Van der Hoeve and de Kleijn (4) were the first to notice otosclerosis in connection with this very interesting anomaly. Out of eleven without blue sclerotics, all were deaf and ten had broken one or more bones.

In their second family three members were deaf from otosclerosis.

Van der Hoeve says: "The blue sclera is observed when the anomaly is there; the fragility of the bones, on the contrary, can be present unobserved because an accident is necessary to put it in evidence, and deafness is progressive, so that it is not perceived before a certain age—so altho all the symptoms of the syndrome may be present only the blue scleras are noticed.

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CANTHOPLASTY.

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In the April issue of this journal Dr. J. S. Wyler, of Cincinnati, describes his method of performing canthoplasty by utilizing the entire thickness of the skin to make the flap. For several years the writer has used the cuticular layer with success and reports the method for the benefit of any one who should desire to try it. Several drops of a four per cent solution of cocaine are first dropped into the conjunctival sac and then the region to be operated upon is anesthetized by infiltration with a one-half per cent solution of novocain, to which is added a few drops of adrenalin. The needle is entered at the commissure, splitting the skin, and pushed templewards for approximately a third of an inch, raising the skin in

the usual bleb of infiltration anesthesia.

A cataract knife is now entered at the commissure, splitting the skin, and pushed outward for approximately a third of an inch. All this time, of course, the skin is kept on a stretch. The knife is at all times perfectly visible beneath the cuticle and this layer is separated from the cutis by "working" the point and body of the knife from side to side until the skin is split into two layers. Next an incision involving the cuticle only is made, commencing at a point about one-eighth of an inch above the commissure and passing upward and outward for a third of an inch. A similar incision starts the same distance below the commissure and extends to a like distance downward and outward.

The little flap now formed is reflected toward the temple, and then all remaining structures, including the deep skin layer, with muscle, etc., is divided with the scissors in the usual way. Finally the apex of the cuticular flap is sutured with fine silk to the middle of the original canthus and one similar suture is placed at the upper and one at the lower edge of the flap to prevent curling. The operation is easy of performance and painless. In very small children, where a local anesthetic is not used, I have infiltrated the skin with normal salt solution and adrenalin to facilitate the separation of the layers.

BEST WAY TO STRAIGHTEN CROSS EYES

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Of the multiplicity of operations for correcting heterotropia, it seems fair to assume that some are more successful than others, and among those some, is it unreasonable to presume that one may be the best? Probably most operators continue the method which they have found successful and in which they have developed the most skill. If one were to approach this

question anew, how could he obtain the correct answer?

The inquirer would find equally acknowledged authorities advocating tenotomy of the strong muscle, tucking of the weak muscle, resection of the weak muscle, advancement of the weak muscle either with or without tenotomy of the antagonist, capsular advancement (Fox), musculo-capsular advancement; or some modification of some popular technic.

It must be evident that the only way to settle the question is to compare the results, and in order to do this the results must be tabulated on some sort of uniform schedule which will make comparison possible.

The report of Dr. Fernandez on his experience with the Reese operation in the American Journal of Ophthalmology, June, 1918, is an example of insufficient data. It gives the angle of deviation (probably perimetric) before operation, but what after? Simply "good result," and "failure." Now what constitutes a "good result" is open to various answers. Many a patient is satisfied with a partial correction and considers it a "good result," and it is possible the operator may share this opinion. What is a "failure?" Was no change produced? Was it a partial correction? Were the eyes straight immediately and crossed later? Or was the eye lost?

Four years ago Wells and Sternberg published* a report of sixty-nine cases, operated by the Wells modification of the Worth advancement, giving the following data:

Indication of case and eye.

Deviation with perimeter, degrees.

Constant, (c). Occasional, (oc). Alternate, (alt).

Age of patient.

Age of onset.

Refraction with cycloplegic.

Vision.

Glasses ordered.

Time worn.

Deviation with Glasses on.

Fusion Training.

Previous Operations.

Advancement.

Antagonist Muscle.

Anesthetic.

Results: Perimeter, Phoria, Stereoscopic.

Remarks.

It was hoped that others would follow this example so that the results might be studied comparatively. Presumably all of us would like to adopt the method which gives best results, but this cannot be decided until results are reported on uniform schedules. Our national societies should adopt such a schedule. Probably the one presented would not meet with general approval, but it would seem possible to agree upon some form which would satisfy a majority. Naturally it is first necessary that there be some general desire to secure a correct answer to the question propounded. It is quite possible that such a study would show that one technic is best for exotropia, another for esotropia, one for high degrees, another for low degrees, but these details would be evolved once the importance of reporting results on uniform schedules were recognized.

*Journal of Ophthalmology, Otology, and Laryngology, September, 1914.