ment up to the beginning of November. Visual fields had remained about stationary.

During my attendance the people had begun suit against the sanatorium where the operations had been done, and by the end of October a settlement was effected. The operating surgeon could now be prevailed upon to make the following statement. For the prevention of "post operative gas pains" he had ordered 5 grains of quinin hydrochlorid per enema, every four hours. After 30 grains (some always being lost, he figures on an actual intake of 25 grains) patient showed signs of failing heart. This was not attributed especially to the drug. However, the order was changed to every twelve hours. Instead the nurse administered the clysmas every two hours. After 60 grains in all, the general condition of the patient becoming alarming (weak pulse, etc.) the drug was stopped. Loss of consciousness and blindness following, as related by the patient. No eye examination was made at any time during seven months; only a short while before I first saw her another oculist had examined her. Regarding the indication for quinin in this case, the doctor said that he had been very enthusiastic about it after an interview with another practitioner who claimed to have had extensive experience with the method. A leading surgeon confirms my suspicion that the method is unknown to surgeons in general.

I have failed so far to get the consent of the patient to try sclero-corneal trephining as proposed by Elliott. The procedure as defended by him appears worth trying. We know that in fresh cases of ischemia retinae a reduction of intraocular pressure thru iridectomy has yielded excellent results. This fact led me to advocate at the A. M. A. meeting of 1905 the early performance of iridectomy in methyl alcohol poisoning where I believe an ischemia retinae precedes the cumulative effect of formic acid on the eye. I now wish to go on record as recommending prompt broad iridectomy for fresh cases of quinin amblyopia, since contraction of

retinal vessels here is so uniformly a primary feature, together with low general blood pressure and mostly normal intraocular tension.

OCULAR LESIONS OF INFLUENZA.

EDWARD STIEREN, M. D., F. A. C. S.

PITTSBURGH, PA.

From a paper read before the Allegheny County Medical Society.

The following observations were made during the present epidemic of influenza on patients admitted to the South Side Hospital from the beginning of the epidemic until December 10th, 1918, and from a smaller number seen in private practice.

Influenza, 221 cases; died 27. Mortality 12.2%.

Influenza with pneumonia, 104 cases; died 70. Mortality, 66.3%.

Influenza with pregnancy, 6 cases; died 6. Mortality 100%.

Of the total number of cases the eye department was called in to see 54, or about 16%. These were for the greater part acute congestion of the ocular conjunctiva, not a catarrhal type, but marked by a dilation of the bulbar conjunctival vessels with some edema of the conjunctiva, and not infrequently with small subconjunctival hemorrhages which soon became confluent. Photophobia was present in practically all these cases.

Cold moist compresses gave the greatest relief and usually resulted in an amelioration of the congestion in from 36 to 48 hours. In the few cases with a catarrhal discharge the palpebral conjunctiva was inflamed and rough, a simple collyrium of zinc sulphat and boric acid affording prompt relief.

A young man, convalescent for about a week, developed a violently inflamed eye, the palpebral conjunctiva, especially of the upper lid, taking on a finely granular or mulberry appearance. The cornea developed a uniform haze of the epithelium, so dense that the color of the iris could not be determined, vision being reduced to inabil-

ity to count the fingers at 6 inches. There was no pannus.

The application of various astringent remedies, 1% silver nitrat, alum stick, copper stick, even rubbing with 1-1500 bichlorid were without avail; dionin had no effect on the corneal haze and atropin was impotent in dilating the pupil.

Finally, calomel dusted into the eye proved to be the remedy needed, and the patient is now steadily making progress, the lids are almost normal and the corneal haze is limited to an area covering the center of the pupil, while atropin, instilled three times daily, has dilated the pupil to about one-half of maximum.

Repeated smears were made from the discharge from this eye, but at no time could any organism be detected.

Two cases of double cellulitis of the orbit occurred. Both recovered without the formation of abscess under constant moist Ochsner compresses.

Four of the six cases of pregnancy were examined with the ophthalmoscope shortly before death. The other two cases had died before it was realized how fatal influenza is to a pregnant woman.

All four had abnormally large pupils, which responded feebly to light stimulus. Two had a marked neuro-retinitis, (one of these with small flame-shaped hemorrhages), one had a fundus picture closely simulating an albuminuric retinitis; while the fourth had an extremely cyanotic retina, the latter case being complicated with pneumonia.

SOCIETY PROCEEDINGS

ROYAL SOCIETY OF MEDICINE, SECTION ON OPHTHAL- MOLOGY

November 6, 1918.

President, MR. W. T. HOLMES-SPICER.

The first meeting of the season was opened by the president's address.

Corneal Changes Following Inflammation.

THE PRESIDENT first thanked the Section warmly for having elected him to its post of honor, and then proceeded to give an address, aided by numerous sketches shown by the epidiascope, on "Changes in the Cornea Which Follow Attacks of Various Forms of Inflammation." He said this subject had received but small attention in the literature.

After ophthalmia neonatorum, sometimes very little was to be seen but the existence of vascular channels, yet the stagnation of the lymph circulation might bring about slowly advancing changes after all the inflammatory appearances had long since subsided. The presence of clear lines in cases of old corneal

ulcers had been described by but few observers, altho they had been long known, and had been seen before the introduction of the loupe. Nettleship described the linear paths of clear corneal tissue in large diffuse lipomata, the latter having probably arisen after small spots in infancy; while Fuchs discussed the various linear formations existing in the cornea, suggesting that the lines were due to changes in the lymph system and nebulous area. The best description extant of these lines was that by Sydney Stephenson. In one of his cases the lines traversed a nebula with opacity, and there had been repeated attacks of corneal inflammation early in life. Story stated he had seen lines of this character in interstitial keratitis, and he thought they were due to a clearing of vessels. The picture presented to the observer varied according to the depth of the vessels concerned. Besides the surface invasion of trunk vessels, the terminal capillary loops of the limbus were seen involved, these vessels not arising from any main trunk. This was common in marginal inflammations, such as trachoma and acute interstitial keratitis, in which vessels invaded the cornea at all depths.