

United Provinces of India from Calcutta to Bombay," by the Right Rev. Reginald Heber, Lord Bishop of Calcutta, 3rd Ed., Vol. II., (1828). With acknowledgements to author and editor we give the passage in full:

"In our way back through the town a man begged of me, saying that he was blind. On my calling him, however, he came forwards so readily to the torches, and saw, I thought so clearly, that I asked him what he meant by telling me such a lie. He answered that he was night-blind ('*rat unda*'), and I, not understanding the phrase, and having been a good deal worried during the day with beggars, for the whole fort is a swarm of nothing else, said peevishly, 'darkness is the time for sleep, not for seeing.' The people laughed as at a good thing, but I was much mortified afterwards to find that it was an unfeeling retort. The disease of night-blindness, that is, of requiring the full light of day to see, is very common, Dr. Smith said, among the lower classes in India, and to some professions of men, such as soldiers, very inconvenient. The Sepoys ascribe it to bad and insufficient food, and it is said to be always most prevalent in a scarcity. It seems to be the same disorder of the eyes with which people are afflicted who live on damaged or inferior rice, in itself a food of very little nourishment, and probably arises from a weakness of the digestive powers. I was grieved to think I had insulted a man who might be in distress, but Dr. Smith comforted me by saying that, even in respect of night-blindness, the man was too alert to be much of a sufferer from the cause which he mentioned."

ABSTRACTS

MISCELLANEOUS

- (1) **Minsky, Henry (New York).**—Trans-scleral removal of intra-ocular foreign body with the aid of the Berman locator. *Arch of Ophthalm.*, Vol., XXXI (old series, Vol. LXXXVIII), No. 3, p. 207.

(1) **Minsky** reports the use of an instrument for the location of metallic intra-ocular foreign bodies, which should be of value in war surgery. It consists of a diagnostic rod containing the equivalent of two transformers, one in the handle and the other at the tip. The primary coils are connected with a source of alternating current, the secondary, through an amplifying unit, to a volt-meter. Passage of an alternating current through the primary coils induces a current in the secondary ones and these, by a balancing arrangement, are

adjusted so that the volt-meter connected with them reads zero. If now the tip of the diagnostic rod approaches a metallic foreign body, the balance is disturbed and the needle of the volt-meter is deflected. If the point of the rod is passed over an eyeball containing a magnetic foreign body, the maximum deflection of the volt-meter will occur when the tip of the rod is over the foreign body. A case is reported where this instrument was successfully used for the localisation and subsequent removal of a metallic foreign body by the posterior route, using a technique somewhat similar to that described by Stallard in our issue of March, 1944.

F. A. W-N.

- (2) **Goodhill, V. (Los Angeles).—Penicillin treatment of cavernous sinus thrombosis.** *Jl. Amer. Med. Assoc.*, May 6, 1944, p. 29.

(2) A 5½ year old boy had a pimple on his forehead on September 29, 1943. On October 1 he fell and struck his head. The pimple began to swell and became painful, and there was accompanying fever. On the following day his face and eyes became swollen. He was admitted to hospital on October 3.

On examination he was found to be acutely ill with pyrexia. There was an open draining furuncle in the midfrontal region and oedema of the eyelids. There was no chemosis and no muscular paresis. The pupils were equal and reacted normally to light and accommodation. There was no proptosis. Fundus examination showed slight venous congestion. Oedema extended upwards from the furuncle.

Pus from the furuncle on culture yielded a non-haemolytic staphylococcus aureus. Culture of the blood produced a growth of haemolytic staphylococcus aureus.

The condition was diagnosed as furunculosis of the frontal region with probable thrombophlebitis of the frontal veins and superior branches of the facial veins. There was no evidence of involvement of the cavernous sinus.

Immediate treatment with sulphathiazole orally and sulphanilamide locally was applied. On the second day, October 4, the frontal oedema increased and began to involve the lower lids. The temperature curve was septic in character, reaching 106°F. On October 5, oedema of the right lower lid became pronounced and chemosis was noted in both eyes. The retinal veins were now seen to be engorged and it became clear that the thrombophlebitic process was extending to the right and probably also to the left cavernous sinus.

Intravenous heparin was given without improvement. On October 6 the child's condition was grave, with pulmonary involvement. On October 8 other treatment was abandoned and 100,000

Oxford units of penicillin in a 5 per cent. solution of dextrose were given intravenously within the first twelve hours. The temperature immediately dropped to 103°F. and the child began to improve, and was afebrile after seven days. During fourteen days 975,000 Oxford units were given.

On October 15, in spite of striking clinical improvement with diminution of proptosis, the blood on culture still yielded haemolytic staph. aureus and sulphadiazine was started by the mouth. On October 20 the blood was sterile on culture.

On October 19 the condition was as follows:—subsiding bilateral proptosis, dilated superficial veins, ptosis of left upper lid, paralysis left external rectus, paresis right external rectus, pallor of both optic discs, bilateral macular oedema with engorgement of retinal veins. There was no vision at all in the left eye, but with the right eye he could distinguish objects at two feet.

On November 2 the patient was discharged in excellent general physical condition except for left foot-drop, complete ptosis of left upper lid, bilateral paralysis of external recti, and bilateral atrophy of the optic nerves. Later the left ptosis disappeared and the recti paralyses had greatly improved. It is not stated that there was any improvement of the visual acuity.

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CORRESPONDENCE

STRABISMUS OPERATIONS

To the Editors of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

DEAR SIRS—The letter which appeared in the April, 1944, issue of the *British Journal of Ophthalmology*, written by Mr. J. W. Killen, of Londonderry, as of February 22, 1944, contained so many statements with which I disagree that I must not permit it to remain unanswered.

Mr. Killen states that the usual operation of advancement and recession for strabismus "must leave an eye with a mechanically imperfect mechanism for co-ordination, except when looking forward in the horizontal plane, and that the insertions of the muscles should remain in their natural positions." (I presume he is discussing convergent strabismus.) It is difficult to understand his statement. A proper advancement, with or without the resection of a tendon, does not change the position of the scleral insertion. The scleral insertion of, and the arc of contact of the muscle to the sclera, with the enveloping sheath of Tenon's capsule, have, following the surgery, a natural position. It is understood that a logical resection and/or advancement of a muscle tendon includes simultaneously the enveloping sheath of Tenon's capsule.

The advancement which Mr. Killen has diagrammed actually shortens the arc of contact of the advanced muscle and gives during healing a very insecure and easily displaced new position for the advanced tendon. He permits a stump of tendon to remain attached to the sclera, attaching the resected tendon to the natural insertion of this. Such a tendon re-attachment is certain, even if the