added plus lenses (eye being under atropin), J.2, fluently. This made her left eye equal, for distance, to her better eye, which is now getting worse owing to increased bulging, and will probably follow the course of the other one soon.

R.V. : 6/36, c. - 1.0D sph. + 3.50D cyl. 155° : 6/24 and J.5. Furthermore, it may be noted that the intraocular tension was now normal on the side of the iridectomy, while the right eye was hard, and I submitted it again to pilocarpin and bandage at night. I sent her home for a fortnight to feed up, take malt and cod liver oil and fats, and to take plenty of rest and recuperate. On July 8 the final result was :

L.V. : 6/36, c. - 5.0D sph. + 3.50D cyl. 160° : 6/12 full, and - 3.0D sph. and + 3.50D cyl. J.2.

Soon I shall tattoo the stellate leucoma with an artificial pupil.

May 10, 1924. Since writing the above, some ten months ago, affairs have kept steady. There is no bulging of the left cornea or scar. I attempted tattooing at two sittings, and have considerably diminished the glare of the scar, but I refrain from risking the deep tattooing necessary for securing an imitation round black pupil, fearing to do harm. Glasses were prescribed and worn with comfort and great help, the vision being maintained as above. The right eye still holds its own with miotics and an occasional use of bandage at night. The patient's general condition has been built up successfully and I emphasize the importance of this in all cases where debility or other causes require it.

AN OPERATION FOR CONGENITAL PTOSIS

BY

GEORGE YOUNG

COLCHESTER

ON July 17, 1923, Miss E. W., of Wivenhoe, consulted me about the condition of her right eye. Fig. 1 shows her appearance, due to the congenital absence of the levator palpebrae. The right face was distorted in the usual way by complete ptosis, absence of the palpebral fold, inability to raise the right eyelid, even with the frontalis muscle, which merely threw the forehead on the right side into multiple transverse folds, raising the right eyebrow three-quarters of an inch above the left, and productive of a continuous "tic"—the constant impulse to lift the lid sufficiently to let the right eye take part in the act of vision. Altogether a most disfiguring state to behold, in an otherwise graceful and attractive young woman. I will dwell only on the functional disturbance

and its surgical relief, but the psychological factor, so obvious, I leave to your reason. It was the most disturbing element, of wide-reaching importance, and caused the young girl nothing short of mental distress.

The rotators of the eyeball were normal. Operation had been mostly disadvised, the patient's ardent desire of an assurance of cosmetic success making this easy to see. It had been suggested

FIG. 1.

to use a strip of frontalis, but fortunately, I think, not carried out. Its functional result might be perfect, but its cosmetic success would be very imperfect, for it would have cured neither the "tic" nor the unequal level of the brows, nor their furrows. Motais' operation I considered, but it weakens the power of the already very weak superior rectus by one-third or more. Also it forms only a small central attachment at a single point. The first may well be the cause of ensuing diplopia, through limitation of power in looking up. The second is likely to cause a tent-like pulling

up of the centre of the eyelid, and sagging at the sides, particularly the temporal.

I thought out the following operation and venture to publish it because it has led to the best result I have ever obtained, both cosmetically and functionally, and is not followed by diplopia. Fig. 2 shows that all the disfiguring features are removed. The corrugations of the brow are smoothed out, the level of the two

FIG. 2.

brows is the same, the palpebral fold is there and looks natural, the movements are normal. At first there was some deficiency in nictitation, but this was soon removed by exercises in the mirror.

The operation, a long one, requires a general anaesthetic. It was thus performed on July 24. The superior rectus muscle was exposed for about one centimetre up its fleshy belly. With a strabismus hook the eyeball was depressed to the extent of a maximal contraction of the inferior rectus. The upper lid was now everted, and, where the upper edge of the tarsus crossed the

belly of the muscle, the latter was freshened transversely for its whole width with a sharp scalpel, by scraping it. Then the upper end of the tarsus was exposed exactly to the extent of the width of the muscle, and by means of three silk sutures, one taking in the central fibres of the muscle, the other two taking in the two edges, the whole width of the superior rectus muscle was firmly sutured to the tarsus. This fixes the central and nasal portions of the eyelid, but should the lateral part still sag, a point of attachment between the edge of the tarsus and the sclera can be added then and there, or later.

The lagophthalmos present immediately after operation does not last long, so it is not necessary to sew the edges of the eyelids together for a couple of days as I did. I left the sutures in place, as they did not irritate. I did not evert the lid for one month so as to run no risk of loosening the attachments. Firm union had set in, perfect *cul-de-sac*, without pockets for retention of secretions, and no trace of the sutures.

November is gone, I have seen the case once a month. All disfigurement is gone and movements are quite free, even blinking, for they have of course been religiously eliminated in front of the looking-glass. The trick of the brow persisted longest. It was still present at the end of October, and gave the impression only of being a quaint mannerism. It has now ceased entirely.

A persistent flush and lacrimation puzzled us, but was easily explained, when, exactly four months after operation, a suture made its appearance. In future I suggest bringing the three central, and also the lateral stitch, if one be used, through on to the outer surface of the eyelid, and tying them over glass beads.

The eye quieted down completely, all lacrimation has ceased, and now, May, 1924, the functional result and the appearance are excellent.

A CASE OF ECTOPIA LENTIS WITH COLOBOMA*

BY

D. V. GIRI

EASTBOURNE

HORACE B, aged 11, came under my observation as an out-patient at the Eastbourne Eye Infirmary on February 2, 1918.

The mother of the boy was unaware of his defective vision until she was advised by the school authorities to have his eyes seen to. A horizontal scar in the middle of the patient's forehead was caused

* Shown at the Annual Congress of the Ophthalmological Society of the United Kingdom in 1918.