ABSTRACTS

I.—SURGICAL OPERATIONS

- (1) **Gifford, S. R. (Chicago).—Lens extraction following filtering operations for glaucoma.** *Amer. Jl. Ophthalm.*, Vol. XXVI, p. 468, 1943.

(1) **Gifford** describes from the literature a variety of surgical operative techniques for the extraction of cataract in an eye with filtering cicatrix at the filtration angle. The operation, he recommends is a corneo-scleral section on the temporal side from 11 to 5 o'clock in the right eye and 2 to 7 o'clock in the left. The section is made either with a Graefe knife or a keratome with enlargement of the wound with scissors. A corneo-scleral stitch is employed and this is also brought out through a hood-shaped conjunctival flap. An iridectomy is performed on the temporal side. Intracapsular extraction is recommended when possible.

Seven cases treated by this method are reported. In one only intra-ocular pressure rose above the level present before cataract operation. No operative complications occurred. In one case there was delayed re-formation of the anterior chamber.

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- (2) **Regan, T. T. (Boston).—Venesection in a case of choroidal haemorrhage following cataract extraction:** *Amer. Jl. Ophthalm.*, Vol. XXVI, p. 534, 1943.

(2) **Regan** describes the case of a patient, aged 56 years, suffering from arterial hypertension and diabetes who had lost one eye from intra-ocular haemorrhage after cataract extraction. The remaining eye had a mature cataract. At operation on this eye, after delivery of the lens and iridectomy, a brisk flow of yellowish blood came from behind the iris near the surgical coloboma.

660 c.c. of venous blood were immediately withdrawn. Twenty-six hours later, at the first dressing, the aqueous was clear and the eye white and quiet. There was no evidence of intra-ocular haemorrhage. The visual result was good and has remained so for 13 years since operation.

Venesection seems to have been of value in this case.

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- (3) **Berens, C. and Lontfallah, M. (New York).—Resection of the left inferior oblique muscle at its scleral attachment for post-operative hypotropia and left pseudoptosis.** *Amer. Jl. Ophthalm.*, Vol. XXVI, p. 528, 1943.

(3) **Berens and Lontfallah** describe a case of paresis of the inferior oblique with left hypotropia of 20 prism degrees, pseudoptosis of 2mm. and 8 degrees of incyclotropia. The inferior oblique

insertion was exposed beneath the external rectus. Exposure was facilitated by a scleral hook and resection of the appropriate part of the muscle was expedited by using a calibrated muscle clamp. A mattress suture of 6-0 nylon is inserted through the muscle belly then through the cut tendon insertion and the episcleral tissues above this.

The pseudoptosis was completely cured but there was some residual right hypertropia of 8 degrees, estropia of 22 prism degrees and incyclotropia of 4 degrees.

The authors consider that hypotropia when dominant in certain fields and especially when associated with a homolateral pseudoptosis should be corrected by resection of the underacting muscle and not by weakening of the contralateral synergist.

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II.—MISCELLANEOUS

- (1) Sorsby, A. (London).—Tuberculosis and the eye. *The Practitioner*, p. 79, February, 1944.

(1) The most prevalent form of ophthalmia in childhood is phlyctenulosis. This is probably a collection of reactions to a number of exciting stimuli, but at least 80 per cent. of all cases have a tuberculous basis. Histologically it presents the picture of a non-specific round-cell reaction, and experimentally it is possible to excite phlyctenular reaction by sensitizing an animal to a specific chemical, such as peptone or casein, or to a specific organism, such as the tubercle bacillus or the staphylococcus, and instilling the specific antigen into the conjunctival sac. It is therefore an allergic phenomenon. A high incidence of positive tuberculin reaction is found in affected children. In 84 per cent. of 592 children with phlyctenulosis seen at White Oak Hospital positive Mantoux reactions were obtained against an incidence of 15·3 per cent. in a control series of 900 cases of blepharitis. However, clinical evidence of tuberculous disease in children with phlyctenulosis is exceptional, also phlyctenular disease is uncommon in the course of tuberculous disease in children. In the 592 cases of phlyctenulosis mentioned above no less than 6·4 per cent. had tuberculous lesions, while in the 900 controls there was not a single case. On these and other clinical grounds the conclusion is warranted that phlyctenular ophthalmia is the local expression of tuberculous infection.

Chronic cyclitis and iritis are not uncommon and their aetiology is not always established in any particular case; but if it is assumed that non-specific allergic reactions can occur in the tissues of

tuberculous patients and that this non-specific reaction may take different forms depending on the balance between infection and immunity the outlook is clearer.

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- (2) **Pugh, Mary (London).**—Orthoptic treatment. *The Practitioner*, p. 88, February, 1944.

(2) Orthoptic treatment includes all methods of treatment which aim at re-establishing the normal straight position of the two eyes and at developing the normal binocular vision which will keep the eyes in this position. The more obvious condition which calls for treatment is a squint which can be seen; the less obvious is a heterophoria which may later break down into a squint or, if not going as far as that, may yet cause eyestrain and discomfort.

Squints are sometimes present at birth but more often occur between the ages of two and five years. A much smaller number of children develop a squint between the ages of five and ten years.

About 50 per cent. of cases result from an error of refraction which can be cured by suitable glasses, if this is not carried out in the mistaken hope that the squint will correct itself, the squint may become permanent and incurable.

Psychological squints may result from some emotional irritation such as jealousy or they may be imitative. Orthoptic training is useless while the psychological disturbance persists.

The first stage in the training is development of visual acuity in the weaker eye to 6/12 by completely covering the other with a patch. When this has been attained the patch may be replaced by an occluder attached to the spectacle frame.

Exercises to develop normal binocular vision are begun on the amblyoscope as soon as the vision of the weaker eye is 6/18 and as soon as the child will co-operate. Some adult squinters develop firm binocular vision by training following operation.

The number of patients who recover normality by training alone is only about 10 to 15 per cent. The result of surgery alone is about 50 per cent. of successes. The combined measures of spectacles, occlusion, orthoptic training and surgery if necessary give between 80 and 90 per cent. successful results.

Patients with a small degree of hypermetropia and astigmatism may wear spectacles to relieve a strain which is really muscular. Such patients may find that they can discontinue glasses when the muscle balance is restored to normal by orthoptic exercises. Presbyopes with exophoria up to the age of about fifty years, in a few cases, may put off the use of correcting glasses by persevering with suitable home exercises, however, presbyopia cannot be staved off indefinitely.

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