The value of a negative reaction has been studied and its reliability confirmed by the negative reactions obtained in nonsyphilitic affections of the skin. In a series of necropsies in which it was demonstrated pathologically that the aorta was free from syphilitic disease, negative reactions were obtained in 91 per cent.

The conclusions of Dr. Symmers and his co-workers are shown to be fallacious and a misrepresentation of facts owing to:

1. The apparent disregard of the different results obtained by various serologic methods and the employment of a questionable technic.
2. The careless survey of pathologic material.

PRIMARY UNILATERAL OPTIC ATROPHY IN A CHILD, FOLLOWING FRACTURE OF THE SKULL

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REPORT OF CASE

M. S., girl, aged 4 years, was sent to me for examination by Dr. Nichols, April 14, 1918. The child had been run down by a motor truck and knocked unconscious, November 10. She was taken to the Polyclinic Hospital. The hospital record shows that she was still unconscious when she got there. There was bleeding from the nose and ears. The right eye was swollen and chemosed so that the pupillary reaction could not be noticed, but the left pupil reacted well. Roentgenoscopy revealed a fracture of the base of the skull as well as the frontal bone into the frontal sinus. The child was in the hospital four weeks and discharged. There was no ophthalmoscopic examination made. When I saw the child about five months later, I found the following ocular condition: right pupil 3 mm., left pupil 2 mm., reaction in right eye sluggish. There was slight muscular deviation showing an insufficiency of the right internal rectus muscle. Ophthalmoscopic examination (under a mydriatic) revealed the media clear, the disk well defined, somewhat excavated and bluish pale, and the retina normal. Though the child was too young for visual examination, I made the following successful tests: When I held a pencil to the left beyond the median line, the child could see it without turning its head. But when I held the pencil to the right beyond the median line, the child had to make a compensatory head movement to see the pencil, indicating that the right eye was probably highly reduced in visual acuity. I then tied the left eye and asked the child to find the father, who was present at the examination. The child attempted to comply and walked into the chair and into the table standing near by. A diagnosis was made of primary optic atrophy caused by the fracture of the skull.

COMMENT

Primary optic atrophy in children is very rare. In adults it is seen not infrequently in tabes, multiple sclerosis and cerebrospinal syphilis. It may even be the first sign that leads one to suspect tabes or cerebrospinal syphilis. Of course, this form of atrophy, when of constitutional origin, is usually bilateral, affecting both eyes simultaneously or at an interval of a short period. Whenever we find a unilateral primary optic atrophy, we must always think of a possible injury to the skull. Primary atrophy in children probably never occurs as a constitutional condition, but may be caused by trauma. This trauma may affect the optic nerve directly, causing disorders such as laceration of the optic nerve, or indirectly, as a

result of some pressure resulting from the injury. The pressure exerted on the nerve in unilateral atrophy is usually anterior to the chiasm and is due to hemorrhage. The hemorrhage may be in the orbital cavity, flowing into the sheath of the optic nerve. The fracture may, of course, also involve the orbital bones. The prognosis in these cases is very grave, as they usually lead to blindness. I saw this patient five months after the injury, so I do not know when the atrophy began. As I have nowhere seen any record of primary atrophy of the optic nerve in a child so young, the case deserves to be recorded.

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Military Medicine and Surgery

ALL YEAR MEDICAL STUDY AND THE EDUCATION OF MEDICAL OFFICERS

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We in America should be used to making changes in the medical course. We have seen the benefits from rearranging; we are hospitable to new proposals. Do we discuss such proposals as freely as they deserve?

This thought is raised by the paper read by Major H. D. Arnold¹ at the Conference on Medical Education, held in Chicago in February.

Major Arnold's plan, in brief, is to compress medical education into three years, in such a way that next year classes will be graduated four months ahead of the schedule, and each succeeding year another four months earlier, up to the end of three years.

There was very little discussion over this novel plan. Many of those who spoke left the main subject and dilated on the waste of time in vacations by teachers and students, the extravagance of empty class rooms, etc.

As it offers so many different advantages, it will not be surprising if Major Arnold's plan, with or without modifications, is put into effect. If so, I am sure all medical educators will do their best to make it a success. Nevertheless, I believe it may be useful to discuss some of the details, whether it is adopted or not, for they illustrate some important phases of education.

All will agree with Major Arnold that the present standard in medical education must be kept up, and that no concession should be made to those who raise the specious plea of war need, to lower the standards of entrance and of graduation.

No doubt many medical teachers will approve the control over medical schools exercised by the Surgeon-General of the Army (though there seems no reason why the Navy and the Public Health Services should not be concerned), and hope that in time some equally powerful authority will deal with secondary education. Seeing, too, that the federal government will have to supervise medical studies from the beginning, one must hope that it will soon be brought to see the necessity for universal service.

Here a comment may be made on one item of Major Arnold's address—that in which he contrasted the

1. Arnold, H. D.: Medical Education, Medical Interns and the War, THE JOURNAL A. M. A., Feb. 16, 1918, p. 451.