cauterized the scar and sent him to hospital, giving him little hope, as the eye looked like suppurating.

The eye became quiet, however, and two weeks later I found that the iris was absent, and that there had been a laceration of the lens capsule. This was dealt with subsequently, and after removal of the lens, a convex glass gave him 6/9. In this case it was evident that the eye had been pierced by an end of wire and the iris hooked out, as in the first case, through a tiny opening.

D. L., a case of chronic iritis in a deaf and very stupid man, was in hospital at the same time as the preceding patient. There was no causal history except bad oral sepsis. There were "punctate keratitis," and iris bombé. I decided to do an iridectomy, and an anaesthetic was administered. Just as I caught the iris the patient gave a sudden cough, and I instantly let go. On introducing the forceps again I found that the iris was loose and it came out entire, without an apparent tear in it. There was hardly any bleeding and the lens was seen to be opaque. The eye quieted down quickly and there was no more inflammation. The lens has not yet been removed, as the other eye sees well. It would appear that in some cases of obstinate chronic iritis the total removal of a thickened iris is not merely easy, but is very effective as a cure.

DETACHED RETINA

BY

D. J. WOOD,

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THIS case was lost sight of and could not be published in time for the committee of the Ophthalmological Society which reported a few years ago.—Klaas Faure, a boy of twelve, was under my care in September, 1912. His left eye had been blind from detached retina for two years. He gave the history of a slight injury to the good eye five months ago and sight had got bad a month later. He could count fingers at three metres. In the upper part of the right fundus there was some scarring, and much pigmentary change, some similar change on the outer side, a chain of vitreous opacities in front, and a large grey and apparently oldish detachment in the lower part of the fundus. After a week's rest I did a scleral puncture below and removed some clear yellowish fluid. After another week I was unable to satisfy myself that any retina remained undetached except a small area nearly out of view. As I was not able to give the father a definite promise of success he took the boy out of hospital, much to my regret. It was reported to me that in 1916 the boy was able to see well, and in the same year I saw him.

The retina was in place everywhere but the lower part like the rest was covered with irregular changes, pigmentary and absorptive. There was a band of vitreous striae pointing to the old puncture but its site could not be determined. — 2.25 D.cyl. vertical gave 3 letters of 6/12. I saw him again in March, 1919, and found him the same, except that he was developing striae on the back of his lens. He saw 6/18 and said that he had no trouble in seeing and could shoot partridges. His field for a small object was very irregular, but with a big object it was apparently quite full.

The occurrence of late cataract in these cases is, in my experience, common. It occurred in one of the cases reported to the committee and has also appeared in the next case, which I report as an example of a line of treatment which I described at a medical congress at Johannesburg in 1910 but which seems to have been since taken over by Birch-Hirschfeld.

Mrs. J., aged 42. Seen in December, 1913. Left eye with — 14 D. sph.
— 1 D. cyl. hor. sees 6/9. Right eye had been failing a month,

and shewed a large detachment below, not reaching the centre, with a clear vitreous. After a week's rest I punctured the sclerotic below, and passing in a fine hypodermic needle, half filled with sterile saline, I aspirated off some of the fluid, and partially withdrawing the needle reinjected it with some of the saline into the vitreous. The fluid was nearly colourless, and very little reaction occurred. This was done on December 10, and on January 7 I was able to see that the retina was all in place. She had to leave soon after this, and with — 8 D. sph. got 6/60, this poor result being due apparently to central retinal damage, which I did not at first detect. I saw her again this year, and found good tension and projection, but the lens was too opaque for internal examination.

I should like to recommend this method of treatment for trial, though its application is limited. I have treated four cases up to the present, extending over a number of years. The main indication that I have gone upon has been the accessibility of the detachment. Those which do not come well forward present too many difficulties in technique to incline me to try.

The great difficulty has been that no hypodermic needle can be made to puncture the sclera without altogether too much force being used. I have had to make a puncture with a Graefe knife and then to pass in the needle. This is nearly impossible if the puncture is far back as one cannot get a clean sclerotic, and unless it is bare and free from haemorrhage, one cannot find the hole.

The use of saline is, of course, an attempt to plump up the eye more than can be done by merely shifting fluid from behind the retina into the vitreous. In none of the cases was there any bad result, but two were not helped.

In the first case—an only eye, nearly blind—I believe I merely reinjected the fluid under the retina, as the detachment was very complete. In the second case I attempted to penetrate the retina through the vitreous, and succeeded, but the fluid was very dark in colour, and much vitreous opacity resulted. The third case was apparently quite successful, as the retina seemed in place after two weeks, and the vitreous was fairly clear. In this case, as in Mrs. J's, the subretinal fluid was very pale and when mixed with the saline in the syringe was almost colourless. Unfortunately, the patient had to leave and never kept his promise to return.

As regards the operation: if the sclerotic is well exposed and bleeding has been stopped, there is not much difficulty in passing a needle through a puncture in the sclerotic. A very efficient all glass syringe is essential, and I think a little sterile vaseline on the piston is useful as preventing it from slipping back and aspirating air before it is inserted. I started with about five minims of normal saline in the syringe and injected this with what one removed from beneath the retina until there was a distinct sense of tension. I have never been able to follow the needle inside the eyeball by using a mirror, but possibly efficient help might enable one to avoid the wrinkling of the cornea which is the main difficulty. The needle can be introduced till it touches the sclera and one should then be well under the retina. One has, however, less assurance that while withdrawing it the retina does not follow, and cause one to reinject the fluid into the subretinal space again. The idea which prompted one to try the method was of course that the fluid, if clear, was an organic fluid, and would possibly set up little irritation in the vitreous, and be more permanent than saline alone. I should, however, avoid in future making use of darkly tinted fluid, and my impression is that where one meets with this that the fate of the eye is certain blindness. Two successes out of four cases, none of which was promising, seems to show that the method is likely to be useful, and if it has any merit it may be worth recording that it was not done first in Germany.

ACCOMMODATIVE FAILURE IN MALARIA AND INFLUENZA

BY

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WE are all familiar with the ocular paralysis of diphtheria, with the temporary ciliary weakness of nursing women, and with the premature presbyopia of cases of elementary toxæmia, but within