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 87. Weiss. Centralbl., f. prak. Augenh., 1892, p. 28.
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 89. Zur Nedden. Vaccine-Erkrankung des Lidrandes. Deutsch. med. Woch. 1906, p. 1883.
- It is impossible to verify the following, although they seem to have a definite bearing on the subject:
90. Förster. Valzineerkrankung des Auges. Müncher med. Woch., 1900, p. 1090.
 91. Katz. Deut. med. Woch., 1876, No. 36.
 92. Horner. Augenkrankungen nach Variola. Schweizer Aerzte, 1873, p. 264.
 93. Proeller. Vaccinia of Eye. Klin. f. Augenheil., April, 1910, p. 485.
 94. Rivera. Palpebral Vaccine Infection. Ann. di Ottal., 1915, p. 446-294.
 95. Salmon. Annals de l'Inst. Pasteur, 1898, No. IV.
 96. Saltini. Kassegna de Sc. Med., Modena, 1894.
 97. Schapring also mentions a case of Weeks and one of Gruening.

LOSS OF RETINAL PIGMENT (APHYKIA RETINAE).

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This paper reports a case belonging to the class of disorders of pigmentation just beginning to attract the attention they deserve. It proposes a name by which such case should be designated.

CASE: D. C., daughter of G. C., Superior, Wis. Referred by a local optician. Feb. 18, 1918. Age, 8 years, 2 months. Nationality, Scotch.

Family History: Father and mother living and in good health. No other children.

Personal History: Patient had measles at 4 years of age. Has always been troubled with earache and colds in the winter. Ears have never discharged. Has had several attacks of tonsillitis. Two months ago was quarantined for scarlet fever for a period of three weeks. Before that time had never had eye trouble.

Present Complaint: Since recovering from her attack of scarlet fever patient complains of eyes hurting and running water, also of inability to see the blackboard at school. She has had several pairs of glasses, but none have seemed to help her.

Examination: Slight congestion of lid margin, and scaling along the eyelashes. Conjunctival irritation. Pupils 2-3 mm., react promptly to light and accommodation, but slowly to convergence. Under oblique illumination, both anterior segments are seen to be normal. Vision: R., 20/100+1.

L., 20/100+2. Tension: R., normal. L., normal.

Ophthalmoscopic examination: Media clear. Both retinas abnormally transparent, the tenth, or pigmentary layer being transparent as well as the nine inner layers. Choroidal vessels even to the smaller branches easily observed. Retinal vessels of normal size.

Refraction: Manifest. R., +2.00 Cyl. axis 90, Vision=20/65. L., +2.00 Cyl., axis 90, Vision=20/65. Prescribed dark glasses and atropin sulphat 1% one drop in each eye three times a day for three days and once in the morning of the fourth day. On the fourth day retinoscopic examination yielded:

R. H. 6 at 90°; H., 10.50, 180°, L. H. +6.00, 90°; H. +9.00, 180°.

Deducting +1.00 Sph: R., +5.00 Sph. $\ominus$ +3.50 Cyl., axis 90, Vision 20/50. L., +5.00 Sph., $\ominus$ +3.00 Cyl., axis 90, Vision 20/50.

General Examination: Nose and throat: Large adenoids. Tonsils hypertrophied and slightly cryptic. Hearing 20/20, right and left. Examination by family physician shows heart, lungs and urine normal.

Diagnosis: Compound hyperopic

astigmatism with *aphyikia retinae*, following scarlet fever.

Treatment: The following correction was prescribed: R. +3.00 Sph., $\ominus$ +3.50 Cyl., axis 90°. L. +3.00 Sph., $\ominus$ +3.00 Cyl., axis 90°. We leave two dioptres of the hyperopia uncorrected on account of the child's age and for the reason that no glasses have previously been worn to any great extent.

Follow Up Record: April 15, 1918—Patient reports spectacles very comfortable. The vision is much better, and she is doing excellent school work. R., accepts no change of lens. Vision 20/30. L., accepts no change of lens. Vision 20/30.

Jan. 20, 1919: Though present correction has been very comfortable, there is slight headache after close work.

R., with +0.50 Sph., added to glass, Vision 20/30. L., with +0.50 Sph., added to glass. Vision 20/30.

DISCUSSION: Before her attack of scarlet fever, the patient was able to overcome by accommodation the high refractive error. After the attack, she could no longer do so. The wearing of spectacles not only corrects the optical error, but stimulates the formation of visual purple. Hence the continued improvement in vision.

It would seem that the abnormal visibility of the choroidal vessels is owing to a deficiency of retinal pigment. The pigment was probably absorbed as a result of the toxemia. There has been no absorption of pigment from the uvea, as is shown by the fact that the wall of the eye, under

transillumination, is little, if at all, abnormally transparent. A fairly careful search of the literature, including The American Encyclopedia of Ophthalmology, reveals the fact that no term has hitherto been invented to express the condition above referred to. We would therefore suggest that the words *aphyikia retinae* be employed as an exact designation. We have several times noted this condition after attacks of scarlet fever, but have seen no mention of it in the literature.

Just one word as to the formation of this term. *Apigmentia*, instead of *Aphykia*, suggested itself, but was at once rejected, because of hybridity. *Pigmentlessness* would be intolerably harsh. But *aphyikia* (a, privative; *phukos*, pigment [Giles's English-Greek Lexicon, ed. 1843, p. 875] and *ia*, condition,) is euphonic, nonhybrid, and formed by strict analogy with *aphakia*, or absence of the crystalline lens.

We deprecate the common but confusing practice of ophthalmologists who, whenever speaking of matters ophthalmoscopic, assign the pigment (outermost, or tenth) layer of the retina to the choroid. Thus, it is frequently said that "the retina is transparent," "the retina has lost its transparency," etc., and the choroid is continually spoken of as if it included the pigmentary layer of the retina. Such modes of expression, though convenient, lead to confusion of thought, and should be abandoned. When "the retina is transparent," it is only because the outermost layer of that structure, the pigmentary layer, has been absorbed.