

supplying the internal rectus. This, however, seems less likely anatomically.

The case was first discovered in the course of routine examination of extrinsic muscles in the eight cardinal directions, and the extraordinary appearance of the patient on looking down and to the right at once arrested attention (Fig. 1).

It is perhaps not surprising that the facts relative to Fig. 2 were only discovered on minute investigation. At first routine examination the elevation was overlooked.

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ARTIFICIALLY PRODUCED OPHTHALMIA

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This is a condition commonly found amongst Indian troops and followers in the Mesopotamian Expeditionary Force. During the year 1917-18 there were 136 cases recorded, whilst during the same period amongst Indians there were 500 cases of conjunctivitis and 554 of trachoma. The substances mostly used for its production are jequirity, croton oil, and castor oil seeds. On searching the patient's kit we have found all these varieties of seeds, but most frequently jequirity. Most medical men are acquainted with the appearance of castor oil and croton oil seeds, but many, unless they have resided in the East, may not be familiar with jequirity. It is a red seed about the size of a small pea with a little black spot on it and is used by Indian jewellers as a weight. All the above-mentioned seeds can be easily procured in the bazaar. A small piece of the pulp which is white is used, and if found in the eye might be mistaken for a piece of inspissated mucus.

The irritant as a rule is introduced into the lower fornix as this is more accessible, but occasionally it may be introduced into the upper fornix as well and very rarely into upper fornix alone. When introduced into the lower fornix a severe inflammation of the lower lid and lower part of the eyeball results. There is a marked swelling of the mucous membrane of the lower lid, often with oedema of the skin. There is intense chemosis of the fornix and lower half of the bulbar conjunctiva, with usually some ecchymosis at the centre of the lower fornix. This ecchymosis is no doubt due to the fact that the irritant has rested on that spot and consequently

the inflammation is more intense there. Where the inflammation is more severe a slough is formed at the centre of the fornix. The slough may extend on to the mucous membrane of the lower lid and the lower part of the bulbar conjunctiva. The mucous membrane of the upper lid and the upper part of the eyeball is almost normal in appearance except in those cases where the irritant has been inserted under the upper lid. One can often see long after the inflammation has subsided, the trace of a former artificial ophthalmia in the presence of a partial symblepharon at the site of a former slough.

One of the most striking features of this disease is the absence of or the slightness of the discharge. Such an intense inflammation due to bacterial causes would, at least after a few days, give rise to a profuse discharge.

When the irritant is stopped the inflammation clears up with remarkable rapidity. In a few days it is difficult to recognize the case as having been one of artificial ophthalmia.

The cornea is very rarely affected and remains bright and clear. This is in marked contrast to gonorrhoeal ophthalmia, in which with the same degree of chemosis, one would probably get some infiltration of the cornea. In one case, however, which came under notice, the cornea of each eye was involved leading to perforation in one of the eyes. In this case the sloughing in the lower fornix had been very severe, and led later to an abscess of the lower lid.

We find that cases of artificially produced ophthalmia are not usually diagnosed as such by medical officers, but are often diagnosed as gonorrhoeal ophthalmia, a comparatively rare affection, there having been only two typical cases observed in this force during the year. Given a slough in the lower fornix with chemosis of the lower part of the bulbar conjunctiva, there ought to be no mistaking such cases. We consider that the slough in that position, especially when both eyes are affected, is pathognomonic of artificial ophthalmia.

In a case that came under our notice the appearance of the conjunctival sac of one eye very strongly resembled that occurring in artificial ophthalmia, but the case was complicated by the presence of a small corneal abrasion. We found on the patient's person small pieces of what appeared to be the pulp of jequirity seeds. We inserted one of these pieces in the lower fornix of his other eye and kept it there for about twenty minutes. At the end of that time there was only a very slight redness of the lower part of the eyeball. However, thirty-six hours later a very typical artificial ophthalmia appeared with a typical slough. The condition subsided almost completely in about three days.

In another case all the clinical symptoms pointed to artificial

ophthalmia with well-marked sloughs in both lower fornices. The patient, although there was no apparent urethral discharge, gave a history of gonorrhoea eight years before. The medical officer in charge of the case had the prostate massaged and from the slight mucus discharge obtained the bacteriologist was able to find Gram negative diplococci. He obtained a similar bacillus from the eyes. In this case there had practically never been any discharge from the eyes and the inflammation disappeared without treatment in the course of three or four days. We are convinced that in spite of the bacteriological finding this was an undoubted case of artificial ophthalmia, as the objective signs were very typical. It made us both very sceptical of bacteriological results in eye cases.

In one or two of the cases that had been observed by us, there has been a coincident so-called venereal sore of the penis. We have no doubt that the venereal sores were produced in the same way as the artificial ophthalmia.

CATARACT FOLLOWING THYROIDECTOMY

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CATARACT following experimental thyroidectomy in the dog has been recorded by Mr. Walter Edmunds,¹ who also cited two cases of cataract following thyroidectomy for enlargement of the gland in the human subject reported by Schiller and Westphal.

So far as I can ascertain no case of cataract following thyroidectomy in the human subject has been recorded in the English literature, and the following case is therefore of some interest.

The patient, Mrs. E. S., aged 50, of Spitalfields, was admitted into the London Hospital on October 29, 1914, with a swelling of the neck, which had first appeared seven weeks previously, and was rapidly increasing in size. A lump was at first noticed on the right side of the neck, but similar swellings had since appeared on the left side. There was pain of a shooting character in the right side of the neck, which radiated down over the right clavicle and shoulder.

Since the swelling in the neck had appeared the patient had suffered from shortness of breath, loss of voice, and cough. There was no history of haemoptysis.

On admission, there was a hard irregular tumour, the size of a hen's egg, in the position of the right lobe of the thyroid gland, and a similar smaller lump in the left lobe. The tumours moved with