Horace must have had in his mind the effect of the present War on the editors of this Journal when he penned the above words in one of his Satires. Literally translated they mean:—"The body weighted by the excesses of yesterday depresses the intellect at the same time." Our intellect is depressed by the excesses not only of yesterday, but also of last year, and is even more depressed by the fact that what are now "excesses" would, in normal times, just supply that number of calories which would be needed to keep the editorial corpus in a state of active metabolism. Some of our readers may have noted that a paper in our last number was received for publication no less than eight months before it appeared in our pages, and although others have not gone so nearly to full term, it may happen that if the war continues much longer, future papers may have to wait for an even greater time. This does not mean that we would discourage contributions; on the contrary we enjoy the feeling of security given to us by a well filled till under the editorial counter, but we fear that our contributors may be disappointed by having to wait so long for the fruit of their activities to become manifest. We are limited to 56 pages per number, and can no longer expand to 64 or 80 pages, as before the War. It is therefore imperative that authors should be as concise as possible. In the case of papers which cannot be satisfactorily abbreviated, we suggest that the authors should provide abstracts, which might be published instead of, or pending the publication of, the full papers.

Fractures of the Orbit

For clinical convenience the face is divided into thirds. The supra-orbital margin separates the upper from the middle thirds, and the latter ends at the upper teeth. The lower third does not concern the eye surgeon. Fractures of the face are often complex and their treatment frequently requires a combined team, consisting of the neuro-surgeon, the plastic surgeon, the ear, nose and throat specialist, the dental surgeon and dental mechanic, and the eye surgeon. In civil practice such fractures are the result of crush and crash injuries. In war comminution caused by missiles is more bizarre. Priority in surgical handling is sometimes difficult to decide upon. From the plastic point of view it is desirable to reduce a middle third fracture of the face at the earliest opportunity, certainly not to delay longer than 10-12 days, after which time replacement of bone fragments becomes impossible. Early dental assistance is required for fractures implicating the alveolar margin.
and teeth, and it is essential to reduce depressed nasal bones and establish an adequate airway with nasal tubes when the nose is involved. The neuro-surgeon may resent such surgical interference and insist on rest to avoid intra-cranial haemorrhage and for the purpose of recovery from cerebral damage.

Unless the eye has a penetrating wound there is no urgency about ophthalmic surgical attention, but it is desirable in the case of fractures of the floor of the orbit to elevate the depressed fragments soon, and so lessen the severity of the diplopia and allow the origin of the inferior oblique muscle to be restored as nearly as it is possible to do so.

Fractures involving the trochlear pulley for the superior oblique tendon should also be dealt with early.

The pattern of fractures of the middle third of the face varies with the direction and force of the blow. Fractures may be disposed centrally involving the nasal bones, the maxilla and the orbit, or laterally in which the malar, zygomatic and orbit are affected. In less severe injuries, either only the nasal bones or the malar are damaged and there is no involvement of the orbit. The central type of fracture frequently runs through the infra-orbital foramen, the infra-orbital fissure and turns medially to pass through either the lacrimal fossa or the os planum of the ethmoid. The naso-lacrimal duct may be involved and dacryocystitis develop subsequently.

At the time of operation the head is placed so that the mid-line of the face is in line with the body and both sides of the face are equally well seen. For the surgeon seated behind the patient it is convenient to have the head tilted slightly backwards. There are two transient disadvantages of this position (1) there is more oozing of blood than if the head is slightly elevated, and (2) blood may flow upwards over the area of operation. However, these are of no appreciable consequence or inconvenience.

The upper buccal sulcus is injected with 1 c.c. of novotox and adrenalin above the pre-molar and first molar teeth, and an incision 2·5 cm. long is then made parallel with the alveolar margin at this site. This incision enters the antrum, the anterior wall of which is generally in-driven. Fragments of bone completely separated from all attachment to periosteum and mucosa are removed, and blood clot is lifted out of the antrum. The surgeon's index finger is then introduced into the antrum, and the fragments of bone forming the infra-orbital margin and the floor of the orbit are felt for and lifted on the finger tip into their normal position, or as near to this as can be obtained.

The antrum is then packed with one inch wide ribbon gauze, which has been soaked in Whitehead's varnish. This gauze pack forms a mould in the antrum. The wound in the upper buccal sulcus is left open. The ribbon gauze is removed in two weeks under sodium pentothal anaesthesia. At the same time inter-nasal
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antrostomy is performed to facilitate closure of the buccal sulcus wound and antral wash-outs.

In crush fractures of the malar and zygomatic bones when the bone fragments are depressed, an incision 2 cm. long is made in the temporal fossa along the anterior hair line about half way between the external angular process and the ear. A blunt round-headed elevator is passed downwards on the temporal fascia beneath the anterior end of the zygomatico-malar arch. The blade of the elevator is then lifted forwards and slightly laterallywards as the handle is depressed posteriorly and slightly mediallywards. The operator in holding the handle interposes his fingers between it and the temporal region of the vault of the skull so as to prevent damage to the bone at this site. The depressed fragments of malar and zygomatic bones are levered into position. Position is generally maintained without instrumental aids. This skin incision is closed by 3 or 4 interrupted silk stitches.

In some cases it may be necessary to wire the malar to the malar process of the frontal bone or retain it in position by a wire loop which emerges through the skin, and is attached to a metal device secured to a plaster of Paris bandage around the head.

As mentioned in the Council's Annual Report this year, representatives of the Council have recently been negotiating with the Council of the Royal College of Surgeons of England in regard to the institution of a Higher Diploma in Ophthalmology which might meet with general acceptance. As a result of these negotiations, in which the representatives of the Royal College have shown every desire to meet the views of the Council of British Ophthalmologists, it has been agreed to institute such a diploma, and various details have been settled. The following extract from a letter from the President of the Royal College of Surgeons, which was presented to the Council of British Ophthalmologists at its meeting on July 5 shows the result of the negotiations:

"The Council of the Royal College of Surgeons have given careful consideration to the request of the Council of British Ophthalmologists that they should grant a special diploma of Fellow of the College as a higher diploma in Ophthalmology. They agree with the view that a special examination would be more suitable than the usual Final examination for the Fellowship of the College for those specialising in this important branch of practice. It is also clear to the Council that the present regulations for the 'F.R.C.S. with Ophthalmology' are too exacting, in that candidates for this diploma are required first to have passed the usual Final..."