OBITUARY

FRANK GRIFFITH THOMAS

We regret to have to record the death of Frank Griffith Thomas, aged 76 years, on March 22, at Bournemouth, where he had recently been living in retirement.

His passing removes another link with the pioneers of provincial ophthalmology, for his father, Dr. Jabez Thomas of Swansea was one of those medical practitioners, who during the latter part of the 19th century, by reason of a clinical flair allied to wide knowledge and force of character, gradually assumed the rôle of consultant in provincial towns. Jabez Thomas devoted much of his time to the study and treatment of eye diseases, and eventually was responsible for the opening of an eye department at the Swansea General Hospital.

Frank Thomas received his scientific and early medical training at Cambridge where he graduated B.A. (National Science Tripos) in 1893. He finished his training at Guy's Hospital where after graduating M.B. B.S. in 1897 he became House Physician and Clinical Assistant. Concentrating on ophthalmology, he acted as a Clinical Assistant at Moorfields, and later became Registrar at the Royal Eye Hospital before returning to Swansea in 1900, where he succeeded his father as Honorary Ophthalmic Surgeon to the Swansea General and Eye Hospital. He shortly afterwards married Dr. Florence Margaret, daughter of the late Dr. Price of Carmarthen, and herself an ophthalmologist, who assisted her husband in his work. His hospital and private practice developed rapidly, and it was not long before he was recognized as a leading ophthalmologist in Wales. He was a neat and careful operator, who adhered to well-tried and orthodox technique, which his excellent results more than justified. Moreover, he was not only a sound ophthalmologist, but also an experienced Physician, whose belief in his own abilities gave him an assured manner with both patient and doctor. In abstruse or difficult cases, however, he was always ready to call a colleague into consultation. In his earlier days he was frequently seen at clinical meetings as a member of the Ophthalmological Society of the United Kingdom, the South West Ophthalmological Society, and a founder member of the Oxford Congress. He acted for many years on the General Committee of this Journal.

His spare, well-groomed figure and lean features with clipped moustache suggested a military background; never effusive, he had the quiet assured manner of one who, having pondered his problems, came to definite conclusions, and was rarely prevailed upon to alter
them. He always seemed to have his emotions under control, and only a twinkle revealed his sense of humour or a tightening of his jaw muscles his displeasure; he rarely displayed anger in his speech. He enjoyed the company of his friends, whom he chose with care, and he was fond of all sports, but golf, at which he had a single figure handicap, was his favourite form of recreation.

To a large circle of friends, colleagues, and to innumerable patients, his was a personality which will be remembered and mourned. To his widow and family we tender our deepest sympathy.

J.J.H.

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**CORRESPONDENCE**

**RECESSION OF THE INFERIOR OBLIQUE**

*To the Editorial Committee of*

**THE BRITISH JOURNAL OF OPHTHALMOLOGY**

**DEAR SIRS,—**I have read with interest the article written by Mr. Ivor Lloyd on the subject of recession of the inferior oblique muscle, but I doubt whether the writer’s view concerning the cause of overaction of the inferior oblique is as convincing as that of Chavasse. According to Chavasse* the “elevation in adduction” in a case of convergent strabismus free from obvious paresis of the ipsilateral superior oblique, or contralateral superior rectus, is due to the fact that, when an eye is adducted, the inferior oblique’s elevating action is intensified because it is a stronger muscle than its direct antagonist—the superior oblique. Chavasse’s explanation is more likely than Mr. Lloyd’s. The latter argues that an effort of abduction which involves overaction of the inferior oblique is made in order to counteract excessive convergence.

I agree with the writer concerning the need for correcting both the horizontal and the vertical components in squint, but it is open to question whether there is any advantage in performing a recession of the inferior oblique rather than the simpler procedure of myotomy or myectomy.

It would have been more convincing if the case-results had contained not merely the statement that the overaction of the