

There is little doubt that Cowan's "Refraction of the Eye" will attain the popularity it deserves in this country, because, in addition to being readable, well produced, and adequately illustrated, it constitutes a most useful reference book.

A Text-book of Ophthalmology. By SANFORD R. GIFFORD, M.A., F.A.C.S. Third edition. 470 pp., 260 illustrations, including 43 in colour. W. B. Saunders Company, Limited, London and Philadelphia. 20/-

That this remarkable text-book has reached its third edition is a tribute to its worth and its appreciation by medical practitioners and students. This edition was completed before the author's death, and the revision of this work shows his characteristic thoroughness and care.

New sections have been added about ptosis, contact lenses, cyclo-diathermy and epidermic keratoconjunctivitis. The text is well balanced in its treatment of the commoner eye diseases and has been brought up-to-date.

The illustrations, many of which are photographs, are excellent and give the student a vivid picture of disease processes affecting the eye. This book is especially valuable for general practitioners, house surgeons and students. Its production is of a high standard.

CORRESPONDENCE

LATERAL ORBITOTOMY (Krönlein)

To the Editors of THE BRITISH JOURNAL OF OPHTHALMOLOGY.

DEAR SIRS,—This operation is so rarely performed, that the difficulties encountered in so few as six cases have prompted me to add to this correspondence. I hope to publish these with other cases in detail later.

Cases 1 and 2.—In both cases I found that a Hey's saw made little impression on the orbital margin, and that I could not thread a Gigli saw through the infraorbital fissure. This was due to the awkward angle of approach, the uselessness of the ordinary Gigli saw-guide, and obscuring haemorrhage.

I repeated the operation on the cadaver and found that absence of haemorrhage made little difference, the chief difficulty being due to the temporal muscle, and its malar attachment.

It should be noted that Stallard departs from the classical procedure in this respect, detaching the muscle completely from the bone, thus obtaining much better access without the necrosis anticipated by earlier authors.

As I had performed over 150 mastoid operations prior to that time, I expected it would not be too difficult to complete the bony sections by chisel, but in each case and also in the cadaver, I found that the hard bone splintered so easily, that access was only possible by reducing the outer orbital wall, and rounding the edges by Rongeur forceps. As in both cases an infiltrating tumour necessitated exenteration, the cosmetic aspect proved ultimately unimportant.

Case 3.—Professor Loewenstein was kind enough to demonstrate to the Leeds Infirmary ophthalmic staff, the division of the orbital margin in two places by Albee electric circular saw, and completion of the section by a small mastoid chisel.

This type of saw he indicated does not cut as deeply as the electric chain-saw, and is therefore not quite as effective.

I also observed while assisting, that the spray of blood from the saw edge makes it difficult to watch the cut closely, and that extemporised retractors (like flat tongue depressors) made retention of swollen orbital tissues an awkward task. An orbital angioma, $33 \times 28 \times 23$ mm. was removed with excellent cosmetic result. The operation in 4,506 cases were performed by the same technique.

Case 4.—I assisted my colleague on the infirmary staff the next day to use an identical technique. In this case also a smaller non-malignant orbital tumour was removed successfully.

Case 5.—I found in this case where the orbit contained a very large angioma, $36 \times 30 \times 28$ mm., that Axenfeld's (plates) orbital retractors (Down Bros., catalogue of ophthalmic instruments, 1930, p. 733, Nos. 733, 7 and 8), still did not give as good an access as I wished, and therefore had a spade-shaped retractor, 3 cm. wide by 5 cm. long made by Thackrays of Leeds. The prototype of this is illustrated in Operative Ophthalmology (Haab), Philadelphia, 1905, p. 285, No. 113. The flat surface was curved in this new design.

I also found that the small angulated chisel made by Thackrays to the design illustrated in Ophthalmic Surgery, Meller, 3rd edition, 1923, p. 171, Fig. 112, was very sharp, and cut better than the blunter mastoid chisel, but that the point was obscured by the holding fingers in use. This tumour was also successfully removed, but a total ophthalmoplegia followed which is now recovering.

Case 6.—A tumour of the lacrymal gland was removed successfully. The retractor worked well during the sawcut, but I still found it difficult to observe the point of the chisel at the moment of striking, and I have accordingly designed a metal chisel holder which I hope will permit a better view while chiselling in future. The bony fragment in this case could not be held in good apposition, nevertheless the cosmetic result was quite good.

Most of the orbital tumours I have seen could be removed without bony resection, and were quite clearly in the ophthalmologist's

exclusive province; a minority were extensions of intracranial tumours, or could be determined pre-operatively to have intracranial extensions and obviously were not.

For the remainder I feel with previous correspondents that lack of ophthalmic enterprise has led the neuro-surgeons to place their claims too high, and would suggest that the transfrontal approach for purposes of diagnosis or tumour removal is only indicated where the tumour interferes with the function of the optic nerve (not the macula), and is probably situated at the orbital apex, or far back on the inner side.

As the general surgeon is not so careful about the condition of instruments as ourselves, I have found it advisable to inspect those borrowed two or three weeks before operation, so that they can be put in order in time.

Yours faithfully,

JOHN FOSTER.

LEEDS.

OBITUARY

ANDREW MAITLAND RAMSAY, 1859-1946

ANDREW MAITLAND RAMSAY died at St. Andrews on March 20, 1946, in his eighty-seventh year. He was born in Glasgow on November 9, 1859, and was educated at Linlithgow Burgh Grammar School and the University of Glasgow. He was a great clinical ophthalmologist after the manner of William Mackenzie in whose steps he walked and whom he greatly admired. In 1882 he graduated M.B., C.M., and obtained the higher qualifications of M.D. and F.R.F.P.S. during the next ten years. Later he became an LL.D. (*honoris causa*) of his old University and a Fellow of the Royal Society of Edinburgh. His early graduate experience was obtained in the Western Infirmary, Glasgow, and in the Glasgow Eye Infirmary. There he came under the influence of Gavin Tennent, and Thomas Reid. His experience was enlarged by a period in general practice prior to his devoting himself to his chosen speciality. Throughout his long life he retained an admiration and devotion to his early teachers in the ancient University and in his turn added to the clinical traditions which he admired so much.

In the wider field of British Medicine he had many personal friends particularly Osler and James Mackenzie. The main belief of these great clinical observers that laboratory work of all kinds must take second place to the patient received wholehearted support