3. That by shifting the position of the red spot the range of the scale is increased, and it is impossible for the patient to know what its position should be in relation to the letters.

4. That patients with any degree of binocular vision at all apparently find no difficulty in seeing the spot and the letters. With the Maddox rod, it is often very difficult to get them to see both the light and the streak.

It is not necessary that the test should be carried out in a dark room, but the light must not be sufficient for the patient to see more than the red spot with the one eye, or the results are vitiated by the fusion sense. The apparatus can be obtained from Messrs. C. W. Dixey & Son, 3, New Bond Street, London.

## A CASE OF AN EYELASH PERFORATING THE CORNEA AND ANTERIOR LENS CAPSULE

BY

R. GRAHAM BROWN,

BRISBANE.

No. 7363 Pte. A. C——, 1st Wiltshire Reg., aged 26 years. This patient was seen by me on September 26, 1914, at No. 3 General Hospital at St. Nazaire. He had been shot through the left lower jaw on the 20th September. (My notes do not give more details on this point. I am, however, almost sure that the wound entrance was inside the mandible below, and the exit on the cheek just below the left lower lid). The patient stated that he suffered no pain in the eye until about two minutes after the wound when "the eye felt as if it was burning all over." He was told that it was blistered. The same night he had swelling of the eyelids. Until seen by me (six days after he was wounded) no treatment of the eye condition had been carried out. I found that there was a great deal of chemosis, which almost covered the whole of the cornea. There was no purulent discharge. The tension was not increased, and there was no ciliary tenderness. An anaesthetic was given to allow of a complete examination of the cornea. A deeply infiltrated area of about 2 mm. in diameter was discovered at about 6 o'clock, and 1 to 1½ mm. from the limbus. On gently probing the infiltrated area, which was, by the way, sodden on the surface, a small black foreign body was seen. On seizing this with a pair of iris forceps and applying traction, an eyelash was withdrawn. This surprised us not a little. My notes say, "Eyelash 4 mm. long—? from the lower lid." The iris was clear and not contracted, and the lash had penetrated the lens capsule. Atropin was instilled; and fomentations were applied to the orbital region.

On the next day the pupil was three-quarters dilated, and the chemosis was rapidly disappearing. On the 29th (two days after anaesthetic) there appeared early signs of traumatic cataract, with a slight increase in tension. The next day a small amount of lens matter was protruding into the anterior chamber. On October 2 the eye was almost quiet, and the pupil was fully dilated. On the 5th the traumatic cataract was stationary. The following day the patient was shipped to England with notes and a supply of atropin drops. I was later informed that the eye had been excised in England on October 12, 1914.

It is to be regretted that fuller notes were not taken nor an X-ray examination made. Pressure of work at that period is, I think, sufficient excuse. I am of opinion that there was no foreign body in the eye and that the eye was excised in the fear of sympathetic affection in the other eye. This procedure occurred, I fear, on more than one occasion in the early days of the war. I can find no notes referring to the state of the light projection, although perception was present when the patient left my care.

## PHLYCTENULAR CONJUNCTIVITIS AND ADENOIDS

BY

GEORGE MILNE, M.D., D.P.H.,

CAPTAIN R.A.M.C.

LATE CHIEF CLINICAL ASSISTANT MOORFIELDS EYE HOSPITAL

THE following two cases are of interest in connection with Captain Hird's article on "Phlyctenular disease and its relation to Tuberculosis," in the April number of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

CASE 1.—W. G., a boy, 4 years old, was brought to me by his mother, who stated that he had been in his present condition for the last eighteen months. He had been at irregular intervals attending the out-patient department of more than one London Hospital without any apparent relief. He had intense photophobia and blepharospasm, much injection of his conjunctivae, and typical raised phlyctens in both eyes. Atropin ointment was ordered and a week later his refraction was estimated showing low hypermetropia and astigmatism (about 1 D.). Correcting glasses were ordered to be worn constantly. Syr. ferri iodidi was given internally and weak yellow ointment locally, and the mother was advised to keep the boy out of doors as much as possible. At the end of a month there was no appreciable improvement.

The boy then had an attack of acute follicular tonsillitis. This