indicate, but if the anterior chamber is closed and a prolapse of iris exists, there is but small hope of drawing the iris away from the cornea.

I must confess that I have a strong preference for the use of atropin in all cases and often make use of solutions of 2 per cent. strength.

In later stages of a case, if the lens be pressing forwards and giving rise to hypertony, the question of surgical intervention must be considered, but usually, unless the eye remains fairly quiet, it is better not to draw off the lens, as if the eye is in a state of iridocyclitis, to open it is usually found to give rise to further irritation.

Such seriously injured eyes should be very carefully watched for at least three months and the first sign of reduced tension should be the signal for immediate excision.

In conclusion, I would express my conviction that a double bandage is of great importance both from the point of view of rest and in order to prevent the occurrence of squint at a later date.

RETINITIS PUNCTATA ALBESCENS

BY

DR. JAMES J. HEALY,

LLANELLY.

WHILE ophthalmic surgeon, I/C Army Ophthalmic Centre 79, I saw a case of this rare disease. The appended notes may be of interest.

July, 1918.—Driver H., A.S.C., aged 23 years, two years' service, was sent for examination owing to his inability to drive a motor vehicle at dusk.

Personal history.—From earliest recollections he had difficulty in seeing in a failing light, a disability which had increased since he joined the army. He also suffered from congenital deafness. On October 24, 1917, he contracted syphilis, and had a course of mercury and salvarsan, which finished December, 1917. Medical history sheet showed Wasserman reaction negative on June 13, 1918.

Family history.—His mother and a younger brother suffered from defective vision with symptoms similar to himself. These symptoms, he understood, were displayed by several other members of his mother's family. His father and several other brothers and sisters had very good vision.

Examination.—V.R. and V.L., 6/12. In a darkened room he frequently fell over obstacles, and found his way about by groping. Field of vision contracted in each eye, extending to 70° on temporal side and 30° on nasal side, contour regular. Fields of colour vision contracted and interlacing. There were no signs of

external ocular disease, the media were clear. Fundus examination showed hundreds of whitish, yellow opaque spots, up to $1\frac{1}{2}$ mm. diameter, lying apparently in the deeper layers of the retina or in the lamina vitrea. The spots were most numerous in the equatorial zone, fading towards the periphery, absent from the macular area, and more numerous again in the immediate vicinity of the disc. The retinal vessels crossed the spots, which lay superficial to the choroidal vessels. The fundus was markedly tessellated. Migratory pigment formed four or five branched collections along the veins in the equatorial zone. The retinal vessels were slightly narrowed; the disc had a dirty, greyish tint; no evident cupping. Both fundi were equally affected and presented similar pictures.

Hearing tests.—Conversation three feet; whisper and watch not heard; high tones lost. Bone and air conduction markedly diminished; bone more so than air. Galvanic and rotary vertigo tests indicated diminished labyrinthine sensibility. Apparently a case of partial nerve deafness. I had this patient under observation for six months, during which there was no change in vision, field of vision, or night blindness.

In this patient the disease shows a resemblance to some early cases of retinitis pigmentosa, both in symptoms and also to some extent in the fundus picture. The tessellated fundus, the narrowing of the arteries, and the appearance of the disc are sometimes seen in the latter disease, and in a few instances whitish-yellow spots in a similar position are to be noted. It is possible that the two diseases have a similar pathological basis.

In retinitis punctata the pigment is abnormally deficient, migration being thus limited, and the disease in the deeper layers being rendered more prominent. It is probable that the pathological process underlying the two diseases is a perivascular degeneration of the choroidal end vessels, with atrophy of the highly developed cells and replacement by fibrous, hyaline, or fatty elements. The nutrition of the overlying retina suffers as a consequence; the nervous elements undergo partial reduction by degeneration, resulting in slight atrophy of the optic nerve and symptoms of a retina less sensitive to light and colour. The slight degeneration of the retinal arteries is probably due to less demand for their services by the retina.

I have the patient's address (near Wrexham) in my possession, in case anyone near that neighbourhood is interested.

It is only by keeping in touch with such a patient that we can ever hope to get a pathological report.

The water colour sketch gives a good impression of the character and distribution of the spots.