CORRESPONDENCE

PENETRATING CORNEAL GRAFT

To the Editorial Committee of the BRITISH JOURNAL OF OPHTHALMOLOGY

DEAR SIRs—In your issue of September, 1953, Mr. I. C. Michaelson draws timely attention to the difficulty of even penetration by the trephine into the anterior chamber in full-thickness keratoplasty. Michaelson turns this difficulty to advantage by placing the initial area of penetration according to various pathological conditions of the host cornea (*B.J.O.*, 1953, 37, 562).

The ideal of even and simultaneous penetration of the anterior chamber by the trephine at right angles to the horizontal corneal plane is rarely achieved with safety. It is assisted by the use of a very sharp trephine which does not cause the host eye to rotate even when the cornea is thick and irregular, by firm fixation with multiple tooth forceps, such as the Barraquer pattern, and by smooth, light, and even finger-and-thumb rotation of the trephine.

We have found further assistance at East Grinstead by a simple manoeuvre which we think is worth putting on record.

When the trephine has been accurately centred on the host cornea, before rotation is begun, the assistant crooks an index finger over the end of the trephine, in line with its body and with the centre of the host cornea. However the eye tends to deviate from position during rotation of the trephine, the assistant's finger always maintains position in line with the centre of the cornea, and the surgeon is thus able to see at once if his trephine is not being maintained at strict right angles to the plane of section. It is easy to correct this adjustment by keeping the trephine always in line with the finger above it. It has been found that about five-sixths of the circumference of the graft section is constantly cut by this simple aid. The remainder is completed by the Arruga knife, taking care not to cut a shelf, or by the Rycroft scissors. Since the best section is made by the trephine, as much as possible of the circumference should be cut by rotation of the trephine, which should never be lifted until the anterior chamber is opened. When such a section is combined with a punch graft an accurate fit is obtained without shelves or tags.

Yours faithfully,

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BOOK REVIEWS

Tumours of the Orbit. BY R. G. INGALLS. 1953. Pp. 410, 140 figs. Thomas, Springfield, Ill., U.S.A., and Blackwell Scientific Publications, Oxford. (83s.)

This book on orbital tumours and "pseudo-tumours" comprises a readable and instructive analysis of 216 eye histories, the material for most of which was gathered from the pathological laboratories of the Institute of Ophthalmology of the Presbyterian Hospital, New York. Each type of tumour affecting the orbital tissues or its walls or invading it from neighbouring parts receives a chapter to itself; each is discussed under the headings of aetiological factors, anatomical location in the orbit, general appearance and behaviour,