

DISCUSSION.

DR. G. E. DE SCHWEINITZ, Philadelphia—Dr. Sulzer's complete presentation of his case leaves little room for discussion, and I will therefore content myself with the exhibition of a drawing illustrating the structure of that type of glioma which receives the name neuro-epithelioma—a name which Wintersteiner believes should always be used in place of glioma. You observe the tubular structure and how the cells send processes through the walls of the tubules into their lumina. The elements here involved are analogous to the cone-nucleus, the membrana limitans externa, and the cone-body of the normal retina. The first paper calling attention to this conception of the ultimate structure of gliomas was written by Dr. Simon Flexner, now of the University of Pennsylvania.

DR. J. L. THOMPSON, Indianapolis—I simply want to speak of the results of these cases. A great many have stated that true glioma of the retina is always fatal. If you recall it, I reported some 17 cases three years ago and 4 out of those 17 are still living. In all of these cases the tumor was examined by Dr. Knapp, or Dr. Weeks or Dr. Wynn, all expert microscopists.

DR. J. M. BALL, St. Louis—I am under the impression that some cases have been reported as glioma of the retina where a careful microscopical examination would have shown the pseudo-glioma. I might report a case which a number of ophthalmologists considered to be true glioma, but which on examination proved to be a pseudo-glioma. A period of three years has now elapsed since the operation, but if that specimen had been badly treated or mislaid, or no microscopic examination made, it would have been considered a true glioma, the operation for which had been followed by no recurrence.

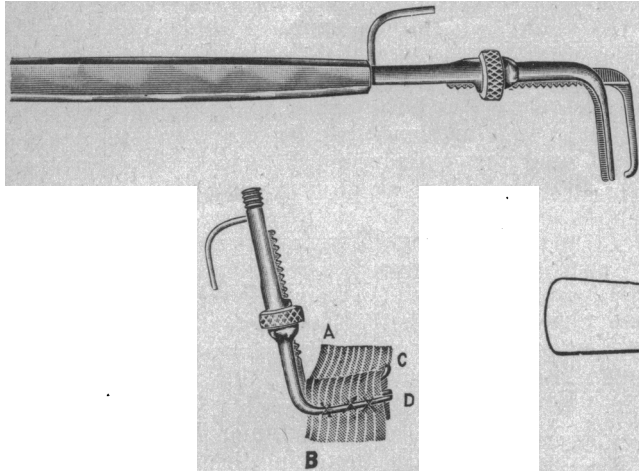
DR. SULZER—I have only to add that both Dr. Shumway and Dr. Flexner saw this specimen and agreed on the diagnosis.

A DOUBLE HOOK FOR USE IN ADVANCEMENT OPERATIONS.*

C. F. CLARK, M.D.

COLUMBUS, OHIO.

This instrument is intended to simplify the operation for advancement of the recti muscles and to make it



A and B is a strip of tape drawn up into a fold by the hook at C D, showing the points for the insertion of sutures at XXX.

possible to regulate with certainty the amount of shortening obtained. It consists of a small hook, the shank of which is embedded in the anterior surface of a larger one, and the arm of which passes between the blades of the forked arm of the larger one. By means of a milled screw and a ratchet the single hook may be projected beyond and between the blades of the double one, so as to take up a fold of the tendon and draw it up

*Presented to the Section on Ophthalmology, at the Fifty-first Annual Meeting of the American Medical Association, held at Atlantic City, N. J., June 5-8, 1900.

between the blades to the desired height, when the sutures may be introduced and the superfluous fold cut off, if so desired. The instrument is made with a detachable handle, so that during the suturing the aid of an assistant may be dispensed with. I have found it operate most satisfactorily when the capsule of Tenon is included with the tendon of the muscle, as this gives greater holding power to the sutures.

I think the accompanying illustrations will make clear the character of the instrument.

AIDS IN THE MEASUREMENT OF REFRACTION.*

EDWARD JACKSON, A.M., M.D.

DENVER, COL.

The two instruments that I herewith present have proved of sufficient value, in facilitating the testing of the refraction of the eye, to justify me in calling the attention of the members of the Section to them. The first is

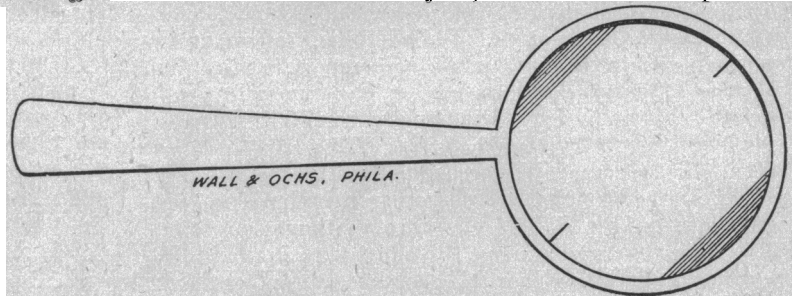
A TRIAL-FRAME FOR SKIASCOPY.

It is simply a light trial-frame, in each cell of which is fixed a metal disc, with a central opening large enough to allow the application of the shadow-test through it.

Upon the disc are enameled bands of black and white, each occupying an angle of 30 degrees of the disc. In the center of each band is marked a point, white in the black bands, and black in the white bands. This constitutes a graduation to 15 degrees spaces. The center of a white band marks 90 degrees, and the center of a black band, 180 degrees, of the usual graduation of the trial-frame. This arrangement affords a kind of graduation that can readily be seen with the light thrown on the eye while applying the test. It furnishes something with which one can easily compare the band of light in the pupil that indicates the directions of principal meridians of astigmatism. This frame has been made by H. C. Boden & Co., of Philadelphia.

CROSSED CYLINDERS.

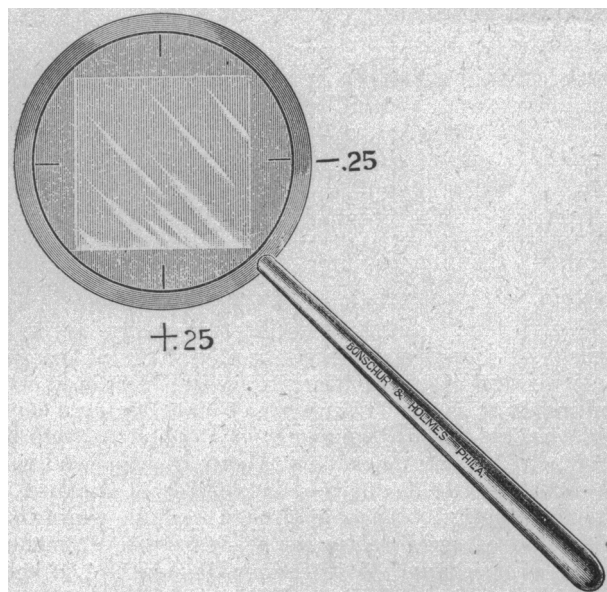
The recent publication by Dr. T. B. Schneideman, of an article urging the value of the crossed cylinder in testing refraction,¹ seems to have stimulated renewed interest in the subject; and two different opticians



have brought me these convenient arrangements for the use of the test. Each has the axis of the convex cylinder indicated in the usual way for showing the cylinder axis. The lens is mounted in a frame having a handle set at 45 degrees from the cylinder axis. Holding the lens before the eye, with this handle between the thumb and fingers, one can, by a very slight movement of rotation, instantly change the direction of the cylinder axis 90 degrees, thus reversing the cylindrical effect. The lens is used as a supplementary

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lens, held in front of the lenses already chosen, which are placed in the trial frame. By this reversal of the axis we alternately increase and diminish the cylindrical effect of the combination before the eye. The lens with the round handle is made by Messrs. Bonschur & Holmes, and the lens with the flat handle is made by Messrs. Wall & Ochs, all of Philadelphia. The one with the round handle (see illustration) is the more easily turned; while the one with the flat handle can be more



readily kept exactly perpendicular to the visual axis. Either will be found of great practical value in refraction work.

DISCUSSION.

DR. W. F. SOUTHARD, San Francisco—Five years ago I devised a method of transillumination for the ophthalmometer, which I believe was the first effort in this direction. I first used ground glass, and gave that up because there was not a good distribution of light, and then I began to use porcelain [exhibiting the instrument]; a 16-candle power, 110-volt lamp is used. I did not think that it was obligatory to have it patented, but that any instrument-maker could be privileged to make it without danger of prosecution and such difficulties as I have experienced. I have testimonials from several manufacturers to show that this instrument was the first of the kind that they saw. One of the gentlemen spoke yesterday of the blurred edges of the mires as they approach each other. That is true and always will be, because it is due to an optical defect. I pay no attention to that myself, knowing that it is an optical illusion, and when at the point of contact there will be a little whitening more than we see here. I have demonstrated this instrument before a number of medical societies, and I desire the privilege of having my claim of priority published now in the transactions.

DR. A. EDWARD DAVIS, New York City—I may say that there was a transilluminated mire in use several years ago. Javal himself had one, but it was not so perfect an illumination as this.

DR. MILES STANDISH, Boston—I want to illustrate a little scheme I have adopted on my ophthalmometer, which aids me greatly in judging the point of contact. I have painted in the center of the solid white portion of the first step a little spot 1 mm. square, so that when the mires approach you have a point still beyond the light diffusion, and by watching this point you can judge the point of contact very accurately. It can be very easily accomplished by pasting a little black square on the mire, and once having placed it there you will never take it off again.

SYMPTOMS AND DIAGNOSIS OF HYPERTROPHY OF THE PHARYNGEAL TONSIL.*

GEORGE MORGENTHAU, M. D.

CHICAGO.

Symptoms.—Hypertrophy of the pharyngeal tonsil is, in many cases, combined with enlargement of one or more other parts of Waldeyer's so-called lymphatic ring of the pharynx, and of the adenoid or lymphatic tissue found in all the mucous membranes. The symptoms produced by these abnormal conditions, while mainly traceable to the pharyngeal tonsil, may not be ascribed to it entirely, but must be considered in reference to a possible constitutional anomaly of which the adenoid vegetations are but a local manifestation. The most common of these is the excessive discharge which flows either into the nasopharynx or into the nose. It is of thick consistency, sometimes with a slight odor, and comes from Luschka's tonsil itself or from the nose. The tonsillar secretion in conjunction with the venous stasis, especially of the posterior ends of the lower turbinals, and the mechanical interference with drainage of the nasal chambers, by the enlarged tonsil, result in chronic rhinitis. This, in turn, is favored by various malformations found so often in patients with adenoid growths, be the relation causal or accidental. The growths being situated behind the choanæ, inspiration may be performed, while in expiration the growths fall against the nose, acting as valves. "Blowing the nose," is, therefore, quite inefficient. They are but seldom large enough to obstruct more than the upper part of the choanæ, so that the children can, although with some effort, breathe through the remaining lower part of the canal. But when this, too—as is most apt to be the case when the children are in a horizontal position—is either obstructed by the accumulating mucus or by the swelling of the posterior ends of the turbinals or even by the action of the erectile tissue in the tonsil, then they are forced to breathe through the mouth. Infants are sometimes unable to nurse at the breast. Bosworth states that acute rhinitis is comparatively rarely met with in a child. In most cases, when it has an apparent cold in the head, it is really suffering from a subacute inflammation of the pharyngeal tonsil. The nose is rendered still more inadequate for breathing by a condition to which Ingals drew attention, abnormal narrowness of the choanæ—a factor which accounts for some disappointing results after the growths have been removed as thoroughly as possible. Nosebleed sets in often, from small capillaries in the anterior lower angle of the septum or in the tonsil. If the blood can not escape, small petechiæ are to be seen in the submucous tissue, especially of the soft palate and the uvula, or in the tonsil itself. The discharge from the nose is apt to excite eczema at the introitus, thickening and roughness of the upper lip, etc., symptoms often attributed to scrofulosis. The chronic inflammatory condition of the nose is, in many cases, followed by impairment of smell and taste; frequently by conjunctivitis, occasionally by blepharitis, and even by keratitis. Or, as discharge gathers in the nasopharynx during the night, it may trickle into the stomach or be unconsciously swallowed, causing vomiting and gastric mischief, thus adding to the malnutrition of our little patients. The laryngeal and bronchial

*Read in a Symposium on Hypertrophy of the Pharyngeal Tonsil, before the Chicago Climatological and Laryngological Association, July 5, 1900.