References


SIR. When the ophthalmic surgeon is seeking a lost or slipped extraocular muscle, he often would benefit by additional means of assistance. The use of the oculocardiac reflex as an aid in this quest was suggested, and subsequently proved, in this article as a confirmatory tool. Dr Bloom correctly points out that this test, like most clinical tests, has a certain false-positive rate. As mentioned in our paper, it also has a certain false-negative rate depending on which muscle receives the traction. As described in the case presentations, the intent of the test was to confirm that a tissue, previously dissected and freed of adhesions, is or is not extraocular muscle. One should not adventurously pull on any tissue strand in the field hoping to elicit the reflex since it might be adherent to the muscle at some point.

As with any clinical test, the results of this test should be evaluated only in the context of other data. If one were to pull on muscle capsule devoid of muscle fibres, as described in the paper by Drs Parks and Bloom, and yet elicit the reflex, it would be reasonable to assume that the capsule was somehow attached to the muscle. One should then follow the capsule posteriorly in the hope of finding the true muscle and then repeat the test on the newly discovered 'muscle'.

In exploring for a slipped or lost extrinsic eye muscle the surgeon is not likely to confuse muscle capsule with true muscle fibres. Capsule tissue is distinctly thin, almost transparent, and without substance. In fact, it was this observation that led Dr Parks to the notion that capsule rather than muscle must have been sutured to the sclera by the previous surgeon when Dr Parks operated on patients with clinical evidence of a slipped or lost extrinsic eye muscle.

In closing, we would like to add that since the time we submitted our paper for publication we have utilised the oculocardiac reflex in identifying 5 additional lost muscles.

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Obituary

Courtenay Hugh Greer, MB, BS, MRCS, LRCP, FRCPath

Hugh Greer, pathologist to the Victorian Eye and Ear Hospital, Melbourne, and one time assistant pathologist at the Institute of Ophthalmology, London, died suddenly on 9 March at the age of 68.

Having qualified in medicine at the Charing Cross Medical School in 1941 and served for several years with the Royal Naval Volunteer Reserve during the second world war, Dr Greer returned to his alma mater to specialise in pathology. There followed a period which encompassed all aspects of clinical pathology at the Whittington Hospital before he took up the post of assistant pathologist at the Institute of Ophthalmology in 1951. Here he rapidly established himself as an authority on the diagnostic problems of ophthalmic pathology.

Thus equipped, he sailed to Australia on Christmas Eve 1954 to take up an appointment he was to hold for the next 25 years. His responsibilities extended to otorhinolaryngology as well as ophthalmology, and before long his opinion in both these fields was canvassed from all parts of the Australian continent and beyond. He was a capable teacher blessed with a straightforward no-nonsense approach and a lively sense of humour, and very many ophthalmologists have reason to be grateful to him for having been given a secure grounding in the pathological basis of their subject. Hugh’s skill as a communicator reached a wider circle when he published a deservedly popular primer on Ocular Pathology in 1963, its success being evident from the demand for 2 further editions in the subsequent years.

Eligible to retire in 1978, he stayed in post until a successor had been appointed and was able to take up the reins, and it is sad that he was not to enjoy the fruits of his retirement. He leaves a wife, Eileen, 3 sons and a daughter and we extend to them our deepest sympathy.

A.G.

Alan Stanworth, MD, PhD, DOMS

Alan Stanworth died on 17 May 1981 at the age of 61 after a year of illness. He had a remarkable career in ophthalmology, which really began in the Manchester Royal Eye Hospital after he left the Army with the rank of captain. His researches spanned the optics of the cornea, the epidemiology of uveitis, contact lens design, and the recognition of microstrabismus as the real state of many ‘cured’ squints. He defined the entity of microstrabismus before it was so called and was years ahead of others in that field. He moved to Sheffield in 1960 and was a consultant there, first at the Royal Infirmary and later at the Royal Hallamshire Hospital.

Alan Stanworth graced other aspects of the British ophthalmological scene. He was for many years a council member of the Oxford Congress and was master in 1971 and 1972. He was also a member of the British Orthoptic Council and later chairman of that body. A staunch supporter of the North of England Ophthalmological Society, he was president in 1968.

His talents extended outside ophthalmology. In his younger days he was a runner of considerable reputation; later he was a keen hill walker, and more recently took up horse riding. He was also an excellent pianist.

I had the good fortune to work in a parallel clinic with Alan for the last 11 years and enjoyed his close co-operation on clinical problems and learned much from his store of experience. The many ophthalmologists and orthoptists whom he taught will remember him with gratitude and affection. We extend our deepest sympathy to his wife Carol, their young son, and his daughter June.

I.M.S.