de résistance of the work, occupying a little over one-half of its 744 pages; the examination and following of which by medical writers is a consummation devoutly to be wished.

About 177 pages are given to 800 biographic sketches of anatomists by Roy L. Moodie of use for references. The preface of 9 pages is historic, and is interesting reading, showing the derivation of our medical terms from the Latin and Greek. The scholar may say "Dog-Latin or Bastard-Greek," for even as now accepted, Greek endings are appended to Latin roots and vice versa.

The multiplication of anatomic terms, even in this form of medical language, has grown to over 30,000, of which but one-fifth are appropriate and really needed. Each language, too, has its colloquial terms, ranging from that jaw breaker "*Brustschlüsselzitzenfortsatzmuskell*" of the Boche, to the Anglo-Saxon "Eye," either of which is nearly unpronounceable to a foreigner of another language. The former is better expressed in Latin by "*Sternocleido-mastoideus*" and the latter by "*Oculus*"; both of which may be sounded the same by all tongues.

Yet for short and pithy speech, we should adhere in ordinary conversation to the English word "Eye," as will the French to their almost unpronounceable "*Oeil*," or the German to "*Kopfniker*" for the neck muscle.

The anatomic association finally decided upon the principle that each part should have but a single name as simple and as characteristic as possible—and succeeded so well that the French proverb "*Qui trop embrasse, mal tient*," was well controverted, in that the great amount of work embraced was well done. The 30,000 odd Latin names are reduced to 4,500, more understandable, more simple and more applicable for the purpose, condensing and clearing up the numerous names to which different text books give different meanings.

Of the terms accepted for the B. N. A., possibly but a hundred have not gone or will not go into regular use; for a few long accepted, as the *Zonula*

Zinnii, *Tuba Eustachii* and others, though they mean nothing except *memoria* to antique authors, will persist. Then, too, common usage has compelled the acceptance of *thalamus opticus* (sleeping room) *acqueductus cerebri* (which contains no water) *acetabulum* (vinegar cup) and other names nowadays ludicrous when translated. These are so well engrafted into all languages that they or their equivalents are parts of daily medical speech.

The work is needed by medical editors, writers and teachers and should be in all medical libraries.

H. V. W.

CORRESPONDENCE.

Records of Visual Acuity.

To the Editor: In your editorial, page 71 of January number of the JOURNAL, you quote from a communication from W. A. Abbott, Deputy Commissioner of New York Department of Labor, regarding percentage vision determination, etc. He writes that vision of 20/20 represents 100% vision and no loss. That vision of 20/30 represents 66⅔ per cent vision and 33⅓ per cent loss. That vision of 20/40 represents 50 per cent vision and 50 per cent loss. "And so on down to 20/200, which would give 90 per cent loss of vision."

I cannot understand this position as commonly accepted regarding percentage vision and percentage vision loss. The fraction 20/20 simply means that the eye sees at 20 feet what a normal eye should see at 20 feet. The fraction 20/30 simply means that the eye sees at 20 feet what it should see at 30 feet. The fraction 20/40 means that the eye sees at 20 feet what it should see at 40 feet. These fractions mean just that much and no more. Percentage means a certain portion of the whole and every like portion of the whole must mean the same amount in percentage, and if taken from the whole must reduce the whole by the same definite amount, no matter from what portion of the whole it is taken. Whether we shovel from either end of the little coal

pile or from the middle, its percentage of potentiality decreases to the same alarming extent.

The trouble with this vision percentage question is that we have been taking too seriously the fractions by which we represent acuity of vision, using them as they were never intended. Arithmetically the fraction 20/40 is half of the fraction 20/20, but the vision represented by the fraction 20/40 is not half of the vision represented by 20/20.

We must establish a definite amount of vision, and loss of vision, for every certain portion of distance between that representing normal vision and that representing blindness. Normal vision we have established at 20/20. I have suggested that blindness or total loss of vision, for industrial or insurance purposes, be established as 20/220. This still gives the afflicted laborer enough vision to get about and do many things denied him by stone blindness; or loss of the globe. We have then to proportion the whole amount of vision between that (vision) represented by 20/20 and that represented by 20/220. This can only be done by allotting 1 per cent of vision to every two feet between 0/20 and 20/220. It was on this basis that I worked out the percentage vision table which I presented before the American Academy of Ophthalmology and Oto-Laryngology at the Pittsburgh meeting last October, and known as "Chapman's Percentage Vision Table."

This of course represents percentage loss only in central acuity of vision. It does not take into consideration the many and various points of damage to an individual on account of lesions following injury to an eye. Every case presents individual problems which must be considered when the matter of compensation is being determined. As a matter of fact, however, ninety per cent of adjustments are made on the condition of central acuity of vision alone; and, made wrong at that.

Sincerely yours,

V. A. CHAPMAN, M. D.

Milwaukee, Wisconsin.

An Omission.

To the Editor: My attention has been called by John Welsh Croskey, M. D., of Philadelphia, to the fact that his name had been omitted from "The History of the Rise and Progress of Ophthalmology in Philadelphia," published in the first issue of the JOURNAL. Will you kindly insert this memorandum taken from his letter: "My Dear Dr. Risley: In 1889, I started as a note taker with the late Dr. Goodman; in 1893, I was elected Assistant Surgeon, and Surgeon in 1897, serving in that capacity until 1902 when I resigned to accept the appointment as Ophthalmic Surgeon to the Philadelphia General Hospital, which appointment I still hold."

Very sincerely yours,

SAMUEL D. RISLEY.

Philadelphia, Pa.

Blood Pressure and Intraocular Hemorrhage.

To the Editor: Anent the article by Appleman and your editorial of comment thereon in the first number of our new American Journal of Ophthalmology: It is my own experience that we must go one step further and investigate the condition of the circulation of these unfortunates. In the great majority of the cases that I have seen of massive hemorrhages into the vitreous, as well as little hemorrhages into the substance of the retina, the blood pressure is above normal, in some cases enormously so, as in the case of a Mrs. M., in which it was over 300 mm. systolic, my sphygmomanometer not registering higher than that. It is a matter of regret that the latter instrument is grossly neglected by ophthalmologists in diagnosis of such conditions. In the case referred to, no urinary lesion was detectable by all the well recognized tests. In other words, while tuberculin is needed in many of these cases, in addition thereto, means must be resorted to to reduce the blood pressure or to make it compensate, and thus we bring to our aid the internist, who sometimes does not give us very much aid because he does not use the