British Journal of Ophthalmology, 1984, **68**, 218

Correspondence

Suxamethonium in surgery for squint

SIR, The procedure of recessing a muscle includes its disinsertion, and if it has been adequately freed it will retract to a greater or lesser extent, allowing it to be sutured conveniently at some measured distance behind the original insertion. Failure to free the muscle completely or any tendency for the muscle not to retract towards the orbital apex may lead to an inadequate result, either because adhesions keep the effective point of insertion further forward than desired or because the new insertion may creep forward.

In the writer's experience failure of the muscle to retract after disinsertion is especially common in the case of the lateral rectus. It might be generally accepted that the lateral rectus can and indeed needs to be set back much further from its original insertion than the medial.

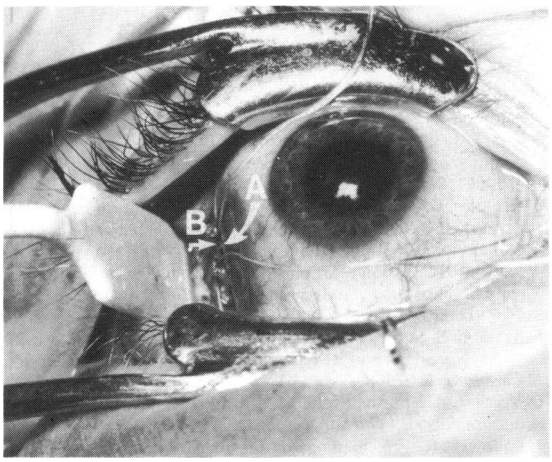

Fig. 1 *A is the insertion of the lateral rectus and B is its cut end.*

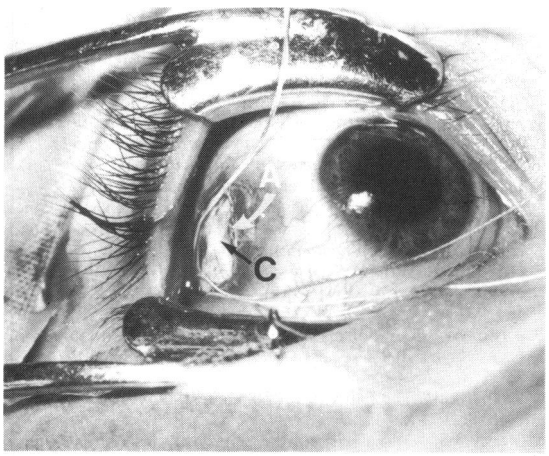

Fig. 2 *After suxamethonium injection the globe adducts, exposing a large bare area of sclera, C.*

Particularly therefore in recessing the lateral rectus it has been found helpful if 25–50 mg of suxamethonium chloride is given intravenously immediately after disinserting the muscle. Within 30 seconds, the muscle retracts (presumably with its sutures already in place) and there is also a marked adduction of the eye due to the contracture of the unopposed antagonist. This latter is itself helpful as it exposes the sclera in the region designated for reattachment of the tendon; the advantage may be offset, however, by the slight enophthalmos which also results (Figs. 1, 2).

The contracture produced is really quite marked, and the end of the lateral rectus will go back into the orbit at least 8 mm, which puts it well behind the desired reinsertion position. The muscle obviously resists being pulled forward to the new insertion, and although anaesthetists refer to the 'scoline twitch' the contracture is far from a short-lived phenomenon. Exact timings have not been carried out, but both adduction and enophthalmos of the globe as well as the contractured state of the muscle last several minutes and during the course of an average operation do not return to normal.

This confirms some previously unpublished work in which rectus muscles were attached to a strain gauge, and the administration of suxamethonium in these circumstances leads to an increase in isometric tensions which do not spontaneously resolve in 15 minutes, or longer in some cases.

For the surgeon who still carries out myectomy of the inferior oblique, suxamethonium administered immediately after the myectomy will ensure substantial retraction of the cut ends.

The preoperative injection of suxamethonium has a marked effect in the above circumstances only if it has not been used in the induction of anaesthesia, and its employment in the way described may require a modification of anaesthetic technique. If suxamethonium is used as a relaxant prior to intubation, a subsequent peroperative injection will have some, but much less, effect.

In conditions other than concomitant strabismus the response to suxamethonium after disinsertion of a muscle is inconstant. In dysthyroid affection there may be little or no elevation of the eye if suxamethonium is administered following detachment of the inferior rectus, even though passive elevation of the eye is manifestly easier than it was with that muscle still attached. Presumably in such a case the superior rectus is less responsive, being itself involved in the dysthyroid process. The result of the injection of suxamethonium may therefore not only be of technical help; it may also, when taken in conjunction with the passive duction test, assume some diagnostic significance.

The injection of suxamethonium has been used routinely by the writer in lateral rectus recession since 1978. No untoward systemic sequelae have occurred.

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Radial keratotomy

SIR, Refractive surgery has had little support in the United Kingdom, and it has been felt that groups should be formed to bring together those practising or wanting to practise this

branch of surgery. Would anyone interested in joining in and forming such a group please write to

The Secretary,
Corneal Unit,
Eye Department,
City Hospital,
Lisburn Road, Belfast BT9.

ERIC C. COWAN

Obituary

Dame Ida Mann, CBE, MA, DSc, MB, BS, FRCS, FRACS

Dame Ida Mann died in Perth, Australia, on 19 November 1983 at the age of 90. She was born in London and educated at its university. Early in her career she published *The Development of the Human Eye* (1928) and *Developmental Abnormalities of the Eye* (1937), which immediately marked her as an individual of outstanding ability. Her embryological studies became the standard works on the subject and have stood the test of time. In 1927 she was appointed to the honorary staff at Moorfields Eye Hospital, and in 1941 she became the Margaret Ogilvie's reader in ophthalmology at the University of Oxford. The appointment carried with it the senior surgeonship of the Oxford Eye Hospital. She accepted this appointment on the assurance that laboratory space would be provided. Lord Nuffield then gave the University £25 000 to build a laboratory, endow a research assistantship, and provide running costs. Her first task at the Nuffield Laboratory of Ophthalmology was to investigate the effect of war gases, and by relating pathology to embryology and to biochemistry she was able to add facets of ophthalmic knowledge outside the grim requirements of war.

In 1945 she was appointed the first professor of ophthalmology at Oxford University. In 1949 she resigned her appointments at Oxford and London to emigrate to Perth in Australia as the wife of Professor William Ewart Gye, FRS, whom she married in 1944. There her interest in ophthalmology was reawakened by the finding of trachoma among the Aborigines in the Northern Territory, and she became consultant ophthalmologist to the Government of Western Australia. The influence of climate and geography on disorders of the eye became the main subject of her research and formed the basis of her Bowman lecture in 1961. She received many honours and she was fortunate in having them offered at a time when she had original work on hand. She was made CBE in 1950, and in 1980 she was appointed DBE for her services to Aboriginal welfare.

It was impossible to meet Dame Ida Mann, even for a few minutes, without being struck by the sparkling brilliance of her intellect. Her lively sense of curiosity was not limited to ophthalmology, so she was able to cast light on any subject under discussion, usually in a most original way. Her move to Australia no doubt fulfilled the aims of her inner life and provided her with lasting happiness. Nor is there any doubt that British ophthalmology, particularly London ophthalmology, lost an inquiring and leading spirit when she left these shores.

S.M.

V. A. F. Martin, MB, FRCSEd, FRCSI, DO, DOMS

Victor Alexander Faris Martin, formerly senior ophthalmic surgeon to the Eye and Ear Clinic, Royal Victoria Hospital, and the Royal Belfast Hospital for Sick Children, died suddenly on 11 March 1983 while on a skiing holiday in France. He was 70.

Martin was born in Ulster in 1912. His early education was at Friend's School, Lisburn, and later at Royal Belfast Academical Institution. His medical training was at the Queen's University, Belfast, where he qualified in 1936. This was followed by residential posts at the Princess Louise Children's Hospital, London, and later at St George's Hospital, Ilford. In late 1937 he joined the Royal Air Force with a regular commission and saw much service overseas in Transjordan, Sudan, the Western Desert, Palestine, and South Africa. After a short period of home service at Farnborough, Inverness, and Andover he retired to civil life in 1945 with the rank of wing commander.

He then decided to specialise in ophthalmology, and having obtained the FRCS in Edinburgh he continued his studies in London and Oxford and took the DOMS and DO Oxon. In 1949 he was appointed to the consultant staff of the Benn Hospital in Belfast and later to the Belfast Hospital for Sick Children. He moved to the new Eye and Ear Hospital at the Royal Victoria Hospital when these departments were transferred in 1964 and worked there until he retired in 1978. He was also chief ophthalmic consultant to HM Forces in Northern Ireland.

On top of a heavy hospital workload, which included undergraduate teaching, and a busy private practice, he was involved with the work of the School for the Blind at Jordanstown, of which he was a governor. He also played a prominent role in medical politics. He was a past president of the Belfast Division of the BMA. For several years he was on the Council of the Faculty of Ophthalmologists and a member of the Ophthalmic Group Committee of the BMA, and also a member of the Ophthalmic Nursing Board. He was a staunch supporter of the Irish Ophthalmological Society, of which he was president in 1974-5, and of the Oxford Congress, of which he was a former deputy master.

Victor Martin was a warm and friendly colleague. He was always ready to put forward his point of view and hold to it steadfastly but was always courteous and considerate. His energy was boundless and he was always active at work or hobby. Some years before he retired he closely supervised the building of his beautiful home 'Drumnamaddy' on the slopes of the Mourne Mountains, and he was never happier than when working in his lovely garden. He also enjoyed golf at the nearby Royal County Down links or relaxing in his caravan in Donegal. Skiing became and remained one of his favourite hobbies, and he died as he would have wished while skiing after three score years and ten of active and fruitful life, free of any suffering or the frustrations and infirmities of old age. He will be greatly missed by his friends, who for many years enjoyed the warm welcome which he and his wife Eirene gave to all in their lovely home. To his wife and two sons we extend our deepest sympathy.

W. C. LOGAN