of this manoeuvre; he aimed . . . at fixing a very small fold of iris under a fold of conjunctiva through an incision just outside the sclero-corneal junction. Sometimes he combined it with an iridectomy, but sometimes no iris was removed. His paper gives so great a variety of methods that it is hardly possible to describe one single plan as 'Holth's Operation.' "

This full quotation will show that we fully understood the underlying principles of the paper, and we express our regret to Professor Holth, if this did not appear obvious to him.

We are, Sir,

Yours very truly,

HAROLD GRIMSDALE,
ELMORE BREWERTON.

HARLEY PLACE, N.W.1,

December 28, 1921.

MERCANTILE MARINE VISION TESTS, ETC.

To the Editor of THE BRITISH JOURNAL OF OPHTHALMOLOGY

SIR,—In your issue of December Dr. A. Greene asks what action the widowed mother of a cadet should take in order to recover the expense she has been put to in having her son trained on the "Conway" under circumstances he details. I should advise her to take no steps at all, and certainly not to throw good money after bad, but I do advise the young man—if he is keen on going to sea—to try another Steamship Company and yet another, and I venture to say he will be ultimately passed and accepted with flying colours if he sits tight and does not reveal the fact that he has already been refused by one Steamship Company on account of his sight. I should not apply at present, as, on account of the slackness of trade, etc., many vessels are laid up and there is no demand for officers. Every ophthalmic surgeon must have met with parallel cases, one very glaring one happened to myself many years ago, an influential county gentleman consulting me on the following point:—He was guardian to a young man and anxious to get him into the Army, but stated to me that the Army authorities had themselves refused him on account of his sight, so he brought him to me to ascertain if they were justified in so doing. Well, I speedily showed him that the sight of his ward's eyes was so bad that they couldn't possibly accept him, and the incident closed.

A few years later this gentleman, consulting me about his own eyes, referring to his ward's case, said, "We got him into the

Army all right," thus stultifying themselves and myself too, who had backed them up.

I remember also another county gentleman with only one eye, and that decidedly myopic, also being accepted by the Army authorities. They make regulations about sight, etc., to which they do not always adhere, so much so that when a young man is brought to me to ascertain whether his vision is good enough for the Army or Navy, and I find that, according to the rules and regulations, he would not quite pass, I say, "Well, according to their rules and regulations he won't be admitted," but they don't always adhere to them, so I should certainly have a try, he may get through," and he often does.

After all, aren't we too particular by far? An officer can get on quite well with a little ocular astigmatism or defect if his brains are emmetropic, but, if he has mental astigmatism or instability, there's the rub.

We don't know whether the immortal Nelson—a Norfolk man—had 6/6, but we do know he had not stereoscopic vision during the most glorious period of his career, and yet managed to beat the Spaniards and his enemies.

(2) Let me just touch on the "Halos of Glaucoma," and their significance, so well brought forward in your issue of November by the man we all owe a deep debt to, viz., Lieut.-Colonel R. H. Elliot, who, with Herbert and Lagrange, has done so much to revolutionize the treatment of chronic glaucoma. Had poor Arthur Pearson put off his dreadful ailment to the present day he would, in the hands of a modern operator—thanks to Elliot and Co.—most probably have retained fair sight to the end of his days, but then there might have been no St. Dunstan's. Halos, as Colonel Elliot mentions, may be due to various conditions and are often of no material importance, though the knowledge that they are frequently an early symptom in glaucoma, may unduly alarm the subjects thereof. I myself often have them, and I remember a very scientific and intelligent medical man who was much troubled with and consulted me about them, but would scarcely be reassured and comforted as to their insignificance in his case, until one day he accidentally got a good dose of atropin into his eyes, which only causing him temporary inconvenience settled his doubts and fears on the matter.

Let me incidentally mention how frequently one comes across a patient with chronic glaucoma, who all along has never experienced any halos.

(3) On "Safety in Ophthalmic Operations," by W. H. Simpson, in your same issue. It is certainly right to be very careful as to securing asepsis, and it's not wrong to err on the safe side.

All reasonable precautions should be taken, but aren't we taking too many? Meddlesome midwifery has long been deplored. May not meddlesome ophthalmology be equally objectionable? e.g., can you sterilize a conjunctival sac by any amount of scrubbing and lavage? It is in direct continuity with the nose by the lacrymal passages; it would be logical, therefore, to train the garden hose on the turbinates, etc.

Quite recently some operators used to tie up the eye to be operated on for 12 hours or so before the operation and see what discharge, if any, was on the pad in the morning. I believe that has largely been given up now. I never did it myself; it always seemed to me to be a way of bringing on a process you specially wished to avoid.

Neither do I wash out the conjunctival sac immediately before operating; I have given it up for years in my endeavour to interfere as little as possible with the integrity of the tissues and not to do anything that is unnecessary. I am old enough, I am sorry to say, to have experienced the antiseptic carbolic steam spray in general surgical operations, and was preciously glad when that method was scrapped; it did not have a very long innings. I do not have a culture taken from the conjunctival sac, but I am careful to ascertain the condition of the lacrymal sac and do not operate when the conjunctiva, lids, etc., are obviously unhealthy. I wait until they are in better order and have much faith in argent. nit. for this purpose; it beats all the new colloid preparations of silver, etc. I do not wear any gas mask or dog muzzle when operating, people who require such should not operate at all, nor do I change my boots or my braces.

But I don't operate in wards in which suppurating wounds, etc., are present. I believe in a healthy environment. That most honest surgeon, Harrison Butler—would that all oculists were equally candid, equally straight and outspoken—laid proper stress on this at the last Ophthalmic Congress at Oxford, where he pointed out that his cases, operated on in different institutions and under somewhat different conditions, did not do equally well.

I believe in a sufficiently large, even, clean-cut incision, and I avoid iridectomy where I can for several reasons. I can't always avoid it. Preliminary iridectomy is a mistake. Why make two bites at a cherry when one will do? Why submit your patient to the risks of two operations when one suffices? Even though you attempt to thoroughly explain it to the patient beforehand, they are generally annoyed to find they see no better after the first operation and that another is necessary.

With an iridectomy I believe the eye is more likely to take on unhealthy action and to suppurate, etc., than without.

Also I believe in quick operating and not exposing the eye to

the open air longer than is necessary, and the fewer instruments one introduces into an eye and the fewer the manipulations the better. Soft matter to any extent should be quickly coaxed or washed out. I have my sterilized normal saline solution ready, but use it as little as possible.

Speed and cleanliness go a long way in operating on eyes, as on the abdomen. Many will remember Lawson Tait's scorn for antiseptics and his brilliant results without them, but he didn't expose his patient's peritoneal cavity for three hours when fifteen minutes were sufficient.

How seldom—almost never—an eye suppurates after iridectomy for acute glaucoma. Yet it is a largish wound, done often in a hurry and without many of the preliminary preparations most modern operators submit their patients to. Why is this? I think the increased vascularity of the acute glaucoma eyes has something to do with it, and doubt whether cocain and adrenalin, by reducing vascularity, do not handicap the eye somewhat. Acute glaucomas are, or were, more frequently operated on under a general anaesthetic than a local one.

I think, at any rate, nothing stronger than a 2 per cent. solution of cocain should be applied, and that not too many times, and that adrenalin had better be omitted.

I have no doubt Mr. W. H. Simpson would have been horrified to see that prince of operators, the late Charles Bell Taylor, of Nottingham, spit upon his instruments to clean them after operating. I have often seen him do it myself and can't say I like it, but his results were good. For pace, dexterity and neatness of manipulation, Stanford Morton was hard to beat, his extractions frequently suggested a conjuring trick. Both he and Bell Taylor objected to iridectomy in cataract extraction. Let me just horrify Mr. Simpson once more by recounting an experience of my own. Many years ago I was doing an advancement for squint under cocain and had divided the muscle and was putting in the sutures with the parts well open when in a flash the child vomited and the vomit went into and all over the operated eye and exposed parts. I cleaned it up with cotton swabs and . . . no eye ever did better!

Yours faithfully,
S. JOHNSON TAYLOR.