reports of our cases maintained graft clarity over an average follow-up period of 6-1 years. The excellent rate of graft clarity in the subgroup with a 15-year average follow-up (90%) indicates that the progressive endothelial cell loss reported with specular microscopy over the first year postoperatively does not forecast ultimate graft failure.

As indicated in Table 6 81% of penetrating keratoplasties provided 6/12 or better vision after 6-1 years average follow-up. 40% of the cases required spectacle correction to achieve this acuity compared with 26% requiring contact lenses and 15% needed no correction.

In summary, penetrating keratoplasty at the present time appears to be the procedure of choice in treating keratoconus, with excellent long-term visual results. The few postoperative complications can be minimised if the patient has been subject to careful follow-up and has been instructed to report immediately if pain, redness, or visual loss develops. The incidence of iatrogenic cataract and secondary glaucoma can be reduced by avoiding the liberal use of topical steroids and by rapidly tapering them off in complicated cases. It is also better to avoid a graft size larger than 8.5 mm, as this carries a higher incidence of rejection reactions.

FIFTY YEARS AGO

Although there is much further work to be done on the subject, from the limited number of cases treated we think the following conclusions may be drawn:

1. In certain corneal conditions - notably ulceration, superficial type of keratitis and chronic corneal opacity - treatment by means of ascorbic acid intravenously is of therapeutic value. The improvement in most cases is almost dramatic.

2. In most cases treated, there is no reason to believe that a general vitamin 'C' deficiency exists. It appears, therefore, that the beneficial results are obtained by flooding the bloodstream with excess of ascorbic acid.

3. Ascorbic acid appears to be of no value in the treatment of iritis. It may even have a detrimental effect in certain instances.

4. The injections used (ascorbic acid 'Roche' concentrated vitamin 'C' ampoules, 500 mgs per injection) caused no local or general reaction.

5. Dosage: We recommend the daily injection of 500 mgs intravenously until active inflammation of the eye has ceased, preferably followed by ascorbic acid tablets given orally (Tabs. ii.t.d.s., each tablet containing 250 mgs). - Conclusion of an article by Wing-Commander Keith Lyle T, Squadron-Leader McLean DW. Vitamin C (ascorbic acid) - its therapeutic value in inflammatory conditions of the cornea. Br J Ophthalmol 1941; 25: 286-95.

We thank Mrs Beth Chase-Grey, Mrs Margot Bain, and Mrs Alma Ayles for their great assistance in the preparation of this manuscript. We are grateful to Dr I D Hill for his valuable assistance in the medical statistics of the paper.