

due to using unsuitable plastic and offered to make up some spheres in material proved to be inert. The firm kindly supplied me with some 17 mm. spheres as illustrated. These have been



used on four occasions up to date; only trivial post operative tissues reaction was noted. One patient seen a year after the implantation was made had a perfect socket with good movement of his double shell (reform) prosthesis, without any history of intervening irritation.

In view of all the trouble which a bad socket can give rise to, as emphasised by one's experience in the present war emergency, it seems well worth while to take pains to give every patient that is subjected to enucleation the opportunity of having a good socket. One should aim at a convex movable stump, covered by smooth conjunctiva as free from scar tissue rucking as possible. This may be obtained by careful limbal incision of the conjunctiva, adequate undermining, a good implant, and closure of the clean-cut conjunctival wound by accurate apposition of its edges.

Such sockets are worth treating with respect and nothing but a double-shell (reform prosthesis) or a carefully filled plastic prosthesis should be used. A single-shell prosthesis is very liable to produce contracted socket, an even greater evil in military than in civil life. Since writing the above it has come to my notice that the idea of using plastic spheres is not new. I understand they have been used in Canada and perhaps elsewhere.

The pattern described is possibly an innovation; at all events the perforations are of considerable importance.

## THE LOCAL APPLICATION OF PENICILLIN SOLUTION TO THE EYE\*

BY

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If it is desired to apply the solution to the conjunctiva and cornea by frequent instillation rather than by some form of contact chamber, which is not always well borne, the following simple device may be employed.

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A Kirkpatrick's double eye shield, as made by Messrs. Clement Clarke is tied in position over a cellophane apron cemented to the skin from the side of the nose to a point above the mid zygoma on the affected side. The apron should be about 8 inches long and 5 inches wide and cut with a suitable curve to lie on the infra-orbital skin, where it is stuck by Portex plastic skin. The free end of the apron should have its edges cemented together for about 3 inches as a sleeve. This enables the drip from the eye to be caught in a suitable vessel. A glass dropper with short taper of suitable length is placed in one of the limbs of the cross aperture and strapped in position so that its tip is just over the caruncle, the other end is attached to a drip feed apparatus, timed for say 2 drops a minute. If the patient is unable to keep the eye open when the actual drop is falling he can be instructed to blink after the drop has fallen on the caruncle. This should ensure regular instillation while the patient is awake and co-operative, and relieve the nursing staff.

This device does not function while the patient is asleep. There are experimental indications that it may not be desirable to allow the drip to continue during the hours of sleep. It may be wiser to allow periods of rest and use the drip with fairly long intermissions. Should a continuous night drip be required and the upper lid be undamaged or relatively free from swelling and distortion, another type of simple device will be found practicable.

An ordinary laboratory pipette is cut about  $2\frac{1}{2}$  inches from where the glass tube abruptly tapers. The cut end is bent in the small by-pass Bunsen flame to form a crook, the short limb of which is about  $\frac{1}{4}$  inch long and parallel to the stem. A short length of small bore rubber tube such as Ryle's, or valve tubing, is threaded on to the crook.

This can be introduced under the inner end of the upper lid, and the pipette with its rubber tube attachment suitably fixed to brow and bed head by strapping.

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## THE END RESULTS OF OPERATION FOR DETACHMENT OF THE RETINA

(With a follow up of fifty successful cases)\* †

BY

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SINCE the beginning of the War, I have had the opportunity, while in charge of an E.M.S. Ophthalmic Base, of operating on a considerable number of cases of detachment of the retina. I have

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† Read at the Ophthalmological Section, Royal Society of Medicine, June 9, 1944.