Conclusion

A case of Gnathostoma in the anterior chamber of the eye is described. This is probably the first recorded case of this worm in a human eye. An incision has been planned to remove the worm which can be used for removing either a cyst or a non-magnetic foreign body from the angle of the anterior chamber.

Thanks are due to Dr. A. K. Mukerji and Dr. N. V. Bhaduri for identifying the worm, and providing the photomicrograph and the measurements of the worm, and also to Capt. E. J. Somerset, I.M.S., for many helpful suggestions in preparing the paper.

REFERENCES


A CASE OF OCCIPITAL LOBE INJURY*

J. MACASKILL, Maj. R.A.M.C.

Lesions of the occipital lobe and the ocular changes accompanying them are well known. There may be interest, however, in the record of an occipital lobe injury in which the extent and nature of the damage were demonstrated at operation.

Cpl. G. M., aged 22 years:—This soldier received a gun shot wound of the thigh at Kohima, in April, 1944. Five days later, when in the Field Ambulance, a shell burst near him and he was hit on the right side of the back of the head, and two days later received further small body wounds.

Consciousness was never lost, but after the head injury he could not see at all to the left side. One week later objects far out on this side could be seen, but he was aware of a non-seeing area towards the centre of vision. He could read newsprint but complained that while seeing one word the one adjacent to it disappeared, and on looking at his hand only saw the fingers on the right side.

When examined three months after the injury, there was a healed depressed wound in the occipital region to the right side of the mid line. Both eyes were normal and had full vision, though the letters on the chart were read scotomatously. The peripheral areas of the visual fields were unimpaired but para-central defects existed which are seen in the reproduction of the central field charts.

* Received for publication, August 8, 1945.
They consisted of left sided, homonymous, hemianopic scotomata with steep edges but the fixation areas were spared.

No other neurological findings were present. X-ray of skull showed several depressed bone fragments in the right occipital lobe underlying the skull defect.

At operation the old skull wound was opened and enlarged to expose healthy dura; the dural scar excised and bone fragments removed from the brain to a depth of 3.5 cms. Haemolytic streptococci were cultured from the bone fragments.

**Discussion**

Although the brain was penetrated to a considerable depth, consciousness was not disturbed, and Knight has pointed out that penetrating wounds of the brain do not necessarily result in loss of consciousness.

The field defects indicate a lesion of the posterior part of the visual cortex mainly on the right side and the findings at operation form a guide to their correlation. The initial loss of the whole field on the left side resulted probably from a functional disturbance of
all the right visual area of the brain at the time of injury, and it may be noted that recovery commenced in that part of the field which corresponded to the region furthest from the injury.

Traquair points out that sparing of the fixation area is common in occipital lobe lesions, but adds that inclusion of the fixation area in the scotomata is more frequent in damage due to injuries; though in the case reported fixation was spared.

There was no opportunity to examine the fields after operation, but the nature of the injury, and the steep edges bounding the scotomata suggest that little, if any, improvement can be anticipated.

I am grateful to the O.C. of the Neurological Centre, India Command, for permission to quote the operation notes of this case and to the appropriate military medical authorities for permission to publish.

BIBLIOGRAPHY
