by competent examiners. (3) Eyesight tests may be used by ignorant or unscrupulous persons as a subject of political propaganda. (4) Pandering to this spirit is rightly regarded by the men as a sign of weakness, and, instead of causing satisfaction, increases that attitude of suspicion to the employers which is so much to be deplored and leads to further and greater troubles.

I am, Sir, yours faithfully,

J. HERBERT PARSONS.

54, QUEEN ANNE STREET, W. 1,

July 24

Titles of Communications

Only those whose business leads them to search ophthalmological or other scientific literature in pursuit of information about a given subject can fully realize the difficulties caused by ambiguous titles. How many valuable contributions are cleverly hidden under such titles as "An interesting Case," "A Case for Diagnosis," and so forth. The writer well recalls a paper being submitted to him entitled, "Supposed death from Atropin," and the indignation with which his query was received when he asked if there was any doubt of the death having taken place. To be of service to readers a title should set forth, as briefly as may be, the contents of a communication, so that the nature of an article may be gathered at a glance. This is by no means always an easy task, but all titles that fail to fulfil the necessary conditions should be ruthlessly dealt with by the editor of the journal in which the article is to be published. On the other hand, there are authors who select lengthened titles, which in point of fact amount to an abstract of the contents of the communication they cover. This is cumbersome, although it is not so much to be condemned as the fault first mentioned. In fact, the briefer the title, consistent with lucidity, the better. The last fault is the omission of a title, throwing the onus of selecting one upon somebody else.

ABSTRACTS

I.—SYMPATHETIC OPHTHALMITIS


(1) Carpenter believes that the more conservative methods of dealing with injured eyes would in many cases be justified since the
improved appearance would outweigh the risk involved. He touches upon some of the substitutes for enucleation, particularly upon evisceration.

S. S.


(2) Weekers' article is of a somewhat speculative type, and is based on his own experience and that of a certain number of other observers, an experience which seems to show that in this war sympathetic ophthalmia is very rare. At the same time he throws considerable doubt upon pre-war statistics as to frequency, pointing out how two completely different conditions, true sympathetic disease and sympathetic irritation, have been grouped together. If only statistics of true sympathetic be taken, the figures will be considerably lower. Weekers avers that in ten years of practice in a hospital town he has himself only seen two cases, while during the war he has had no cases at all among 800 ocular injuries. Similarly de Lapersonne has had no sympathetic among 1,000 cases of war injury to the eyes. The reviewer gathers that Weekers suggests that while in this war sympathetic is certainly very rare, the disease was on the road to become the greatest rarity even before the war. The war cases show by their small numbers that true sympathetic is tending to disappear. This diminution is due to surgical cleanliness. Other points made by Weekers are (1) that early ablation of the eye is not justified from the prophylactic standpoint. One can wait a few days and save a certain proportion of eyes, always bearing in mind that it is better to sacrifice a sightless eye than to run risks; (2) that exenteration is preferable to enucleation. It gives as good security, Weekers says, as enucleation and is much superior in its aesthetic results.

ERNEST THOMSON.


(3) Wilson summarizes the various theories of sympathetic ophthalmia as (1) Nerve irritation, (2) Infection carried by the optic nerves, (3) General infection through the blood stream, (4) Anaphylaxis. There are various objections to the first three. Anaphylaxis may yet be shown to be responsible, but at present the evidence is inadequate and contradictory. The author then proceeds to consider toxaemias. Toxaemias, such as those produced by tobacco, alcohol, etc., affect the eyes in various ways, but do not
produce the condition commonly seen in sympathetic. On the other hand, infective conditions and auto-toxaemias occasionally produce uveitis. The uveitis found in these cases may not have the same histological structure as that found in sympathetic, but such cases are of interest in this connection. Do the organisms or toxins pass into the blood stream and act in a selective manner on the tissues of the eyeball, or do they act primarily on the nervous system and react on the eye tissues? Wilson then adduces as an analogy the fact that herpes ophthalmicus may give rise to sixth nerve paralysis and to uveitis (case given); that localized tetanus may be produced, via the nerve cells, from the introduction of tetanus organisms at the region concerned. "It must, I think, be admitted that central neuro-toxaemias produce peripheral manifestations in various forms, and that among these is uveitis. If so, then the necessity for the presence of pathogenic organisms in the second eye may be excluded. Central disturbances evolve influences—apparently efferent—of an atrophic or pernicious nature, which produce characteristic and constant types of peripheral manifestations. In sympathetic ophthalmia something from the first eye may pass up the optic nerve and tracts and reach the lower centres on both sides. What passes up the nerve and tracts may be a material something, and what returns in response may be only nerve influence, atrophic or pernicious in character." The close connection between the optic and third nerves is well known (pupil reactions). After some further anatomical considerations, Wilson says: "The suggestions from these observations are that in sympathetic ophthalmia—as in tetanus—toxins pass up the nerve and reach the nerve cells. In this case from the decussation at the chiasma they reach the nerve cells on both sides of the brain, causing a central disturbance with efferent influences—as in herpes—which manifest themselves first as capillary changes and then as uveitis." There also follows the suggestion that the disease may be described as neurotoxic ophthalmia. Wilson’s article is a suggestive contribution to the discussion of a subject of perennial interest.

Ernest Thomson.


(4) Schieck comments on the extreme rarity of sympathetic ophthalmia occurring after a preventive enucleation has been
performed. He has brought together all the cases recorded—30, from the Report of the Committee (Trans. Ophthal. Soc. U.K., 1886), of which 6 are rejected, 45 from the recent literature (3 of which he rejects), and from a circular enquiry issued in 1916 amongst colleagues in Germany and other available countries he has collected 24 more (3 not accepted), a total of some 80 cases. Of those in the latter 2 groups he gives a short summary in tabular form.

The failure of a preventive enucleation to avert the outbreak of sympathetic disease may be due to various causes: (a) In the injured eye, an incomplete enucleation (or exenteration), some remnants of the uveal tract being left behind to form the seat of inflammation; the bursting of the eyeball in making a complete excision, whereby some germs in the eye may escape into the severed blood-vessels; by the time the enucleation is performed the sympathetic process has passed beyond the sclerotic (Fuchs) or in consequence of a counter-opening in the posterior part of the sclerotic, uveal tissue has escaped into Tenon’s capsule or the orbital tissues and there formed a focus of inflammation. (b) As regards the sympathising eye, at the time the excision was performed, the infection was in process of extending to it, or had actually reached it, although it was not possible to determine this fact clinically; both eyes suffer from the same disease, the infection being already in the body and not introduced through the injured eye (Meller’s theory).

The fact that the infection may have reached the second eye without showing any clinical signs, leads the author to the opinion that the methods of clinical examination hitherto employed are not sufficiently fine, and it is owing to this fact that the outbreak of sympathetic inflammation has in a certain percentage of cases occasioned surprise. As an additional means of detecting it in its early stages, he strongly recommends Gullstrand’s lamp, and illustrates the advantageous use of it by the report of a case. The difficulty of early detection of the disease after enucleation, is increased by the fact that in some cases it runs a very mild course without any congestion or other apparent signs, and even in more severe cases it may for some time show no symptoms sufficient to attract the attention of the patient or his friends. This may be due to the attenuated virulence of the organism, or to the fact that the disease may have a short preliminary phase, without any gross symptoms, which passes off spontaneously, and only when it recurs is so severe as to drive the patient to seek advice. This latter attack being then regarded as the commencement of the inflammation.

The periods that elapsed between enucleation and the date of onset of sympathetic ophthalmitis in the above series of eighty cases, are shown in a table at intervals of ten days, the majority of cases occurring within the first ten days; the maximum period accepted
by Schieck, as admissible, is fifty-three days—this obtained in two cases recorded respectively by Little and Stephenson. He is of opinion that the danger for the second eye has passed after four weeks from the date of the enucleation, although in exceptional cases it may not be free for two or three weeks more. All observations in which the onset is stated to have exceeded this maximum interval he regards as either unsound or owing their record to the fact that the enucleation (or exenteration) had been incomplete. As regards the pathogenesis of the disease, the author discusses Meller's view, but rejects it as based on findings that would only lead to confusion in our knowledge and conception of the disease. The pure theory of metastasis he does not accept in its entirety. For him only two conditions are essential, viz., the invasion of specific organisms into the circulation, and the facilitating of a foothold in the other eye for them through vascular disturbances due to reflex nerve irritation. He is of opinion that in rare cases the injury introduces the organisms into the circulation and thereby produces a simultaneous infection of the uvea in both eyes. In such cases even enucleation within the first twenty-four hours will not prevent the outbreak of sympathetic ophthalmia.

**THOMAS SNOWBALL.**


In the present paper Van Schevensteen gives the clinical notes and the pathological findings in a case where from faulty cicatrization after extraction of a traumatic (penetrating war injury) cataract, inflammation developed not only in that eye but in the other, which fortunately recovered fully. The soldier, aged 31, had had his right lacrimal sac excised on January 7, 1916, when vision was found to be full, refraction emmetropic, and fundus normal. On August 19, 1917, whilst he was loading a trench mortar the projectile burst, and a small chip penetrated his right eye. On October 18, 1917, when seen by Van Schevensteen, the eye showed a small wound near centre of cornea up-in; anterior chamber normal; pupil reactions normal; iris colour good, but on the pupillary border towards 5 o'clock was a small notch enclosing a small metallic foreign body embedded in superficial layers of the opaque lens, round the foreign body an iron-impregnated halo about 1 mm. wide. Tension normal, projection perfect.

Left eye emmetropic, with full vision and normal fundus.

On Nov. 21, 1917, operation for removal of the cataractous lens. All went well till after the cystotome had been used and lens masses evacuated, when patient squeezed unexpectedly and violently, causing prolapse of iris, which had to be cut off. Anterior chamber filled with blood; atropin; both eyes tied up; to bed; quiet; chloral morphine.
Nov. 22, 1917.—Total hyphaema, no pain; continue atropin and pad. Hyphaema slow in absorbing, for five days after operation it was still 5/6th; 'wound healed, no pain; behaved well during after-treatment.

Dec. 15. Hyphaema gone, no redness or pain; iris slightly drawn up to wound, but coloboma said to be regular; iris markings very slightly dulled; some lens matter in coloboma; vision = fingers at 1m. Tension normal (!) L.V. full.

Jan. 9, 1918. Some pains over left eye; no ciliary injection, no headache; nothing amiss with operated right eye.

Jan. 11. Left, ciliary injection and slight photophobia with watering, globe tender, iris markings slightly obscured; pupil dilates widely after atropin, but pupil edge slightly notched. Fundus not very sharp, disc edges softened, retinal veins full. Vision = 0.4. Tension slightly reduced.


Jan. 15. Left pupil wide, edge of pupil regular now; no precipitates on lens capsule or back of cornea; aqueous clear. Fundus normal; vitreous seems clear. Vision = 0.5. Watering and photophobia gone.

Ciliary injection much less; no pain or tenderness. Novarsenobenzol 0.45.

Jan. 22. Vision 0.6. Fundus less obscured.


Jan. 31. Vision fell to 0.4; fundus barely so crisp; vitreous clear.

Feb. 3. Novarsenobenzol 0.45. Vision = 0.5.

Feb. 9. Fundus crisper; novarsenobenzol 0.45.

Feb. 17. Vision = 0.5.

Feb. 22. Eye quite white; iris colour normal; markings crisp; pupil quite regularly circular. Vision = 0.6. Stop atropin.


April 28. Vision = 1.0 After mydriatic fundus normal.

July 15. Cure confirmed; vision = 1; fundus normal.

Morax examined sections of the eye and reported, inter alia, iris and corneal wound showed lymphocytic infiltration, with some pigmented and non-pigmented deposits on Descemet's membrane. Conspicuous thickening and infiltration of choroid-vessels seen only here and there; retina shows no infiltration; the choroidal lesions are those typical of sympathetic uveitis.

Van Schevensteens refers to Morax's paper* on the Statistics of

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SYMPATHETIC OPHTHALMITIS

these War Sympathetic Cases, and notes that Morax finds 1/3 serious, but Van Schevensteeen says the results obtained at time of recording are not always maintained, and as regards his own case, which got credit for 4/10ths, it really fell to 1/10th. Probably some of Morax's 4/10ths and 3/10ths cases were tested at a stage of only temporary arrest in the process and so further following up of these cases would give even less favourable results than Morax's figures would suggest.

No note is given as to X-ray examination of either eye, nor of the Wassermann reaction, but the case is of sufficient importance to warrant the degree of detail given in this abstract.

W. C. SOUTER.

(6) van Schevensteeen.—Notes on sympathetic ophthalmia. (Considérations sur l'ophtalmie sympathique.) Arch. Med. belges, December, 1918.

(6) van Schevensteeen gives a useful summary of the known facts and theories of sympathetic ophthalmia. He has only met with two cases during his service with the Belgian Army. The results of treatment with novarsenobenzol were good in one case and bad in the other. He discusses very briefly the question of protective appliances for the soldier, and is unable to say which of the different models is most likely to be of service. He concludes that all ocular injuries should come under an ophthalmic surgeon, who must always remember that prevention is better than any remedy in the affection here discussed, and that enucleation should be performed within the first fortnight after injury if certainty of prevention is required.

E. E. H.


Ichikawa claims to have made remarkable findings in the course of an investigation into the bacteriology of seven eyes enucleated for sympathetic ophthalmitis. He had embarked upon the research with the object of throwing light upon the relationship of the exciting cause of the disease to that of syphilis—the favourable results of treatment with salvarsan in sympathetic inflammation being well known.

Levaditi’s method was used for the identification of spirochaetes. Six of the eyeballs had already been embedded in celloidin, and had to be freed from that medium for this method. All the eyes were sympathizing eyes, and showed the typical picture of sympathetic ophthalmia. The result of the investigation, however,
was negative for spirochaetes, and the author proceeded to make further research into the aetiology of the disease.

Although there is some similarity between the histology of this affection and that of tubercle, no one has been able to demonstrate the presence of tubercle bacilli in sympathetic inflammation. His search for other bacteria was also negative. The fact that no one had used the method of Ohtori in investigating sympathetic inflammation led him to employ the principle of this stain. His sections had been kept in the clinic for a long time, and at first his results were entirely negative. Occasionally, however, he found in the inflamed uveal tissue spindle shaped bodies which appeared to him to have special significance, and he describes them in considerable detail.

Morphologically they are spindles measuring from 6.64μ to 2.82μ in length, and from 1.0μ to 0.5μ in thickness. They stain unevenly.—lighter and darker portions alternating so that the spindles show a spotted appearance. They are fuchsinophile, not acid-fast, but alcohol-fast; in long exposure to acid they lose their stain quickly. Giemsa and eosin stain slightly, but methylene blue and Gram are negative. The best method employed was a modification of Ohtori's stain for tubercle bacilli, and was as follows:—

1. Staining with carbol-fuchsin for three to four hours (better in incubator).
2. After rinsing in distilled water for five to six seconds, stain in the following solution:
   - Saturated solution of picric acid 100.0
   - Indigocarmin 0.5
3. Wash in distilled water.
4. Differentiate in absolute alcohol.
5. Xylol balsam.

In successful staining, the spindles stain with fuchsin red, collagenous tissue and nucleus with indigocarmin green, red blood cells reddish-yellow. The granules of eosinophile leucocytes are stained red, and the spindles in the tissue occur almost without exception in the bodies of the leucocytes. They are found exclusively in inflamed uveal tissue, and often in the vicinity of giant cells where the eosinophiles tend to assemble. They always lie singly, and are therefore easily overlooked.

With regard to the frequency with which the spindles occur in sympathetic ophthalmia, of the author's 7 cases only 5 showed their presence, and of these 5 only 2 showed them in any considerable numbers. He was unable to demonstrate their presence in any other type of inflammation, control experiments being made on 3 cases of phthisis bulbi, on 3 cases of non-sympathetic uveitis after perforating injury, and on 1 case of tuberculosis of the iris and ciliary body.
Discussing the nature of the spindles, the author disposes of the possibility of their being artefacts by drawing attention to the fact that of the 5 eyeballs which showed positive results 4 were fixed in Mueller's solution, and the other in Orth-Mueller solution, immediately after enucleation. Of the 2 eyeballs in which the test was negative one was fixed in Zenker's solution and the other in formalin.

The author inclines to the view that they are crystalline in nature, and have resulted from the melting together or crystallization of the eosinophile granules. He instances the theory of the formation of the so-called Charcot-Leyden crystals, believed by some to be crystalline products of these granules. He appears to renounce the idea that the spindles are of the nature of a micro-organism, although he alludes to the existence of fusiform bacilli such as Vincent's bacillus, etc. He is of opinion that further investigation would be necessary to clear up their true nature, but does not intend to assert that they are of any importance for the etiology of sympathetic ophthalmitis.

J. Hamilton McIlroy.

II.—REMEDIES


(1) Rönne deprecates the grave pessimistic prognosis of keratomalacia given in most text-books of ophthalmology, and contends that with timely diagnosis and appropriate treatment the prospect of recovery is quite good.

So far as Denmark is concerned, xerosis is almost wholly a dietetic disorder in the narrowest sense, a grave general disease being only exceptionally the cause of it.

In cases of keratomalacia, the history is almost invariably the same. Change of the child's diet from milk to carbohydrate or buttermilk, necessitated by some disorder of the bowels at a prior date; the putting on of weight and apparent thriving of the child on the new diet, and its unduly long continuance by the parents not noticing that, though the child has grown big, its look is not healthy, being pale and fat with flabby drooping limbs; in a few months, or even half a year—the younger the child the sooner—the onset of an apparently negligible conjunctival ailment, often taken no notice of at the start, and in about eight to fourteen days later sudden appearance of necrosis of the cornea, the child
becoming moribund from pneumonia. Rönne warns parents against continued use of the changed diet without medical advice, especially in infants.

As long-continued buttermilk diet is no less responsible for keratomalacia than carbohydrate diet, Rönne has no doubt that the real cause of the disease is lack of milk or some substance contained in milk, as evidenced by the almost complete freedom from the malady of milk-fed children and the almost miraculous recovery, not only of the eye but of the general health, when milk is given in sufficient quantity to the suffering child.

The disease occurs mostly in spring. Rönne is struck by the relationship between time of year and the incidence of the disease, although in Denmark life as regards diet and fasting is essentially the same all the year round.

The main question is that of treatment. It should be started as early in the disease as possible, and consist of feeding the child with as large a quantity of unadulterated raw milk as it can take, undeterred by the bowel symptoms that may be present and by the statement of the parents that it does not tolerate milk. The milk is extremely well borne, the progress of the keratomalacia stops and the child recovers rapidly within a few days. At first the excessive fluid in the tissues of the carbohydrate-fed child is eliminated by excessive diuresis, thus reducing the weight of the body; this need cause no alarm. Owing to the extreme urgency of energetic and effective treatment in the first few days of the disease, he has not ventured to use cooked milk; he is chary of recommending its use until it has been tried with caution in very benign cases and its therapeutic value proved. D. V. GRIE.


Hegner describes and discusses the following case: An engine driver, aged 45, infected with syphilis twenty years ago, received two injections of neo-salvarsan. This was followed by swelling of the right arm and shortly after by redness of the skin of the whole body. The skin affection soon cleared up but the swelling of the arm was very obstinate. The patient came to the Medical Clinic and was found to be suffering from cerebro-spinal syphilis. The Wassermann reaction was positive. A third injection of neo-salvarsan was given and this was again followed by redness of the whole body. The patient was admitted to the Skin Clinic. The whole of the skin became oedematous, and the temperature rose with symptoms of pneumonia. The eyelids now became swollen and ulcers appeared in each cornea. The whole of the corneal...
ultimately sloughed, and the patient died of pneumonia and heart failure. Before death a large bedsore developed under the sacrum. At the post-mortem the following was found: General infection from the bedsore. Several ulcers of the skin and generalised salvarsan dermatitis. Marked anasarca of the legs, veins patent. Degeneration of the heart muscle and dilatation of the right side of the heart. Oedema and pneumonia of both lungs. High-grade mesoartitis of the thoracic aorta. Cicatrices in the left testicle, and general gland swelling. Chronic lepto-meningitis. Ulceration of the epiglottis and larynx with diffuse-laryngitis. Old ulcer of the duodenum partially cicatrised. Fresh ulcers and large haemorrhagic erosions of the lesser curvature of the stomach. Hypertrophy of the adrenal cortex with fatty degeneration of the whole organ. Hyperostosis of the skull. Pachymeningitis interna with osteomata of the dura. Ossification of the epiglottis and of the cartilages of the first pair of ribs. Multiple abnormalities. There was no doubt that the diagnosis of salvarsan poisoning was correct.

T. Harrison Butler.


(3) Darier relates a very good case of cure of the detachment in a myope by the use of puncture associated with injections of acointed serum gelatine with six per cent sodium chloride, and rest in bed. The case was favourable in so far as it was recent, but unfavourable in that there was a retinal tear. Treatment was instituted in August, 1918, and the retina remained attached at the time of writing. It must be admitted that that is not yet a very long time. Ten years have now elapsed since the reviewer published in the Ophthalmoscope, a series of articles entitled, "Detachment of the Retina Reviewed." How far has the treatment advanced since then? Certainly very little, but in this article Darier seems to have come to certain conclusions as to the best methods upon which to rely. Yet his percentage figure of cures seems to remain pretty exactly at the figure then ascertained for all writers on the subject, namely, 10 per cent. To be accurate, Darier says 10 per cent. of cures and 30 per cent. of "ameliorations" in the cases susceptible of treatment.

What then are the best means upon which to rely according to Darier? First of all, in the comparatively mild cases of traumatic detachment where the case is seen early, rest in bed, a pressure bandage not too firmly applied, leeches, and, if there has been haemorrhage, pilocarpine or eserine and dione. If the detachment remains after five or six days, subconjunctival injections of sodium
chloride 2 per cent. or 4 per cent. even up to 10 or 20 per cent. In the more serious myopic cases Darier begins with the same treatment and goes on when necessary to retinal puncture. Prolonged dorsal decubitus is necessary, and the patient requires careful watching in this respect. Diaphoresis by pilocarpine or salicylate of soda may be employed. In the presence of a positive Wassermann, general antisyphilitic treatment should be carried out, and the subconjunctival injections may be made with cyanide of mercury, according to the following formula:

| Cocain hydrochloride | ... | 0.5 |
| Cyanide of mercury    | ... | 0.05 |
| Chloride of sodium    | ... | 2.00 |
| Sterilized water      | ... | 100.00 |

One cubic centimeter of this to be injected deeply behind the eyeball every four or five days.

If, on the other hand, there is a tuberculin response the treatment should be directed in this sense. Subconjunctival injections of tuberculin are not to be recommended, though hypodermic injections have given encouraging results in the hands of Dor and von Hippel. Darier himself, however, considers that, as in other cases, the best local treatment is that by injections of sodium chloride or cyanide of mercury.

ERNEST THOMSON.


(4) Dor has had under treatment a soldier wounded at the sclero-corneal limbus, with prolapse of the iris, who refused enucleation after the onset of sympathetic about three weeks later. The iris had been excised and the site covered by a conjunctival flap. When the sympathetic affection had already been in existence two months the patient was seen by Dor. After consideration of the actual condition, and bearing in mind the man's definite statement that his sight was improving, it was decided, in consultation with Professor Rollet and Dr. Jacqueau, not now to recommend enucleation. Very vigorous treatment was instituted, in the first place with salicylate of soda by the mouth, and afterwards with intravenous injections of cyanide of mercury. Subconjunctival injections of auto-serum were also attempted, but seemed to do harm. The patient was also leched at the temples and had frontal mercurial frictions. Altogether the man received 24 centigrammes of cyanide and 440 grammes of salicylate. Three months after the onset of the sympathetic trouble the right V. (wounded eye) was 1/5 and the left V.A. 2/3. Dor regards the cure as due to the salicylate rather than to the cyanide.

ERNEST THOMSON.

The authors of this rather interesting little article appear to have been themselves sceptical when in 1914 one of them relieved the pains of iritis with the faradic current. War put an end to further investigations in this branch of therapeutics, but they have now returned to the subject and have treated a number of cases of pain, especially in the eye region, with a very weak faradic current obtained from the simplest possible apparatus. They have been very gratified with the result in cases of neuralgia, irido-cyclitis, acute conjunctivitis, keratitis, glaucoma, and in sciatica. But real migraine and rheumatic pains are not lessened by this treatment. The seat of pain is covered with moist compresses on which rests a large plaque of malleable metal which is attached to one pole of the secondary coil, the other pole being held in the hand by a metal grip. The amount of current should be such as can just be felt without being in any way disagreeable. If a result is not obtained in two or three minutes it is not likely to be obtained by a longer application of the current. This article contains a distinct therapeutic hint which can be acted upon very easily.

ERNEST THOMSON.

Ryerson, G. Sterling (Toronto).—On the treatment of certain forms of opacity of the cornea and vitreous. Canada Lancet, April, 1919.

Ryerson, has found benefit in the denser forms of corneal opacity and, he believes, in opacities of the vitreous, from calomel ointment (one drachm to one ounce of vaseline). A small quantity is placed in the conjunctival sac and a rather thick layer is spread over the eyelids, and the eye is covered with a pad and bandage and with a thin flannel bandage, so as to exert moderate pressure. The dressing is worn for two hours daily.

S. S.


Livingstone has successfully employed colloidal manganese in three cases of gonorrhoeal ophthalmia, and speaks in high terms of the remedy, which is given in doses of 1 c.cm. by injection into the buttock. Details are given of a severe case in a man of 24 years.

S. S.

(8) McIlroy has found the local use of methylene blue (1 in 1,000 saline solution) most useful in the treatment of discharging sockets after enucleation of the eyeball. The prevailing microorganism obtained by agar cultures from nine cases of discharging socket was the staphylococcus aureus, although methylene blue was found to have little bactericidal action upon subcultures made from the organisms obtained from the discharge. S. S.

BOOK NOTICES


In this volume of 763 pages the author gives a very comprehensive account of the Blind in the United States, considered from almost every point of view. He has collected and arranged in handy form a really vast amount of information, general, technical, and statistical, and there is evidence throughout that no pains have been spared to render this information as trustworthy as possible.

As should be the case in all books of reference, an analytical table of contents enables the reader to find, with the least possible trouble, the information he desires. The scope of the work can be indicated most clearly by the headings of its seven parts:

Part I (Chaps. 1-5). General condition of the Blind.
Part II (Chaps. 6-11). Blindness and the possibilities of its Prevention.
Part VI (Chaps. 43-45). Organizations interested in the Blind.
Part VII. Conclusions with respect to the Work for the Blind.

A detailed review of Mr. Best's book would occupy much space; all that we can undertake is to refer briefly to some of the many statements of general interest which it contains and to offer a few criticisms.

The number of persons returned as "blind" in the United States Census of 1910 (the latest available figures) is 57,272, but the