SOME APPARENTLY TRIVIAL OPHTHALMIC SYMPTOMS WHICH MAY BE OF IMPORTANCE.

BY

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THERE are a certain number of ophthalmic symptoms which patients regard from two entirely different standpoints. They are often so intensely alarmed at their occurrence that they are led to consult their medical man immediately, because they are convinced that such symptoms are an early sign of "blindness" coming on. On the other hand, they often attribute the symptoms to "liver," "nervousness," "run down state of health," and other causes equally indefinite, while some patients even regard them as interesting phenomena which are hardly worth mentioning.

Some of the symptoms to which I specially wish to refer here are such as may be capable of quite a harmless interpretation, and yet I hope to show that the same symptoms may indicate pathological changes of a serious nature. The practitioner must, therefore, be on his guard and be prepared to make a thorough examination of the eye before committing himself to any definite opinion.

FLASHES OF LIGHT BEFORE THE EYES.

Speaking generally, this is always a sign of abnormal retinal stimulation of some kind. It may merely indicate a hypersensitiveness of the retina in a person of neurasthenic temperament, or it may be induced by reflection from minute vitreous opacities, in which case an encouraging prognosis can be given, and the fears of the patient regarding the possibility of serious consequences may be allayed with confidence. On the other hand, such symptoms may be associated with definite retinal disease—for example, albuminuric or diabetic retinitis, or detachment of the retina.

In cases liable to detachment of the retina—e.g., high myopia—it is a most valuable sign of threatening detachment, and in such cases the symptoms should be allayed seriously.

A methodical examination of the fundus should be made, the vision accurately recorded, and the field carefully plotted out; and in any case, even if nothing is actually found, advice should be given to avoid stooping, lifting, or straining. Again, flashes of light of various formations are complained of in cases of migraine, and the history of such attacks should be carefully investigated, since the symptoms and signs of an attack are unmistakable though they vary in severity.

TEMPORARY DOUBLE VISION ESPECIALLY WHEN TIRED.

This does not create such an unfavourable impression on patients as one might expect, and they very often pass over it very lightly in describing their symptoms. It is a symptom which manifests itself more frequently after a severe illness or towards the end of the day. It means that there is some defect of muscle coördination, and the eyes can only be kept straight owing to the fact that there is good binocular vision which stimulates the muscle balance coördination, whenever that tends to go wrong, so that the weaker muscles are kept in a constant state of overaction, and thus the eyes remain parallel. When, however, the muscle tone is lowered by weakness following a severe illness, or from ordinary overwork, the weaker muscles no longer overact, and the stronger muscles therefore come into play. Thus the eyes fail to remain parallel, and diplopia is produced. Frequently headaches are common as a result of this muscle balance defect owing to the strain of continuous abnormal muscular action, and this cause must never be overlooked as being responsible for headaches of ocular origin in the absence of refractive error.

There are various methods of examination by which this condition can be diagnosed, but one of the commonest and most reliable is that known as the Maddox rod test. The fundamental principle underlying any test is the temporary abolition of binocular vision, and if no Maddox rod is available at the moment, a very efficient test can be substituted by using the following method. While the eyes are directed towards an object, say the finger held up in front of the patient's face, the eyes remain parallel; then cover one eye or the other. If now the eye which is covered be observed behind the screen it will be seen to have deviated in some other direction than that of parallelism; on removing the screen, the eye that was covered will make a rapid movement in order to assume the position of parallelism again, and this movement can be observed.

TEMPORARY MISTS.

This may be merely a temporary failure of accommodation in a case of hypermetropia, where parallel rays of light tend to come to a focus behind the retina, and therefore where accurate vision is impossible except by the continual effort of accommodation. Should this fail at any moment temporary misty vision is produced. It may also be complained of in chronic conjunctivitis where a film is produced in front of the cornea by the mucoid discharge.

These are comparatively simple explanations of this symptom; but there is another side to it which must never be overlooked. Temporary misty vision is one of the early signs of chronic glaucoma, and if at the same time pain and dimness of vision are also complained of, a strong

case is made out in favour of a more serious view of this symptom.

A careful examination should therefore be made, the fundus should be examined for any sign of cupping of the disc, and the field of vision should be taken with the object of discovering whether there is any constriction in the peripheral regions, any enlargement of the blind spot, or scotomatous areas round the fixation point.

SEEING TO READ WITHOUT GLASSES AFTER BEING ACCUSTOMED TO THEM.

There are people, well over presbyopic age, accustomed to wear glasses for reading, who suddenly find they are able to see to read without them. This is regarded as a matter for congratulation by the patients, and they conclude that, because many people younger than themselves still have to wear glasses for reading, their own eyes have become very strong; but they often fail to notice at the same time that their distant vision is not so good as it formerly was. The reason for this symptom is that the patients have become myopic, due to swelling of the lens, so that the parts which are not sclerosed—e.g., other than the nucleus and parts immediately surrounding it—become more convex, and thus parallel rays of light come to a focus in front of the retina, producing the same result as in axial myopia, where the lens is in a normal condition and the eyeball is lengthened.

This condition is often one of the first signs of cataract, and the lens should be carefully examined from this point of view. In the early stages no opacity may be found, but this eventually develops before long. This symptom is also an early sign of diabetes, though it is possible that the cause is not so much the direct result of excess of sugar in the blood as the effect of this excess on the lens, which so often becomes cataractous; therefore the urine should always be carefully examined when a patient complains of this symptom.

MULTIPLE IMAGES.

This is a symptom which patients often complain of, and more especially when looking up into the sky at the moon or any special star. It is as well to make sure from the history that patients are not complaining of true double vision (diplopia), which is only possible when both eyes are open. Multiple vision may occur when either one eye or both are used. Now diplopia with one eye only is extremely rare, and is only possible when the lens is dislocated, and in such a position that one half of the pupil is occupied by the edge of the lens and the other half is without any part of the lens behind it.

Multiple images are a sign of cataract where the rays of light from an object are broken up by the spokes and spots of opacity which are beginning to form in the lens, thus conducing to the appearance of more than one image. The lens should be examined to discover if possible such opacities,

both by reflected light (red reflex) and by the direct method of ophthalmoscopy with a +12 lens behind the sight hole.

DISTORTION AND UNEVENNESS OF STRAIGHT LINES OR LINES OF PRINT.

This symptom is, as a rule, not regarded by the patients as anything very unusual, and they often merely mention it casually as an interesting fact in their visual perceptions. It must always be regarded, however, as a symptom of extreme importance, and a careful examination of the eye must be made under a mydriatic.

Roughly speaking, it indicates some interference with the anatomical position of the cones at the macula, and therefore this part of the fundus should be examined very critically. Sometimes there is very little to be seen, while at other times some definite picture of choroidal or retinal disturbance is observed. Occasionally this symptom proves to be the earliest sign of a new growth—e.g., sarcoma of the choroid—in which case the earlier the diagnosis can be made the better. Under any circumstances diseases of the macula generally produce a permanently injurious effect on the visual acuity, and therefore patients, where this symptom is present, should be periodically watched, and an unfavourable prognosis should be given, as regards ultimate recovery in vision.

FLOATING SPOTS IN FRONT OF THE EYES.

This symptom produces an extraordinarily variable effect on the patient. He sometimes regards it very lightly, saying he supposes it is only "liver," and therefore hardly a matter worth mentioning to the ophthalmic surgeon. Others, again, are unduly alarmed, and are convinced that it is the first sign of cataract, or some form of "blindness," and they come for immediate advice in a state of great trepidation.

Any moving opaque body is almost certain to be associated with some change in the vitreous, and we must, therefore, carefully investigate this region with a view to determining the cause. We cannot, and must not, commit ourselves to a diagnosis without such careful examination, and yet the patients are frequently in a great hurry "to know the worst," and may press us for an opinion before we have had time to carry out our investigations.

It is important to remember that floating opacities may be a sign of active choroidal inflammation, cyclitis, or hæmorrhage into the vitreous, while in high myopia they are extremely common and often assume a translucent appearance. Some floating bodies are coarse and easy to see, such as those found as a result of hæmorrhage, while others may be fine dust-like in character, and are often difficult to detect. Those not due to hæmorrhage are albuminous exudates, and originate from the choroid or ciliary body.

An examination should always be made under a mydriatic and by direct ophthalmoscopy, using

a plain mirror with dull illumination. When the eye is moved in any direction and then brought to a standstill the bodies can be seen to float across the field of vision. After this other confirmatory signs should be looked for, such as white oedematous areas in the fundus, indicating acute choroiditis, or keratic precipitates (K.P.) in the case of cyclitis. Hæmorrhages are usually coarse in appearance and dark in colour. In all these cases the vision is generally below the normal, and sometimes to a considerable extent.

The large majority of floating bodies are due either to entoptic phenomena, or to small fibrinous deposits of so minute a character as to be invisible by ophthalmoscopic examination, and yet owing to their proximity to the retina of the patient are therefore magnified and distinctly visible to them. Under no circumstances must we say that the bodies are non-existent, but if we find the vision perfectly normal, we can give a favourable prognosis, and inform our patients that there is no need to worry about them, unless the vision is interfered with, and that in time they will learn to ignore them.

Reviews

ANABOLIN IN HIGH BLOOD PRESSURE.

The Hepatic Principle, Anabolin, Detoxication by the Liver and the Control of Functional Hypertension. By H. R. HARROWER, M.D. London: Baillière, Tindall and Cox. 1927. Pp. xii. + 147. 10s. 6d.

OUR forefathers did not pay much attention to high blood pressure, for they had no convenient instrument for estimating it, but now the laity as well as doctors talk about it. A patient is satisfied if he is told he is suffering from blood pressure, but, quite apart from this popular aspect, the pressure of the blood in the arteries is of profound interest to physicians and physiologists. How does it come about that as years advance it rises? Is it a good thing that it should rise? What are the dangers of this increase? What are the effects of it, is it desirable to control it, and if so, how can this be done?

Dr. Harrower's little book is concerned chiefly with the questions at the end of this list. He insists on the importance of the internal secretion of the liver, especially that part of it which acts as a detoxicating agent, and he believes that he has discovered a substance which he calls anabolin which can be extracted from the liver; this he claims is neither histamine nor choline, nor a mixture of them. He claims that anabolin will lower high blood pressure in man. His investigations have reached the stage at which we must wait and see if they are confirmed by others. We know that many doctors are giving hepatic extract for cases of hypertension and that some claim a great benefit for this treatment.

Clearly anyone wishing to learn about this new drug cannot do better than consult this book by Dr. Harrower, the author of what may turn out to be a new and most important chapter in physiology and therapeutics.

Our publisher desires that readers of the JOURNAL should be informed that it would be possible to supply covers for binding the numbers for the year if there is a reasonably large demand for such.

EDITORIAL NOTES

THE attention of our readers is particularly directed to the contribution of Sir ARTHUR ROBINSON, First Permanent Secretary to the Ministry of Health, on "Our Duty to Our Colonial Visitors," printed at the beginning of our current number.

Sir ARTHUR ROBINSON, as will be generally known, is one of the "lay" members of the Departmental Committee on Post-graduate Education sitting at the present time under the presidency of Mr. NEVILLE CHAMBERLAIN, Minister of Health, and as such his communication will be read with the greatest interest.

We are more than glad to be able to publish it as representing the gist of the address he recently gave on Jan. 31st under that title at the Post-Graduate Hostel. It is to be welcomed for several reasons, among others because it gives a historical account of the evolution of the organisation known as the London School of Hygiene and Tropical Medicine, of which Dr. ANDREW BALFOUR is the first director; further, and especially because it foreshadows the moving principles of the Committee in relation to the wider post-graduate teaching, of which, it is hoped, we may learn more in the near future. As would be anticipated, we desire to withhold any comment until the complete plan of recommendations is in the possession of the Fellowship of Medicine.

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As will be known to many of our readers, two cottages for recovered tuberculosis patients are to be erected and prepared at the Cambridge-shire Tuberculosis Colony at Papworth as a memorial to its late President, Sir Thomas Clifford Allbutt. It is stated that they will be chosen from among those who could not, under ordinary circumstances, support themselves and their families. This scheme will make a moving appeal to the believers in the colony system of the after-care of tuberculous patients as well as to the host of admirers of the late Prof. Sir Clifford Allbutt. It is intended that the cottages shall be ready for occupation in the coming summer. Any of our readers who are moved to contribute to the Fund should send their donations, small or large, to Mrs. MARCUS DIMSDALE, Papworth Hall, Cambridge.

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As showing how the medical post-graduate idea is spreading throughout the English-speaking world, we are glad to give the following information, quoted from *The Medical Journal of Australia*, recounting the work done in 1926 through the Permanent Post-Graduate Committee of Melbourne which was founded by its branch of the British Medical Association in 1920. In June ten practitioners entered into residence at the Women's Hospital for two weeks when lectures