Cocain, as a local anaesthetic, has not many faults, either when used in general surgery or in some special branch thereof, but occasionally there are disagreeable symptoms when used by the infiltration method. If the use of cocain could be confined to legitimate surgical purposes within the limits of its anaesthetic capacity no one would wish to find a substitute. But it cannot be so confined. Cocain is rampant in the land and the strictest supervision has failed to control it. The public conscience is strongly roused, and there is an outcry for the international suppression of the illicit use of a drug which is sapping the moral and physical well-being of the world.

We must accept things as they are and find a means of stopping the plague altogether. But a root-and-branch policy cannot be made effective until an equally good substitute, which is absolutely innocuous, is available. Of those which have been long in use, novocain, stovain, alypin, and others, not one has been able to compete with cocain for general use. Each has its merits in specific cases, but their action is limited and they can never challenge the supremacy of cocain. In ophthalmology, for instance, none can satisfactorily replace cocain in operations for cataract and glaucoma. In laryngology there is also a similar limitation.

During the last year the new substitute—*butyn*—has arisen and challenges cocain in all the spheres dominated by that drug.

As yet it has not been subjected to the fiery furnace of criticism. Its claims are great, and if it can substantiate them it should go far to shake the foundations of cocain.

But thorough and prolonged clinical experience alone can decide what the final result will be. At present its value in dentistry seems to be undoubted. In ophthalmology it is quite satisfactory for all operative work which has previously been carried out under cocain anaesthesia. In America, *butyn* has been extensively used with very satisfactory results. In India it is reported to be quite satisfactory for cataract operations by Major Dickson.* But more experience not only by ophthalmic surgeons but also by laryngologists is urgently required.

Yours faithfully,

BATH.

W. M. BEAUMONT.

MINERS' NYSTAGMUS

To the Editor of THE BRITISH JOURNAL OF OPHTHALMOLOGY

SIR,—Under the heading *The Aetiology of Miners' Nystagmus* in the July number, I see a reference to my two communications to the *British Medical Journal* (May 5, June 9).

*BRITISH JOURNAL OF OPHTHALMOLOGY, p. 575, 1922.

The object of both of these notes is to contest the validity of the claim that deficient illumination is the essential factor in the production of miners' nystagmus.

It should be noted also that the cases of nystagmus quoted are those arising in the year 1922.

Clearly, if deficiency of light were the essential factor, the percentage of nystagmus among the hewers should be very nearly equal to that among the other underground workers.

Further, on June 9 I gave the only evidence I could obtain of pits that were or had been using electric light only; electric light in these pits was associated with a great increase of nystagmus.

Therefore, in all the pits in the North, of which I have detailed information, the evidence is conclusive, and is opposed to the conclusions of the Miners' Nystagmus Committee.

My own view is that the disease only occurs in those who have a congenital pre-disposition to it; and that it is chiefly found amongst coal-hewers, and that deficiency of illumination is a negligible factor in its causation.

The last two points I have proved in those pits in the North.

Yours truly,

NEWCASTLE-ON-TYNE.

A. S. PERCIVAL.

OPERATIONS FOR CHRONIC GLAUCOMA

To the Editor of THE BRITISH JOURNAL OF OPHTHALMOLOGY

SIR,—I believe that the reason why a bleb forms after sclero-corneal trephining in some cases and not in others may be due to the fact that some glaucomas require much freer drainage than others.

I agree with Lt.-Col. H. Herbert (*Operative Treatment of Glaucoma*, 1923), that chronic glaucomas may be divided into two classes: (1) Where very little drainage only is necessary to restore the balance; (2) others in which only free drainage will effect this result. Iridectomy is probably only successful in No. 1, and, in my opinion, only then when a piece of iris happens to be left in the wound which acts as a drain—in other words "Iris inclusion." In nearly all cases of success after iridectomy careful examination with a high power will detect iris inclusion. It often happens that after sclero-corneal trephining the conjunctiva over the trephine opening becomes opaque, almost completely obscuring the hole, but pitting of the conjunctiva is well marked. On the other hand, if the case is in Class 2, then a bleb, more or less in size will form, due not, I believe, to the method of operation, but entirely caused by the amount of fluid which has to drain away. In these cases iris inclusion would most certainly