Complications are infrequent, but when present greatly increase the gravity of the case.

VI. TREATMENT.

The importance of wasting and of continued vomiting in the prognosis suggests that special attention should be paid to the diet. To maintain an adequate state of nutrition and to conserve the patient's strength, feeding must be carried out with the utmost regularity, and will need the most untiring patience and tact. A careful record of the food that has really been taken should always be kept, especially when the mother is the nurse. Nasal or rectal feeding is rarely necessary. The food should be diluted too much rather than too little.

There is so much doubt concerning the value of external applications in pneumonia, and so many obvious disadvantages connected with the use of some of them, that no measure calculated to disturb or fatigue a patient should be adopted without serious consideration. Poultices are, in my judgement, an unmixed evil. A child has enough to do to raise its ribs sixty times a minute without being obliged to raise a heavily linseed meal poultice sixty times a minute as well. It has been said that this objection is removed if the poultice is only applied to the back. This is true, provided that the patient simply lies in the poultice, which is not fixed to it in any way. There cannot be many to whom this procedure will commend itself.

The use of ice-bags and the abstraction of blood are measures which also have their advocates. Whatever may be their value in the case of adults, I never employ them in children who have sound cardiac muscle and whose chief danger lies in respiratory, not cardiac, muscle-exhaustion, and who, as Sir James Barr remarks, may die from failure of the respiratory muscles to secure adequate entrance of air into the chest.

A free supply of fresh air is of prime importance. I believe that one reason why a larger proportion of cases recover in a hospital than in the homes of the lower and lower middle classes is that there is always a free current of air in the ward, and too often a stuffy, used-up atmosphere in the home. Inhalation of oxygen may be a substitute for this, but it is a poor one. Oxygen is probably of most use in those cases in which respiration is very feeble, and the possibility of introducing enough fresh air on the one hand, or too much oxygen on the other, is therefore small. In a few cases it appears to be of service; more often it fails. When employed it should be warmed and diluted. Three yards of tubing and a reservoir bag should be used. Part of the tubing should lie in a basin of warm water, and the nozzle should not be held close to the mouth. Steam-kettles are worse than useless. The room should not be lighted by gas, since its products aggravate the cough.

Drugs have little influence over the course of pneumonia in childhood, except so far as they act as stimulants to the circulation or the respiration. These are needed at the first suspicion of respiratory or circulatory failure, as shown by the occurrence of cyanosis or an increase in the rapidity of breathing. They are especially needed in prolonged cases of the scattered pneumonic type. They comprise strychnine, ammonium carbonate, spirits of ether, sparteine, and alcohol. Expectorants are only of use when the accompanying bronchitis is an important feature of the case; otherwise they should be avoided.

Save your patient every possible source of alarm and fatigue. Caution the friends against exciting and exhausting the patient by new toys, and all the other attentions which, in their ill-informed devotion, they love to bestow. So large a proportion of cases recover that recourse should never be had to measures of doubtful utility. Be always on the look-out for the earliest sign of any complication. The desire to avoid worrying a patient is often a temptation to be slovenly in one's examination of an affected organ. I learned from Sir William Jenner an aphorism I never lose an opportunity of repeating: "More mistakes are due to want of examination than to want of knowledge."

By Ministerial decree, an inquiry has been ordered into the prevalence of measles and whooping-cough at German health resorts and watering places, with the object of formulating a system of preventive measures that will prevent outbreaks of these diseases during the bathing season.

Remarks

ON COMPLETE VOCAL REST DURING THE SANATORIUM TREATMENT OF LARYNGEAL TUBERCULOSIS.

BY
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In a recent issue of the *BRITISH MEDICAL JOURNAL*,¹ Sir Felix Semon drew attention to the great value of absolute rest of the voice in the treatment of laryngeal tuberculosis. Since the date of the opening of the King Edward VII Sanatorium (July, 1906), all patients admitted suffering from laryngeal tuberculosis have been treated on the lines suggested by Sir Felix Semon, and, in view of the considerable proportion of consumptives who have laryngeal complications* and the measure of success which has resulted from our trial of complete vocal rest in their treatment, we think that the following report may be of interest.

The six patients whose progress under treatment we now record, had all well-marked tuberculous disease in the lungs, in addition to tuberculous disease in the larynx. They were all treated, generally, on the usual sanatorium principles; the laryngeal disease was especially treated by complete vocal rest, and in three cases periodic local applications of lactic acid were made.

As the possibility of carrying out the complete vocal rest treatment in sanatoriums. Considerable doubts have been expressed by many as to the possibility of persuading patients faithfully to carry out such an irksome treatment as complete silence for a period of several months continuously. The treatment, certainly, is very irksome to many, but in practice we have found that patients carry this out much better than might be expected. Several observers have stated that it is best to keep laryngeal cases, treated in this way, apart from other patients under treatment in a sanatorium. They have advised that a room be set apart where laryngeal cases can have meals together, and have recommended that these patients should always be sent out for their walks, either alone, or in company of each other, so that they should be less exposed to the temptation to talk. These measures, though necessary in some instances, are not in our experience indicated for the majority of patients with laryngeal disease. A tendency to introspection, depression and analysing of symptoms, which is apt to arise when consumptives are aggregated together in any number, is much lessened if patients are kept occupied and cheerful, and it is in practice found inadvisable to cut off certain patients from the general social life and amusements of the sanatorium if it can possibly be avoided. We allow most of our patients on the silence treatment to take their walks with patients who have no laryngeal disease, and also to have their meals at the general tables. Considerable care must, however, be exercised in this. The companions of the laryngeal cases on their walks, and their neighbours at meals, must be carefully chosen, for on them, almost as much as upon the laryngeal patients themselves, depends the efficient carrying out of the treatment. Companions of sound common sense are, indeed, a valuable asset to the patient on vocal rest, and to secure success the sanatorium physician must pay some particular attention to these patients' friends as well as to the patients themselves.

The silence treatment, carried out on these principles, is, we find, much less irksome than when the laryngeal patients are isolated, for these patients can, by signs and gestures, and with the aid of scribbling books or slates and

* Of the first 150 admissions to the King Edward VII Sanatorium 33 patients (or 22 per cent.) had some abnormal condition of the larynx. Of these 33 patients 21—that is, 14 per cent. of the first 150 admissions—had definite tuberculous disease of the larynx. The remaining 12 patients were suffering from general catarrh of the larynx, relaxation of the vocal cords, or some other abnormal condition not due to local tuberculosis—for example, one patient had complete paralysis of the left vocal cord, probably due to pressure of a gland on the recurrent laryngeal nerve. The proportion of patients suffering from definite laryngeal tuberculosis in the sanatorium at any one time has fluctuated between 10 per cent. and 20 per cent., the average number working out at 14 per cent.

pencils, to a considerable extent take part in the conversation and amusements around them. It goes without saying that the *rationale* of the silence, cure must be thoroughly explained to patients to whom it is prescribed, for the clearer the understanding the patient has on this point the greater is the chance of the treatment being carried out conscientiously.

In a large community, such as a sanatorium, the thoroughness with which this treatment is carried out also depends a good deal upon the general discipline of the institution, and the personal interest of those responsible for its management. If at the outset the laryngeal patients are carefully watched, and constantly urged to persevere in their treatment, silence soon becomes to be a recognized part of the sanatorium routine, and one in which both laryngeal patients and the other patients take an intelligent and personal interest. Again, on the principle that "nothing succeeds like success," the obvious fact of laryngeal patients rapidly improving upon complete vocal rest, soon becomes a valuable ally to a physician in charge of the cases thus treated. Patients will put up with some inconvenience when convinced on the evidence of their own senses that it is in their own interest to do so; as Sir Felix Semon, at Berlin, replied to a critic who said that this treatment would never be carried out, "Grey, my dear friend, is all your theory, and green the golden tree of life" (Goethe).

RESULTS OF THE TREATMENT.

In the following table we give the conditions of the six patients on admission to the Sanatorium and on discharge, or at the present time if still under treatment. It will be noted that all six patients had well-marked disease of the larynx, four of them having definite ulceration, in addition to congestion of the vocal cords. In the remaining two cases there was swelling and congestion of the cords and of the mucous membrane of the arytenoids or the interarytenoid region. All the patients had pronounced hoarseness, and two of them had some degree of dysphagia. As a result of treatment extending on an average over five months, the laryngeal disease in all these cases has immensely improved. In the four cases in which there was definite ulceration on admission, the ulcers have completely cicatrized, and the congestion and swelling have very much diminished, or entirely cleared up. In five cases the normal voice has been restored, and in the sixth case the hoarseness is much less. It will be noticed also that in every case the improvement in the larynx has been associated with great improvement in the lungs and general health. This is, unfortunately,

not always the case. We have under our care at the present time a patient whose lung disease has been well arrested, and whose general health has been perfectly restored, but whose laryngeal disease has at the same time definitely progressed. We might add, too, that this particular patient had, throughout his stay in the sanatorium, carried out the complete vocal rest treatment most thoroughly.* Sir Felix Semon, in his paper, states that "complete vocal rest is neither absolutely certain nor indicated in all cases of laryngeal tuberculosis, nor is its exclusive use sufficient in many instances in which it may be advantageously employed. I rather look upon it as a very valuable helpmate which, although it might in some cases render local treatment superfluous, is not at all intended to altogether do away with the latter. On the contrary, in more severe cases a combination of the two methods will often produce excellent results."

Our experience, up to the present time, is thoroughly in accord with the opinion thus expressed by Sir Felix Semon.

Reports of Cases.

CASE I.

Mr. P. N., aged 27, clerk in motor works. Admitted July 11th, 1906. He gave a history of cough since February, 1906, and loss of voice and hoarseness since April, 1906. On admission he was found to have infiltration in all three lobes of his right lung and at the apex of the lower lobe of the left lung. His laryngeal symptoms were an irritable cough and very marked hoarseness; there was no dysphagia. In the larynx there was an ulcer at the posterior end of the left vocal cord, and a small erosion in the corresponding position on the right cord. He was prescribed the usual sanatorium régime and complete vocal rest for the larynx. In November, 1906, the following report was made on his larynx: "On the posterior end of the left vocal cord there is still some irregular thickening but no actual ulceration; the rest of the larynx is normal, and the voice very much improved."

He was now using his voice again. Associated with this laryngeal improvement there was marked improvement in his lung disease. This progress towards recovery was steadily maintained, and at the date of his discharge, on January 12th, 1907, his general health was completely restored, and the signs of disease in the lungs were limited to a few moist sounds of cough at the apex of the right lower lobe only. In the larynx there was a scar in the situation of the former ulcers, but otherwise the larynx was practically normal. The voice was very much improved—in fact, it was practically normal—a slight alteration in quality, rather than huskiness, only remaining. It is perhaps worth recording that this patient took a part in two of the plays performed by the patients at the New Year entertainments. He was perfectly well heard

*For the past fortnight this patient has been treated with lactic acid application, twice weekly, in addition to vocal rest, and has distinctly improved.

Table of Results.

	Condition on Admission.					Condition on Discharge.			Remarks.
	Type of Disease.	Duration of Disease.	Laryngeal Disease.		Length of Treatment.	Lung Disease.	Laryngeal Disease.		
			Objective.	Subjective.			Objective.	Subjective.	
Case I ...	Infiltration of 4 lobes	11 months	Ulcer on left cord	Cough, hoarseness	6 months	Incomplete arrest (A)	Scar only	Nil	Returned to work.
Case II ...	Infiltration of 2 lobes	3 months	Ulcer on epiglottis and on right ventricular band.	Hoarseness, dysphagia	4 months	Complete arrest	Scar only	Nil	Returned to work.
Case III...	Infiltration of 2 lobes	18 months	Congestion and erosion of left cord	Slight hoarseness	3 months	Incomplete arrest (A)	Much improved	Nil	Still in sanatorium.
Case IV ...	Extensive disease of 5 lobes	7 months	Interarytenoid swelling and congestion	Hoarseness	6 months	Incomplete arrest (A)	Some interarytenoid thickening	Hoarseness	Returned to work.
Case V ...	Chronic disease of 5 lobes	6 years	Swelling and congestion of cords, etc.	Hoarseness, dysphagia	6 months	Incomplete arrest (B)	Much improved	Nil	Still in sanatorium.
Case VI...	Infiltration of 2 lobes	6 months	Ulcers on both cords	Hoarseness	4 months	Complete arrest	Scars	Nil	Still in sanatorium.

Definition of Terms used.

Complete Arrest = General health completely restored in every respect, and lung disease completely arrested (apparent cure), there being no physical signs present, or only such as are compatible with a completely healed lesion.

Incomplete Arrest (A) = General health completely restored, but physical signs of lung disease, though much improved, not entirely cleared up—for example, perhaps limited to a few moist sounds on cough.

Incomplete Arrest (B) = General health only imperfectly restored, and physical signs of the disease—for example, moist sounds, etc., still well marked.

Chart for Case IV.

by the audience, and his larynx did not suffer in the least by this additional use of his voice.

On discharge from the sanatorium this patient returned to work.

CASE II.

Mr. C. G., aged 40, lecturer, admitted September 10th, 1906. This patient gave a history of pain in the larynx and dysphagia three years previously. Eight months before admission he had practically lost his voice, and the pain in the larynx and the difficulty in swallowing had since then become much worse. He had been under treatment in London for his larynx for a month before admission, and the advisability of having the larynx curetted had been considered, but it was decided to see what sanatorium treatment would do for him before taking operative measures. On admission his general health was very poor; he was obviously ill, and was a stone below his normal weight. On examination he was found to have early disease at the apices of both lungs. In the larynx there was active ulceration of the right free border of the epiglottis as well as on the inner aspect of the right aryteno-epiglottidean fold. Both the vocal cords were congested, and the mucous membrane over the arytenoids was considerably swollen. Subjectively he had marked hoarseness and a good deal of dysphagia. This patient was prescribed complete vocal rest, and, in addition, the ulcerated surfaces of the larynx were, twice a week, treated with Lake's mixture, and later with pure lactic acid. After two months' treatment the patient was immensely improved in every respect. He had gained 10 lb. in weight, he had lost his fever, and was walking eight miles a day without the least fatigue. In the larynx there was still active ulceration in the same situations as on admission, but he had completely lost his dysphagia, and his voice was very much improved.

On discharge on January 19th, 1907, his lung disease was completely arrested, and his general health and capacity for work restored. At this date Sir Felix Semon made an examination of the larynx and made the following report: "The condition of the larynx is a good deal better than when I last saw him. The ulcer on the edge of the epiglottis now seems quite cicatrized; of the ulceration on the right ventricular band only a little yellow spot is seen; on the vocal process of the right vocal cord a clear loss of substance which also seems to be already cicatrized is visible, and his voice is practically normal."

March. This patient returned to work soon after leaving the sanatorium and is now in good health.

CASE III.

Aged 34, captain in the Indian army, admitted November 17th, 1906. This patient gave a history of cough and gradual loss of weight for eighteen months, and hoarseness for the month previous to admission. On examination he was found to have somewhat extensive early disease of the upper and lower lobes of the right lung. In the larynx there was considerable congestion of both cords and of the interarytenoid space, and an erosion of the posterior end of the left vocal cord. He had no laryngeal symptoms except the hoarseness. He had slight fever, but his general condition was very fair. This patient was prescribed vocal rest, which he carried out very thoroughly. After two months' treatment his condition was greatly improved. He had gained a stone in weight, his temperature was normal, he was walking about eight miles daily, and the physical signs of the lung disease were much less marked. Examination of his larynx at this date showed that there was still a small erosion on the left vocal cord though the congestion was markedly less, and his voice was practically normal. This patient is still in the sanatorium, and continuing to make good progress under the same treatment.

CASE IV.

Mr. W. L., aged 19, clerk in insurance office, admitted July 11th, 1906. The history in this case was "a succession of colds in January, 1903, followed by gradual loss of strength and appetite." He first noticed some hoarseness in February—four months before admission—and gave up his work in the following month. On admission, he had extensive infiltration, with some breaking down in both lobes of his left lung and recent infiltration of the upper and lower lobes of the right lung. In the larynx there was considerable swelling of the interarytenoid fold and also distinct swelling of the mucous membrane over the arytenoids; both vocal cords were very congested, but there was no actual ulceration. His only laryngeal symptom was extreme hoarseness. For the first month after admission he was kept in bed owing to his having fever, and he was advised to keep his voice at rest. This patient made steady and uninterrupted progress, and after three months' treatment his temperature was normal and the condition of his lungs and his general health were much improved. In the larynx there was much less congestion of the vocal cords, but swelling of the interarytenoid region still remained and prevented the vocal cords meeting on phonation; his voice in consequence was still very husky.

On discharge in January, 1907, after six months' treatment, this patient had made remarkably good progress. The rate of his improvement is well shown by the weekly average chart of his temperature, weight, etc., which we give. His general health was excellent, and he was walking from ten to fourteen miles daily with perfect ease. He had gained 25 lb. in weight, and his working capacity was sufficiently restored to allow of his return to duty as an insurance agent in the country.

The signs of disease in the lungs were much less, though they had not completely cleared up. The general condition of the larynx was greatly improved, and the cords were healthy. The swelling over the arytenoids was much less marked, but some thickening in the interarytenoid region still remained and prevented the complete approximation of the cords on phonation. There was still, in consequence of this, some hoarseness, though very much less than on admission. This patient had been on complete vocal rest until discharge from the sanatorium; and on leaving he was advised to use his voice as sparingly as possible on his return to work.

CASE V.

Miss M. M., aged 32, teacher, admitted December 3rd, 1906, gave the following history: Eleven years before admission she had congestion of the lungs, three years later bronchial catarrh, and two years later pulmonary tuberculosis was diagnosed. She then had a month's treatment and returned to work, at which she continued until February, 1906. Two years before admission her voice first became husky, and since that date it had never been quite right; since May, 1906, she had had intercurrent dysphagia. On admission her general health was very poor. Examination of her chest showed extensive chronic disease of both lungs with excavation of both lobes of the left lung.

In the larynx both cords were very congested, and the mucous membrane over the arytenoids and interarytenoid space was considerably swollen. Subjectively she had marked hoarseness and some dysphagia. She was prescribed complete vocal rest and a spray of zinc sulphate. After two and a half months' treatment she had considerably improved in every respect. She had lost her fever, was walking six miles daily, and was up to her normal weight, having gained 11 lb. since admission. In the larynx there was still some congestion of the cords and swelling of the mucous membrane, though much less marked. At the present time, after six months' treatment, she has made still further progress. The

larynx has a very much more healthy appearance; the vocal cords are practically white, the swelling of the mucous membrane is very much diminished, and her voice is normal.

CASE VI.

Miss M. F., aged 32, school teacher, admitted October 1st, 1906. On admission this patient gave a history of two years' general failure in health, with loss of weight and strength; cough and huskiness came on first in February, 1906, but she remained at her work until six weeks before admission, when she was compelled to give it up, largely on account of her loss of voice. Examination on admission showed that she had infiltration of the upper and lower lobes of the right lung. In her larynx there was an ulcer on the interarytenoid fold, and also on the posterior end of the right vocal cord, there was also a longitudinal cleft at the posterior end of the left cord, and both cords were in addition considerably congested. She had marked hoarseness but no dysphagia. Her general health was poor, she was obviously below proper weight, and had slight fever. For her laryngeal condition she was prescribed complete vocal rest and a spray of zinc sulphate. She has persevered very thoroughly in the treatment prescribed for her, with very satisfactory results. At the present time—she is still a patient in the Sanatorium—her lung disease is arrested, and her general health wonderfully improved. She has gained 16½ lb. in weight, and is walking eight miles daily, her temperature being absolutely normal. The larynx has greatly improved, the cleft in the left vocal cord has quite disappeared, and there is now only a scar in the interarytenoid fold; the general anaemia of the larynx has quite disappeared, the congestion of the vocal cords is much diminished, and the voice is clear.

REFERENCE.

¹ Therapeutic Value of Complete Vocal Rest during the Sanatorium Treatment of Laryngeal Tuberculosis. BRITISH MEDICAL JOURNAL, December 8th, 1906.

An Address

ON

THE VALUE OF OPHTHALMIC SYMPTOMS IN GENERAL DIAGNOSIS AND PROGNOSIS.

DELIVERED BEFORE THE RICHMOND DIVISION OF THE BRITISH MEDICAL ASSOCIATION.

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MR. PRESIDENT AND GENTLEMEN,—Cases presenting all degrees of complexity are met with in general medical practice, and you have frequently to deal with obscure symptoms in different organs of the body entailing difficult clinical analysis. I propose speaking to you about the aid that you may obtain in your work by paying due attention to ocular affections.

One important plea in favour of my theme is that such ophthalmic symptoms as I shall mention are easily observed, and do not need any very special training; one of the greatest charms of ophthalmic work, indeed, consists in the ease with which, generally speaking, our observations are made.

Much more attention is paid to-day by the medical practitioner to disorders of the eyes *per se* than obtained twenty years ago, and the early treatment of such affections as iritis, glaucoma, and ocular headaches has proved highly beneficial to the community. But I hold that there is still much to be desired in the recognition of ophthalmic signs as indicative of general disease. Accordingly, I desire to describe very shortly some readily-recognized symptoms which often present valuable evidence of past disease; which in some instances afford the earliest indications of a threatened serious general ailment; or, again, which are often of value in differential diagnosis when the true nature of a general affection is otherwise doubtful. Some of these ophthalmic signs are entirely subjective; others are first, or most readily, detected by subjective symptoms; while yet others are objective only.

Subjective Signs.

A patient, most often a woman between 20 and 30 years of age, comes with an account of rapid, recent failure of vision in one eye. Outwardly the eye looks normal, and the ophthalmoscope shows no fundus change. There may be deep-seated pain experienced on pressing the globe

backwards into the orbit, and even on moving the eye in different directions. The amount of failure of sight varies, but may be almost complete; in slighter forms the eye fails to distinguish small pieces of red and green at or near the fixation point. The pupil may contract fairly well to light for a moment, but then dilates again under continued exposure, behaving quite differently from that of its normal fellow.

We should here be justified in diagnosing some affection of the corresponding optic nerve in its course between the optic disc and the chiasma. Locally, the prognosis is favourable, as sight is usually gradually recovered in the course of two or three weeks. But the chief importance of the diagnosis lies in this, that a very large proportion (quite one-half) of these cases have already developed, or will within the next few years exhibit, other signs of disseminated sclerosis; and that we have to regard the retro-ocular nerve affection as a local "island" of this disease. We are thus prepared to guard our general prognosis, and may be enabled early to put the patient on a judicious system of life treatment. Cases of this kind are very liable to be confused with a one-eyed hysterical amblyopia, particularly as the same patient not uncommonly has other symptoms that are undoubtedly functional in character. Attention to the behaviour of the pupil which I have described is, however, sufficient to prevent such a mistake from being made. Further, although commonly enough there is no ophthalmic change at first, some days later we often find evidence of neuritis, and this is succeeded after some weeks by a decided pallor of this optic disc.

Occasionally, a patient who similarly complains of loss of sight in one eye is found, when we examine the nature of the failure, to have in reality lost half of each field of vision. Thus he may state that his right eye is blind, while, in fact, the right half of the visual field is blind in each eye, while the left half of each is still retained. This condition, *homonymous hemianopia*, is an evidence of intracranial disease, the site of the lesion being one optic tract, the visual centre in one occipital lobe, or, finally, the fibres connecting the tract and sight centre. There are indications in the nature of the pupillary reaction in such cases which serve to localize the lesion more precisely, whether it be in the tract or posterior to it, but into this question of finer localization I need not enter at present. In elderly people homonymous hemianopia is generally due to vascular disease, and may be a valuable indication of a more general arterio-sclerosis.

In a third important subjective group, the outer or temporal half of each visual field is lost (bitemporal hemianopia). This is a symptom of localizing value as showing the presence of some disease involving, usually by pressure, the part of the optic chiasma where the optic nerve fibres cross. It is found in cases of tumours or hypertrophy of the pituitary body, among other causes, and sometimes constitutes an early symptom in acromegaly.

Ophthalmic Signs connected with the Position of the Eyeballs in the Orbits, and Muscular Anomalies affecting the Eyes and Upper Eyelids.

Prominence of the eyeballs, when accompanied by retraction of the eyelids, gives rise to a remarkable staring facial expression familiar as a common symptom of Graves's disease or exophthalmic goitre. This appearance is often what leads us to look for clinical evidences of this disease. In early stages the proptosis may not be well marked, and where our suspicions are aroused we ask the patient to look slowly downwards, and note whether the upper lid drops gradually as in health, or whether it lags behind, remaining for some time in its initial retracted position. This latter is a valuable sign of Graves's disease, even in its slighter forms and earliest stages, and if accompanied by decided tachycardia and muscular tremors the diagnosis may, I believe, be considered complete.

Nystagmus is occasionally of more than local significance. By nystagmus I mean a fairly rapid to-and-fro movement of the eyes, often constant, and always very evident when one attempts to examine the fundus with the ophthalmoscope. It is common in those whose sight has always been defective. But when met with in association with normal eyes, and when of comparatively recent development, this symptom is of value as indicating the