eye has become myopic, the original refraction of +3.0 D. having changed to -4.0 D.sph. This change is not uncommon in children with congenital syphilis, especially after an attack of interstitial keratitis. The choroiditis did not seem to be sufficient to account for the amblyopia, and the macula was unaffected, so I ascribe the amblyopia of the left eye to the change in refraction and the squint.

Comment.—It is quite obvious that the condition of Jean, the child that was treated with sulphostab, is far worse than that of her sister who received no treatment, and yet both children had the same infection, and similar natures. The logical conclusion is that in this case the arsenic preparation had a deleterious effect upon the optic nerve. It would, however, be wrong to infer from a few isolated examples that tri-valent arsenic preparations are dangerous and liable to cause optic atrophy. The fact that they have been used in thousands of cases without any ill effect upon the optic nerve proves the contrary, but we cannot escape the conclusion that occasionally the optic nerve may suffer.

I cannot explain the discrepancies in Jean's vision with and without atropine, but a long experience in school clinic work has taught me that children are apt to behave in this way.

RETINAL DETACHMENT OCCURRING PROBABLY AFTER HERPES ZOSTER OPHTHALMICUS IN A CASE OF SIMPLE GLAUCOMA

BY

A. A. B. SCOTT

DUNDEE

MR. R., aged 64 years, consulted me in January, 1928, complaining that the vision of the left eye had been failing for a year, and that the eye was now almost blind.

Examination of the left eye showed dilated conjunctival vessels, a slightly steamy cornea, pupil 4 mm., regular and inactive, tension (Schiötz) 70 mm. Hg, and vision reduced to seeing hand movements at 1 foot distance on the temporal side only. Transillumination was normal. In the right eye the optic disc was flat and of good colour, the retinal arteries were a little sclerosed, tension was 25 mm. Hg, and vision 6/6 easily with correction for a low hypermetropic astigmatism.

As regards the subsequent history of the right eye, it need only be mentioned that by the use of eserine drops, increased gradually in strength and frequency, the tension has been kept at 20 mm. Hg, with 6/6 vision, and normal visual field.

When he was seen again a week later, the eserine had reduced the tension of the left eye to 40 mm. Hg; the cornea was clear, and the whole of the fundus could be viewed. The disc was pale and deeply cupped. He was referred to his physician, Dr. G. Rankine, who found that the blood pressure was raised; this condition responded to suitable treatment. He came to see me every four or five months for observation of the right eye. By May, 1929, there was no perception of light in the left eye. On October 31, 1929, the left eye was examined for the last time before the attack of herpes; the tension was 40 mm. Hg, at which level it had remained for the previous twenty months.

He returned on May 15, 1930; during the interval, Dr. Rankine had attended him for an attack of herpes of the ophthalmic division of the left fifth nerve, which commenced in February. On enquiry, it was ascertained that there had been conjunctivitis, but that the side of the nose had not been affected. Examination showed the typical scars on the left side of the forehead. The conjunctival vessels were dilated, and there was a small superficial central corneal nebula. Sensation, tested by cotton wool, was markedly impaired over both the cornea and conjunctiva. The pupil was regular and contracted by eserine. The tension was 18 mm. Hg. Through the contracted pupil it was possible to make out a retinal detachment; on instilling homatropine, the pupil dilated regularly and normally, and the retina was seen to be detached, except above the disc for an area of about a quarter of its extent. The detachment was deepest below, where it could be focused with a +8 D. lens, the refraction of the disc being emmetropic. No holes or tears were visible; transillumination was normal. There were no corneal precipitates or vitreous opacities.

By the end of 1930 the detachment had become opaque and more extensive, and there was incipient cataract. The last examination was on March 9, 1932; the lens was then too opaque for the fundus to be seen. The tension was still 18 mm. Hg.

Commentary.—The condition of the left eye, prior to the attack of herpes, would appear to be simple glaucoma. In support of this, there was the absence of any sign of intra-ocular inflammation, haemorrhage, or neoplasm during the period from January, 1928, to October, 1929; there was also the tendency, kept in check by increasing dosage of eserine, for the tension of the right eye to become raised.

It must be admitted that the left fundus was not under observation during the three months that elapsed between October, 1929, and the onset of the herpes, so it cannot be definitely established that the detachment was subsequent to the herpes. However, as there was no history of injury, severe cough or physical strain during this time, and as the state of the eye had remained unchanged during some twenty months' observation, the presumption is that

the reduction of tension and the retinal detachment took place after the herpes.

In the literature it is recognised that the intra-ocular tension may become reduced during an attack of herpes zoster ophthalmicus; the writer has not been able to find any recorded case of retinal detachment occurring as a complication. The suggestion is made that in this case the detachment is due to the lowering of the previously high tension. It is not thought that a short clinical note is the place wherein to attempt to explain the mechanism of its occurrence.

WILLIAM BRIGGS, M.D. (1650-1704)

BY

R. R. JAMES

LONDON

ACCOUNTS of the work of William Briggs have long been available in Munk's *Roll of the Royal College of Physicians* and in the *Dictionary of National Biography*; but it may not be out of place to notice him in this journal as an ophthalmologist of the seventeenth century, a date when qualified ophthalmologists were few and far between.

The Briggs family was of respectable antiquity in East Anglia. The pedigree printed in Blomefield and Parkin's *History of Norfolk* (1808) begins with a William atte Brigge, of Salle, *temp.* Edward the First and Second, and living at Salle in 1334. From this William descended Augustine Briggs, son of Thos. Brygge, Esq., of North Wotton, 1546; whose son, Augustine Briggs, of Norwich, was the father of our ophthalmologist.

Augustine Briggs junior was born in 1617 and died in 1684. His wife's name was Elizabeth Aldred. He was a prominent citizen of Norwich. Elected Alderman in 1660, he was named as one of the Aldermen in the new charter given to the City by Charles the Second in 1663. He was Mayor of Norwich in 1670; and in the year 1667 was elected Burgess of Parliament for the City without opposition. This post of M.P. was retained by him at three subsequent elections. Augustine was a benefactor to the City; for, by his will, he made provision for the Boys' and Girls' Hospital (*i.e.*, schools) of the City, and he left a sum of money (£200) to the Mayor and Corporation, the interest on which was to be used yearly for putting two poor boys to convenient trades. These boys were to be chosen from his own ward if possible and in the event of no candidate being forthcoming in any year the