schnyder in 1923, Marx describes three cases under his care, the third one differing considerably from the classical type. It concerned a boy aged 19 years suffering from diabetes. He had become short-sighted rather suddenly, first in the left, then in the right eye; almost simultaneously he was affected with very peculiar opacities in the lens, in the nature of vacuoles situated deep in the anterior cortex, which gradually spread over the greater part of the cortex. This appearance of vacuoles deep in the cortex is a striking contrast to the usual subcapsular opacities.

Arnold Sorsby.