

(L) = C.F. just. Detachment is shallower. Patient now quite rational since December 8 when vision returned. December 18 as above.

*Discussion.*—This case is thought worth reporting because of the detachment which occurred eleven days after the onset.

*Diagnosis.*—Rests between a toxic amblyopia due to quinine and retro-bulbar neuritis occurring in acute encephalitis. The history of quinine having been given, the vascular changes, the deafness and the residual extremely contracted fields favour quinine. There is no exact record of the exact amount of the drug given but he was on it for two—three days and the administration of thirty grains a day is standard treatment in the Army—so that it is reasonable to assume that he received between 60 and 90 grs. (It is a pity that he was kept on the drug in spite of the toxic signs seen within twenty-four hours.)

*Treatment.*—He was seen too late for paracentesis to have been of value. Amyl nitrate had no effect on the vessels, nor did the ergotamine ethanosulphate, the improvement which occurred after its administration was probably *post* and not *propter hoc*.

*The detachment.*—This was restricted to the worse eye and was only present in the area immediately above the disc, it extended upwards for a distance equal to one disc diameter, the lower edge overhung the upper margin of the disc, no hole was visible. The finding on December 16 (detachment shallower) was faulty, while under observation it did not vary.

*Summary.*—A case of severe quinine toxic amblyopia, with a spontaneous detachment and severe atrophy is reported.

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## A SIMPLE DEVICE FOR TESTING DIPLOPIA\*

BY

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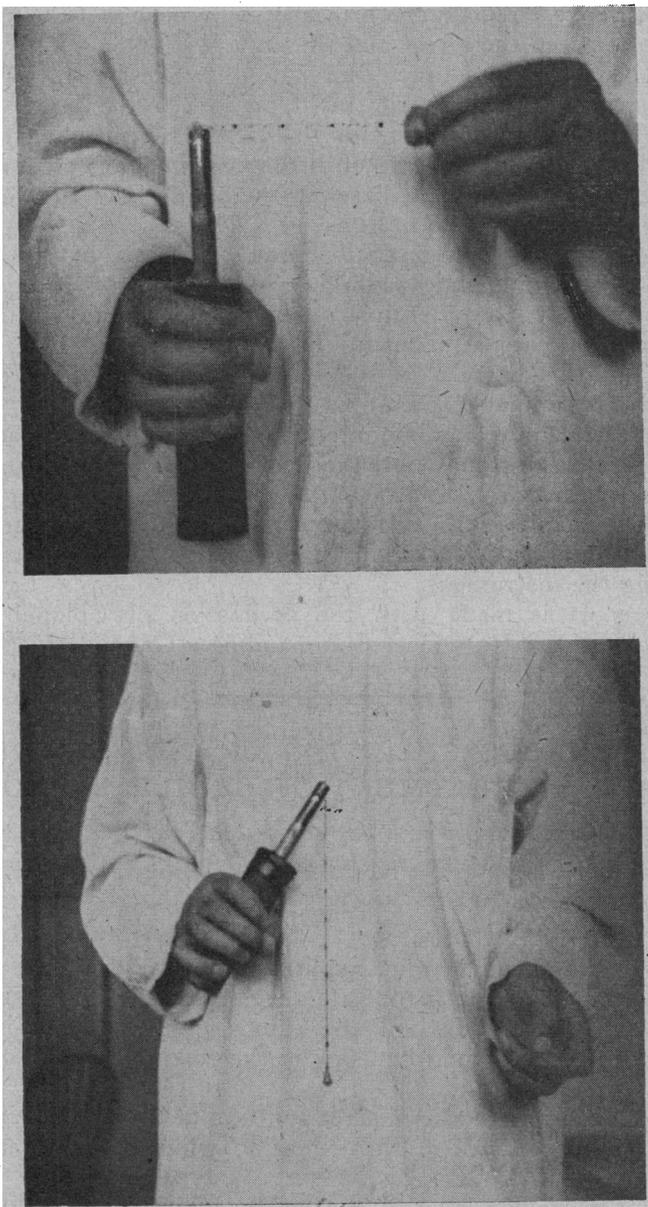
THE requisites of a suitable test object in investigating diplopia are as follows:—

- (1) It should have a bright, easily recognisable appearance.
- (2) Its form should be linear so that the smallest separation or tilting can be easily noted.
- (3) It should be turnable to all directions so that vertical separation can be easily noted as horizontal cases.

The simple device illustrated serves these purposes. It fits to the Hamblin Ophthalmoscope lamp handle and consists of an arrow perforated tube closed at the top and cut-away in its posterior wall so that a flat sloping surface painted white reflects the internal light

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to give the arrow an even illumination. A 10-inch string fixed to the top of the tube, marked with little pieces of metal into inches, and weighted at its free end gives the instrument the following additional advantages:—

(1) The distance between the false and the true images can be found by asking the patient to touch the arrow and then to point to

the false image. The surgeon measures by means of the string the distance between the arrow and the patient's finger. This obviates dependence on a sometimes dull patient's assessment. The inch spaced pieces of metal enable this to be done in the dark.

(2) The degree of tilting of the false image can be found by tilting the handle of the lamp until the false image is erect and then noticing by touch the angle between the handle and the dependant string.

This device has been used for some time and has been found useful. It is simple and has the advantage of always being at hand in that it is not "another instrument" but a simple fitting that can always be carried about in the ophthalmoscope case. It has been of particular help in the examination of bedded patients, especially those unable to sit up.

Messrs. Theodore Hamblin intend making this device an accessory to their Lister-Morton Ophthalmoscope as soon as the pressure of war work permits.

I wish to thank Capt. C. J. King, R.E.M.E., Officer Commanding Surgical Equipment Workshop, R.E.M.E., for his kind co-operation in making the instrument.

This report is made with the permission of Colonel W. B. Stevenson, R.A.M.C., Officer Commanding a General Hospital.

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## SUBCUTANEOUS SPLITTING OF THE LID IN THE OPERATIVE TREATMENT OF SENILE ECTROPION\*

BY

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THE bugbear of the marginal splitting of the lid in the Kuhnt-Szymanowski operation is the late development of trichiasis as the marginal scar tends to pull the canals of the lashes inwards. Another drawback is the frequency of the cutting through of tarsal sutures.

The following method avoids the splitting of the lid margin, while giving sufficient control of the extent to which the lid margin is inverted.

The skin-muscular layer of the lid is separated from the tarsoconjunctival layer by subcutaneous splitting from the incision AB at the outer canthus (Diagram 1).

The splitting of the lid is best done by an angular pair of scissors, and should be extended up immediately underneath the lid margin keeping close to the anterior surface of the tarsus.