

dred pages, the principal part written by Wood and "Injuries of" by Würdemann, of course with abstracts from many other authors.

The section on Serology probably by the editor, Casey Wood, is quite complete; that on Skiametry, Dynamic is certainly complete, and that on Skiascopy by Edward Jackson is a condensed but clear and complete exposition on the subject. Advantage has been taken to bring the subject up to date under subsidiary titles such as additional matter under sarcoma of the choroid; the main description of which is published under "Choroid-Sarcoma."

On the whole this volume keeps up the high class of its contents, and shows the controlling mind of its principal editor, Casey A. Wood. Certainly the series makes an exhaustive treatise on ophthalmology and one from which the practice and application of scientific medicine may be safely drawn.

H. V. W.

CORRESPONDENCE.

ACRIFLAVINE AS A STAIN FOR CORNEAL ULCERS

To the Editor: Considerable interest has recently been manifested in the therapeutic properties of some of the acridine dyes. Most of these derivatives have no amebicidal properties. One of them, however, known as "Acriflavine," is claimed to possess high antiseptic power. It is derived from a coal tar base. If this claim is substantiated by further investigation, its value and desirability as a stain for corneal ulcers is apparent.

In order to determine its staining power I recently had a quantity made up of two per cent strength in normal salt solution, and used it just as fluorescein is used for this purpose. A single drop, on the upper part of the eyeball was allowed to flow down the ulcer, the eye kept closed for about two minutes and then the eye and conjunctival sac thoroly irrigated with warm boric solution.

The result has been uniformly satisfactory in the few cases in which I

have been able to try it. The stain is a bright emerald green. Its freedom from toxic properties, and the absence of any irritation to the cornea or conjunctival membrane, would make it appear that in this preparation we have a valuable addition for our use in ocular therapeutics.

Proflavine is a substance having similar properties, but its antiseptic power is not as great as that of Acriflavine.

CHAS. P. SMALL.

INVERSE ASTIGMATISM AND ASTHENOPIA.

To the Editor: Under the caption, "Observations on Astigmatism" by John Green, Jr., and William F. Hardy (January issue of the "Journal," page 64) I note the following:

"One of the reasons for the greater degree of asthenopia in eyes with inverse astigmatism is the greater interference with the legibility of ordinary printed type. In direct astigmatism the vertical components of letters are distinct, whereas the opposite is the case in inverse astigmatism. Letters with vertical components distinct are more easily recognized than those with horizontal components distinct."

As the authors base many of their conclusions upon the above statements, it is obvious that if their premises are incorrect their views require substantial revision.

Is it true that in all instances, or even in the majority of cases, of direct astigmatism, the vertical components of letters are distinct? When one recalls the physiologic optics of the principal dioptric meridians of the eye, namely, that the vertical meridian is used for seeing the horizontal aspect of the object looked at, while the horizontal meridian deals with the vertical aspect of the object, it is evident that if the horizontal meridian is at fault (as obtains in direct hyperopic astigmatism) the vertical components of the object are less distinct than any other part of it and, consequently, less clearly perceived; while in reverse hyperopic astigmatism (where the vertical meridian is subnormal) the vertical parts of the

object are more easily seen than the horizontal parts and consequently the object is more readily recognized, the very reverse of what the authors assert. One can quickly convince himself of this by simply placing before one eye (the other being closed) a minus two cylinder axis 90 degrees, which renders his refraction that of direct hyperopic astigmatism; and he will observe that under these circumstances, when, looking at Snellen's test type for distance, or Jaeger's for near, his vision is much more impaired than if the same glass is put before his eye axis 180 degrees (which makes the eye inversely astigmatic). The author's reasoning is sound when the case is one of myopic astigmatism, but when applied to hyperopic astigmatism, it runs counter to well known principles of physiologic optics.

JOHN H. BAILEY.

Brooklyn, N. Y.

[The meridian seen most distinctly will depend on the exertion or relaxation of the accommodation. It would be worth while to observe and record the actual facts regarding these cases, to ascertain when inverse astigmatism does cause greater asthenopia, and when it does not.—Ed.]

NATURAL HISTORY OF CATARACT.

To the Editor: The undersigned would like to announce that 1,200 return postal cards, like the following, have been sent out.

"I am preparing a paper on the Natural History of Cataract. I hope to show what per cent of untreated lens opacities disappear, remain stationary or increase. Should a sufficient number submit data such a table would be useful in determining by comparison the value of different therapeutic measures. If your reply shows that you have any available statistics, which you are willing to contribute, a more detailed questionnaire will be submitted.

Reply Card.

"Do you always treat incipient cataract?"

"Have you records of any number of untreated cases?"

"Do you make sketch of opacity as well as test vision?"

"Are you willing to co-operate?"

Anyone who failed to receive one of these postal cards, and wishes to co-operate, please send his name and address to Hotel Westminster.

DR. DAVID W. WELLS.

Boston, Mass.

NEWS ITEMS

Personals and items of interest should be sent to Dr. Melville Black, 424 Metropolitan Building, Denver, Colorado. They should be sent in by the 25th of the month. The following gentlemen have consented to supply the news from their respective sections: Dr. Edmond E. Blaauw, Buffalo; Dr. H. Alexander Brown, San Francisco; Dr. V. A. Chapman, Milwaukee; Dr. Robert Fagin, Memphis; Dr. M. Feingold, New Orleans; Dr. Wm. F. Hardy, St. Louis; Dr. Geo. F. Keiper, LaFayette, Indiana; Dr. Geo. H. Kress, Los Angeles; Dr. W. H. Lowell, Boston; Dr. Pacheco Luna, Guatemala City, Central America; Dr. Wm. R. Murray, Minneapolis; Dr. G. Oram Ring, Philadelphia; Dr. Chas. P. Small, Chicago; Dr. John E. Virden, New York City; Dr. John O. McReynolds, Dallas, Texas; Dr. Edward F. Parker, Charleston, S. C. Volunteers are needed in other localities.

DEATHS.

Clinton Brotemarkle, Salisbury, Md., aged 59, died in a sanatorium in Philadelphia, about October 23rd.

Stephen O. Richey, Washington, D. C., aged 70, a member of the American Ophthalmological Society, died at his home, October 8th, from cerebral hemorrhage.

James F. Smith, New York City, aged 62, died at his home October 18th, from pneumonia. He was assistant surgeon of the eye

department of the Manhattan and a member of the staff of the Post-Graduate Nose and Throat Hospital.

Charles F. Sterling, Warrenton, Virginia, aged 73, once professor of the eye and ear, University of Michigan, died October 28th from cerebral hemorrhage.

Francis Valk, of New York City, aged 74, died in St. Luke's Hospital, November 5th. Dr. Valk was a noted author and teacher, for many years Professor of Ophthalmology in the New York Post-Graduate School.