

pitals during a period of five years showed only three cases of optic nerve and retinal changes due to lead, and of these two were doubtful. The same writer also states that chronic lead poisoning is a well known cause of paralysis of the external ocular muscles, the abducens, according to Schroeder, being most frequently affected, a condition perhaps similar to the palsies of the extensor muscles of the extremities.

MONOCULAR TRACHOMA.

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In the voluminous literature on trachoma, scarcely any mention of the condition being limited to one eye can be found. Würdemann, in the November number, 1921, of the *AMERICAN JOURNAL OF OPHTHALMOLOGY*, cites five cases, three of which were first reported in 1896 in the "*Annales d'Oculistique*." In the past two years two cases have come under our observation with unmistakable monocular trachoma, both having typical granulations on the tarsal conjunctiva and fornix, marked pannus, and one ulceration of the cornea.

CASE 1.—A. J. C., American, age 43. First seen December 24, 1920. For past two months has been troubled with watery discharge from right eye, photophobia and diminished vision. Examination showed typical trachomatous granulations covering upper tarsal conjunctiva and cul de sac. Lower conjunctiva swollen, but no granulations. Pannus covered the upper half of cornea. Usual treatment with copper sulphat and silver nitrat. The patient has been very negligent in his treatments, has returned every two or three months with an acute exacerbation, and at the last return showed a large corneal ulceration. Usual treatment with prompt improvement. The left eye has always been normal. We feel that in such a case, resection of the tarsal cartilage is the only hope for a permanent result.

CASE 2.—Mrs. H. W., Japanese, age 26. First consulted us January 20, 1922. Has had trouble with left eye for six months. Examination showed a condition similar to Case 1—a typical monocular trachoma limited to the left eye. Upper cul de sac covered with granulations. Mild pannus covering upper third of cornea. Copper sulphat stick and yellow oxid ointment treatment. The pannus has practically cleared and the granulations have about disappeared from the upper fornix.

SELF EXPRESSION OF LENS.

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Altho this is not an unusual occurrence, I would like to report a case in which the lens was expressed by patient. There was no indication of orbicular spasm, and except for a rather narrow palpebral fissure, the appearance was normal.

Iridectomy was performed in the usual manner preliminary to extraction of cataract (senile). Nothing unusual developed and the patient was put to bed. On the second day, he complained of pain in the operated eye. The bandage was carefully removed, and on opening lids, the whole lens was found in the lower cul de sac. Despite all precautions and treatment, an iridocyclitis developed and light perception was the best vision obtainable.

This necessarily brings up the question of routine injection of the orbicularis muscle. It is a very important one for lessening the dangers of cataract operation. The effect of novocain and apothecin has proven efficient during operation, but at best lasts only a few hours.

The suggestion of Col. Smith is a good one, that when a drug is discovered which will paralyze the orbicularis for several days, the worry of vitreous escape and prolapse of iris will be at a minimum. Used routinely it would prevent just such an accident as occurred in my patient.