

The Supply of Spectacles

We regret that the notice by the Association of Dispensing Opticians Ltd., which was printed in our advertisement columns last month reached us too late to enable us to comment thereon in the November issue. It is obvious that at the present time some delay in supplying spectacles must arise and the reasons for this are set out in the pages in question and need not be recapitulated here. Ophthalmic surgeons may rest assured that the optical trade will do all in their power to minimize this delay and surgeons will, it is hoped, explain to their patients that the goods cannot be delivered with that speed which was so noticeable before the war. After all the delay is part of a world upheaval and must be endured patiently.

It is worth while pointing out that surgeons can help in this matter by refraining from ordering glasses which have to be made specially, in cases where such glasses are not essential. For instance, a presbyope without signs of eye strain can do with an ordinary presbyopic correction even if an eighth of a dioptre of astigmatism be present. The total resources of the country in the provision of spectacle lenses are much less than the number required, and the manufacture of out of the way lenses only adds to the difficulties and delays.

ABSTRACTS

MISCELLANEOUS

- (1) **Maxwell, J. S. (Fairmont, West Virginia).—Modification of the Hotz operation for entropion due to trachoma.** *Amer. Jl. Ophthalm.*, Vol. XXIV. p. 298, 1941.

(1) **Maxwell** describes the technique he favours for the Hotz operation for entropion due to trachoma. He suggests that the trachoma virus is in the tarsus and that the conjunctiva suffers recurrent inflammation from this source. He believes that post-operative fibrosis in the tarsal plate checks the egress of the virus.

The author stresses the importance of adequate preliminary treatment to clear up active conjunctival inflammation. He uses applications of silver nitrate 1 and 2 per cent. for this purpose. It is important to pay attention to thorough surgical work at the extremities of the elliptical incision which should pass 2 mm. beyond the line of cilia at the inner and outer canthus. An ellipse of skin and a band of orbicularis muscle 4-5 mm. wide are excised and the tarsal plate pared down from near its upper margin to an

incision 3 mm. above the lid margin which nearly traverses its entire thickness. Three mattress sutures are inserted from near the upper margin of the tarsus to the lid margin where they are tied the ends left long and carried upwards to be secured to the frontal region by strapping. Sutures are removed on the seventh day.

H. B. STALLARD.

- (2) **Verhage, J. W. C. (Leyden).**—Miners' nystagmus and disturbances in adaptation. (**Bergmannsnystagmus und Adaptationsstörungen**). *Ophthalmologica*, Vol. XCIX, p. 503, 1940.

(2) After a short discussion of the more important theories on miners' nystagmus, **Verhage** points out that working incapacity does not run parallel to the degree of nystagmus. A thorough examination of eight patients led to the finding that all eight men had a disturbance of adaptation, thus confirming the results obtained by Ohm and Weekers. Twenty-five patients suffering from miners' nystagmus were examined for the purpose of determining exactly the degree of adaptation (uniform light adaptation, mydriasis, correction of the difference in the size of the pupils, etc.). For control purposes the adaptation of 91 miners, on sick leave owing to their nystagmus, and 47 normal miners was determined without the above-mentioned precautions. Adaptation was seen to be normal in the case of the normal miners, disturbed in well over 70 per cent. of the patients with nystagmus.

The author holds that an important, if not the greater part of the subjective troubles of the patients are caused not by the nystagmus but by the disturbance of adaptation. The cause of the disturbance of the adaptation, he considers to lie in strong contrasts which exist in the mines between source of light and the field of work.

ARNOLD SORSBY.

- (3) **van Waveren, W. F. J. (der Helder, Holland).**—Amotio retinae attending scleritis and its possible relations with Harada's disease. *Ophthalmologica*, Vol. XCIX, p. 543, 1940.

(3) **van Waveren** describes a case of retinal detachment in the left eye seen in the course of recurrent bilateral scleritis in a woman aged 41 years. He discusses the condition in relation to somewhat similar clinical pictures described by different writers. Thus Harada has drawn attention to the characteristic picture of diffuse choroiditis and retinal detachment. Tagami and others showed its inflammatory character. Several authors stress a possible relationship between Harada's disease and the disease of Kovanagi and sympathetic ophthalmitis.

Retinal detachment in cases of scleritis is not frequent. Horay and Lund, therefore, assumed a relationship between such cases and Harada's disease.

It is possible that there is a connection between the cases of scleritis with retinal detachment and Harada's disease in so far as the scleritis may be part of the full Harada syndrome.

The author emphasises the high sedimentation rate in his case and the prompt recovery on salicylate treatment.

ARNOLD SORSBY.

(4) **Keiner, G. B. J. (Zwolle, Holland).—Cholesterin deposits in the eye. (Ueber Cholesterinablagerungen im Auge).** *Ophthalmologica*, Vol. XCIX, p. 459, 1940.

(4) **Keiner** describes clinically and histologically three cases of deposits of cholesterin in the eye. After discussing the formation of fat and lipoids there follows a review of the three lipid diseases: Niemann-Pick disease, Gaucher's disease and the Schüller-Christian-Hand syndrome. The author suggests that ocular cholesterinosis may possibly be a symptom of the latter affection. The ways in which crystals are formed in primary and secondary fatty changes are discussed. Attention is called to the important rôle of the reticulo-endothelial system in the formation of deposits of cholesterin in the globe.

ARNOLD SORSBY.

(5) **Halbertsma, K. T. A. (Delft).—The presence of histamine in the human aqueous.** *Ophthalmologica*, Vol. XCIX, p. 443, 1940.

(5) **Halbertsma** obtained aqueous by operation from patients with and without glaucoma. This was added to Lâwen-Trendelenburg perfusion fluid. The first group showed a definite vasoconstrictory effect, which was lacking in the second group. This was demonstrated on guinea-pig bowel by Tyrode perfusion. The contraction of the capillary vessels was typical for histamine and histamine-like substances. The concentration lay between 1:10·6 and 1:10·7. These experiments confirm Frederick Ridley's work showing the presence of a histamine-like substance in the aqueous of the glaucomatous eye. Glaucoma may be due to the influence of histamine on the intra-ocular capillaries.

ARNOLD SORSBY.

(6) **Deutman, A. F. (Leyden).—Formolized cornea and keratoplasty in rabbit's eyes.** *Ophthalmologica*, Vol. XCIX, p. 418, 1941.

(6) **Duetman** reports on partial penetrating homokeratoplasty performed on five normal rabbits' eyes. Pieces of normal rabbit's cornea that had been fixed in 4 per cent. formaldehyde for one day

and then washed in running tap-water for 48 hours, were used as transplant material. To avoid the advantages and disadvantages of one single method of operation, two essentially different techniques were applied. In all cases the formolized transplant took with less tissue reaction than transplants of normal cornea from freshly enucleated rabbit eyes. All the transplants clinically observed during 3, 5 (3 cases) or 11 months after operation, remained opaque. On stereoscopic photographs these opacities were seen localised in the posterior layers of the corneal parenchyma. Histologically these opacities were seen to result from a connective tissue membrane that had developed behind the formolized graft, which appeared surrounded by the neighbouring corneal tissues as if there was an attempt at encapsulation. The result of these experiments suggests that keratoplasty material which has been formolized for a short time is more fit for tectonic purposes than for optical improvement.

ARNOLD SORSBY.

- (7) **Guyton, J. S. and Woods, A. C. (Baltimore).**—**Advances in the use of sulfanilamide compounds in ophthalmology.** *Amer. Jl. Ophthal.*, Vol. XXIV, p. 428, 1941.

(7) **Guyton and Woods** comment on the necessity for full therapeutic doses of sulphanilamides in order that they may be effective in certain ocular disorders. The blood concentration should be sulphanilamide 6 to 11 mg. per cent.; sulpha-pyridine slightly less than this; and sulphathiazide 3 to 9 mg. per cent.

For gonococcal conjunctivitis sulphapyridine has been used but recent trials show that sulphathiazide is better. This disorder is cured in 1 to 4 days but it is important to continue the treatment for 3 days after a negative smear. It seems that sulphanilamide has a direct effect on the trachoma virus according to the authors. Fourteen cases of inclusive blenorrhoea cleared up promptly with sulphanilamide. Koch-Weeks bacillus infection of the conjunctiva was rapidly cured by the same drug. Sulphanilamide is less nauseating when combined with an equal quantity of sodium bicarbonate.

Sulphathiazide was not entirely satisfactory in the treatment of staphylococcal infections. In pneumococcal lesions of the conjunctiva and cornea it operated equally well as sulphapyridine. It proved to be best in the treatment of *B. coli* infections and dysentery. Meningococcal infections did better with sulphapyridine than sulphanilamide.

An appendix of doses according to body weight is given at the end of this paper.

H. B. STALLARD.

- (8) **Pinars, M. H. (Brooklyn, New York).—Monocular diplopia.**
Amer. Jl. Ophthalm., Vol. XXIV, p. 503, 1941.

(8) **Pinars** describes a case of monocular diplopia occurring in the only eye of a coloured male, aged 50 years. The other eye had been lost from injury. The peculiar feature of the case was that the images became more widely separated as the object receded. There was no detectable intra-ocular disorder likely to cause the diplopia, neither was there any evidence of hysteria nor grounds for suspecting malingering. The condition was still present and unchanged four years after the onset. The author was unable to give any explanation to account for the monocular diplopia.

H. B. STALLARD.

- (9) **Barbour, A. and Fralich, F. B. (Ann Arbor, Michigan).—The posterior approach for removal of magnetic intra-ocular foreign bodies.** *Amer. Jl. Ophthalm.*, Vol. XXIV, p. 553, 1941.

(9) **Barbour and Fralich** comment on the risk of damage to the lens by extracting some foreign bodies through the anterior route. The site of the foreign body is carefully localised by radiography. The sclera is trephined by a 1.5 or 2 mm. trephine at a point 4.5 to 5 mm. from the corneo-scleral junction and over the pars plana of the ciliary body at the nearest accessible point to the foreign body. Part of the trephined disc of sclera is allowed to remain hinged. Before the trephine has penetrated the sclera a suture is passed through the sclera at a point just posterior and then just anterior to the trephine cut, the loop of the suture is drawn aside and the trephine cut completed, the pars plana of the ciliary body is incised antero-posteriorly parallel with the long axis of the veins. The giant magnet is applied to the trephine hole and the foreign body is withdrawn. The trephine disc is replaced and secured by the suture, the ends of which are then brought out through the overlying conjunctival flap and tied.

The authors have performed 14 operations according to this technique and in none has sympathetic ophthalmitis occurred.

H. B. STALLARD.

- (10) **Ballantyne, A. J. (Glasgow).—The reflexes of the fundus oculi.**
Proc. Roy. Soc. Med. Section of Ophthalm., November, 1940.

(10) **Ballantyne's** Presidential address before the Section of Ophthalmology of the Royal Society of Medicine occupies 24 pages of the proceedings, and contains 26 illustrations. His work on the fundus has been known for years as always of a very high standard.

“The fundus reflexes reveal, in a manner not yet completely understood, the texture and contour of the reflecting surfaces and

the condition of the underlying tissues. In this way they may play an important part in the microscopy of the eye."

He emphasises the importance of comparing the appearances seen with the long and short wave lights such as those of the sodium and mercury lamps, in addition to the usual ophthalmoscopic lights in the investigation and interpretation of these reflexes. Reflexes are of course both physiological and pathological and may be linear or annular in type. "Punctate reflexes, other than Gunn's dots, are pathological." "It is characteristic of the pathological reflexes that they come and go, and change their character according to the progress of the pathological condition. The linear reflexes in particular may change from one form to another, and may be finally transformed into surface reflexes of physiological character."

The author has done a service to ophthalmology by this address which is helpful in many ways and shows the importance of a subject to which too little attention has been devoted in the past.

R.R.J.

- (11) **Shimkin, N. I. (Haifa).**—The treatment of trachoma with sulphanilamide. *Medicina*, December, 1940.

(11) **Shimkin** reports, in the Hebrew journal *Medicina*, 32 cases of severe trachoma complicated with pannus and ulceration treated with sulphanilamide. Photophobia and blepharospasm cleared up by the third day of treatment at latest. For adults one gram of sulphanilamide was given thrice daily after meals, 0.5 gram for children thrice daily. Pannus cleared up in 10 to 14 days' time. Up to November 1940 more than 200 severe trachoma cases were treated with good results. In the year 1940 six cases of gonorrhoeal conjunctivitis (the brand in adults) were treated with dagenan. After four days' treatment no gonococci could be found in the smears.

The paper is in Hebrew but a convenient summary in English is appended.

R.R.J.

- (12) **Gordon, White and Hassard (Toronto).**—Retinopathy in diabetics. *Canadian Med. Assoc. J.*, June, 1941.

(12) This is a paper read at the Seventy-First Annual Meeting of the Canadian Medical Association, Section of Ophthalmology, Toronto, on June 20, 1940.

Gordon, White and Hassard here report on one hundred cases from the diabetic clinic at the Toronto Western Hospital. The intention is to make "a routine eye examination of all diabetic clinic patients, which will give a cross-section of the occurrence of retinopathy in these patients."

Their conclusions are as follows : " In this series of 100 diabetic patients the incidence of retinopathy increases with advancing age, and duration and severity of diabetes, and the association of cardio-vascular-renal disease. However, there are six cases of retinopathy in the series without cardio-vascular disease, and the main factor in this group appears to be the severity and control of the diabetes. This factor, however, cannot be responsible for all the cases of retinopathy. The only factor, so far discovered, common to all these cases is the diabetes itself, and until some other factor is discovered diabetic retinopathy must be considered a clinical entity, in which the vessel walls of the diabetic are affected by some factor other than and in addition to those operating in cardiac disease, hypertension and nephritis."

R.R.J.

(13) **Buxton, R. (Weston-super-Mare).—Bomb splinters in the eye.** *Med. Press and Circ.*, July 2, 1941.

(13) **Buxton** contributes a short practical paper on bomb injuries of the eye which will be of value to those engaged in first-aid practice who are called on to examine such cases in the first instance. Severe injuries, of course, must go to the nearest ophthalmic surgeon and it is better to wait a few hours than to risk losing the eye by ill-advised surgery. He deals with first-aid treatment for minor injuries and gives clear rules for the examination of the injured eye, relates two cases and details the correct treatment under the headings of lids, burns, conjunctiva, cornea, wounds, iris and sclera. His final remarks are on the routine preparation of the patient for intra-ocular operation. His second case was that of a lady whose left eye had been severely injured by glass splinters, whose cornea was ruptured with iris prolapse. The right eye had not been reported on, and was found to have a penetrating wound with iris and vitreous prolapse and retinal detachment. Buxton covered the wound in the left eye with a complete conjunctival flap secured by purse-string suture. In the right eye the prolapsed iris and vitreous were excised. With such a serious injury to the right eye it would not have been correct to remove the left eye at once. Sympathetic ophthalmia nearly always gives one about a fortnight's grace before declaring itself. As it happened the left eye did not improve and was removed on the tenth day.

R.R.J.

(14) **Lloyd Morgan, A. (Toronto).—Plastic repair of deformities of the eyelids.** *Canadian Med. Assoc. Jl.*, June, 1941.

(14) **Lloyd Morgan** gives brief descriptions of three cases with illustrations to show the method adopted. Case I was cicatricial

ectropion of the lower lid in a boy aged 12 years. The second case was of congenital ptosis with epicanthus and very narrow palpebral fissure in a female child of 4 years of age; the third was a female child, 4 years of age, born without a left upper lid. We reprint here the author's discussion:—

“Plastic repair of deformities about the eyes will not always restore the condition to normal, and the results are sometimes discouraging both to the doctor and the patient. The best that can be hoped for is to improve the appearance, and to achieve that end this type of plastic surgery requires special consideration. Care must be taken not to make new scars which will prove more unsightly than the original ones. If possible, incisions should run in the same direction as the fibres of the orbicularis muscle.

Cicatricial ectropion of the lower lid, as in Case I, is usually the result of accidents in which there has been a loss of tissue with contracting scars and traction downward of the lower lid. The lid margin is often intact. In the area bounded by the orbit the skin is of a different texture and pigmentation from that of other parts of the face; therefore, grafts from other parts of the body, as behind the ear or under the arm, show a contrasting colour. Hence, the best source of skin is from the upper lid of either the same or the opposite eye. There is plenty of loose skin in this situation, and grafts 40 mm. long and 20 mm. wide can be obtained. The grafts should contain nothing but skin. These full thickness grafts take well. Pedicle grafts are usually unnecessary. All bleeding on the surface to be grafted must be stopped before applying the grafts, as any haemorrhage under the grafts prevents proper adhesion. Before applying the pressure dressing, the best material to use directly over the graft is a thin layer of perforated cellophane, lightly smeared with vaseline. This method was first described by Wheeler in 1920, and gives excellent results.

Lid adhesions perform a very important duty; they protect the cornea, and prevent post-operative contraction of the graft. They should be used to prevent corneal ulceration in any type of operation which requires a pressure dressing. It is usually unnecessary to have more than two, one on each side of the pupil. The adhesions stretch slightly and the patient is able to see through the slightly open fissure.

Grafts forming a new lid must be lined with mucous membrane to prevent contraction. Conjunctiva is better than buccal mucous membrane as it forms a smoother surface. There are several ways to repair ptosis of the lids, all based on three main types: (a) Suspension of the tarsus from the frontalis muscle; (b) shortening of the levator palpebrarum; (c) use of the superior rectus.

Type (a) should be used when there is a unilateral paralysis of

the levator or narrow palpebral fissures. Type (b) can be used only when there is some action of the levator. Type (c), when there is bilateral ptosis due to levator paralysis but no mechanical restriction of movement of the upper lid.

Fascia lata is an excellent material to use in suspending the upper margins of the tarsus to the frontalis muscle. It does not stretch nor undergo absorption. Wright modified his original methods so that the technique is much simpler."

R. R. J.

(15) **Kirwan, Lieut.-Col. E. O'G. (Calcutta).**—The enumeration of the blind in India. *Indian Med. Gaz.*, March, 1941.

(15) **Kirwan's** short paper with the above title was read at the Eighth Conference of the All-India Ophthalmological Society at Bangalore in December, 1940. The first blind relief association in India was started in the Bombay Presidency in 1913, by the late Mr. C. C. Henderson, I.C.S. A survey of the blind in some districts by this association found that the actual number of blind persons was far higher than that indicated by the census returns.

The prevention of Blindness Society of Bengal has carried on this pioneer work and during the period of $4\frac{1}{2}$ years has surveyed 379 villages of different districts in that Presidency. The large figure of 670 completely blind persons out of a total population of 340,240 has been found. This gives 196.91 blind persons per 100,000 in contrast to the figure of 73 per 100,000 in the census for 1931. "It is probably correctly written that there are about one and a half million blind persons in India, and for every one person blind there are three partially blind, out of a total population of 353,000,000, whereas the census figures of 1931 show a little over three-fifths of a million blind persons." These figures speak for themselves.

R. R. J.

BOOK NOTICES

The Medical Annual, 1941. Bristol: John Wright and Sons, Limited. Price, 23/-.

Editors, contributors and especially the publishers are to be congratulated on the appearance of the 59th volume of this important work. Enemy action interfered grossly with the appearance but could do no more than postpone it. The scope of the work is of course well known to our readers; as in past years Sir Stewart Duke-Elder is responsible for the ophthalmic section. He supplies short articles on glaucoma, iritis, trachoma, and uveitis with