

outlines of capillaries in which the endothelial lining is still present. These are, however, distended and the lumen is replaced by old connective tissue elements. Quite frequently in such obliterated blood vessels small round cell infiltrations may be noted. The hemorrhagic areas are composed mainly of thin-walled capillaries, lined by flat endothelial cells: their lumina are distended and filled with red blood cells. Some of these capillaries reach the

diameter of 0.75 mm. Many of the capillaries are surrounded by a sheath of fibrous connective tissue cells, reaching a depth of seven or eight layers, arranged in a perithelial fashion. However, nowhere can any proliferation of endothelial elements be noted, and there is no invasion of the surrounding fatty fibrous tissue by the tumor.

"Diagnosis: benign hemangioma (partly hyalinized and fibrotic)".

*104 Passaic avenue.*

## NOTES, CASES, INSTRUMENTS

### OPTIC NEURITIS AND VITAMIN B

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All eye physicians from time to time have optic neuritides of apparently undiscoverable origin. The Wassermann in these is negative, no pus can be discovered anywhere, and in fact the general system as well as the anamnesis is absolutely negative. The patients simply have optic neuritis, and that appears to be the whole story.

In two such cases, recently, I used vitamin B in large doses. In each instance the patient made a prompt and complete recovery. In one of the cases I employed a well known wheat germ extract (vitavose); in the other, yeast. I have often, in optic nerve affections, found much value in yeast. In the latter of these two recent cases, however, I used nothing but yeast, and the result was most excellent.

Or was there really any "result"? Was there merely coincidence? I don't know. But the sequel, if not the result, was so impressive that I now ask others to give vitamin B a trial, in order that the truth may be ascertained.

We all know that in some way vitamin B does profoundly affect nerve tissue.

*629 East First street.*

### A SUGGESTION IN CROSS CYLINDER TECHNIQUE\*

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The papers by Jackson, Schneideman and Crisp on the use of the Jackson cross cylinder in refraction are very interesting and instructive. Those who use the cross cylinder are enthusiastic about the facility with which an accurate determination of the amount and the axis of the astigmatism may be obtained. One is, however, frequently confronted with a patient who insists on repeating, "I see better without it". This is the more apt to occur when one approaches the exact correction.

It is, of course, understood that one should preface every refraction with the cross cylinder by saying something similar to this: "Now I know that at times you will see better without this than with it, but all I want you to notice is which side of the glass is the better of the two". But it is psychological for the patient, especially the clinic patient, to persist in believing that the examiner is trying to make every change a little better, and his confidence may waver just a trifle when his vision is made worse.

To impress the patient that there is

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no mistake, one may proceed from a different viewpoint. To this end in our clinic Dr. Donald H. O'Rourke uses the question, "Which is the worse of the two sides?" while Dr. Phillips Thygeson asks, "Which side blurs it the more?"

To assist the patient in ignoring the image experienced before placing the cross cylinder there are several methods that may be employed. Usually all that is necessary is to pause a moment before asking the question after the cross cylinder is in place. Or one may hold the cross cylinder constantly in front of the eye while changing the axis or the amount of the cylinder. But by far the most reliable method in obstinate cases, in my experience, is to have the patient close both eyes while one is making a change, and to place the cross cylinder before the eye while it is still shut. There are then only two ways between which to make a choice, and this choice is facilitated by one of the fundamental advantages of the cross cylinder, that of instantaneous contrast. The rest which eyes and brain obtain from closing the eyes for a short while is of itself a valuable asset, many patients making a quick decision after whereas they vacillated before closure.

The essential value of the maneuver here suggested lies in reducing the possible choices from three to two by the simple procedure of having the patient close both eyes while the examiner changes the lenses and places the cross cylinder in front of the eye which is being tested. Obviously one will need to utilize this suggestion more frequently with clinic patients and children, and special questions are often called for in individual cases.

4200 East Ninth avenue..

### BAD REFRACTION VERSUS BAD PSYCHOLOGY

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A man aged forty-four years had had severe headache almost constantly

for several years. When I had corrected his optical errors and phorias, he was for a time greatly improved. Then the headaches began again.

After each periodic, semiannual check-up his headaches would totally disappear. But soon they would return without, so far as immediate rechecking could demonstrate, any mistake having been made in his correction.

Once we put him through the entire clinic to see what else than the eyes could be at fault. The result was altogether negative.

The situation was, in fact, mysterious in the extreme—until one day when the patient's wife came to see about her own eyes. I then inquired concerning her husband, and she replied that she herself had cured his headaches. Asked how, she answered: "Well, you see, hubby at night is always very tired, or else lazy. So, after dinner, he used to sit in the living room and go to reading with his distance glasses, his near glasses being upstairs, therefore too far away for him to go and get them. He always expected to read 'just for two or three minutes'. But always, of course, he would stick to the job for two or three hours. Next day he would have a frightful headache.

"I at last decided to take a hand in the matter. Whenever he sat down after dinner to read 'just for one or two minutes', I would rise, traipse upstairs to where he had left his reading glasses, traipse down with them, and make him put them on and use them.

"The result was—no more headaches".

At this man's next periodic check-up, I prescribed for him, willy nilly, a pair of bifocal glasses. Result: no more headaches, also no more unnecessary "traipsing" upstairs and down again for his wife.

It seemed that after each periodic check-up the man would be sufficiently interested in his eyes for just a few days to get and use the near glasses for night reading. After a time, however, becoming less interested in his own case, he would fall into the habit of reading with the distance lenses—at

least of nights when he was tired. That was, of course, just the time when he needed the near lenses most. On arriving home, each evening, he would, apparently, first of all go upstairs and, having used his near glasses there for some purpose, perhaps shaving, lay them on a table, put on his distance glasses, and, after a time, having donned coat and vest, go downstairs without his near glasses.

The problem, on the surface, seemed to be one of optics, but it was really one of psychology.

In a similar case a man already had bifocals. Still, from time to time, he would suffer from severe headache. He was a short man whose occupation necessitated frequent conversations with other men on the public streets. That, of course, meant frequent near gazing on the human countenance and facial expression at a distance of perhaps three feet, often less. This gazing, inasmuch as the patient was a short man while his interlocutors were frequently tall, generally had to be done through the upper segments of his glasses. I therefore prescribed for him a pair of grabs, +1.25 D., to pop over his bifocals whenever he was speaking with anyone on the street. Result: no more headaches.

At one meter the demand is for one diopter of accommodation. Closer still, it is of course more. The patient in question, being an advanced presbyope, had only been able, without his grabs, to squeeze and squeeze his much stiffened crystalline lenses ineffectually and with consequent cephalalgia.

A woman of twenty-five years, for whom I had prescribed +0.50 D., found her glasses excellent for distance, but productive of much blurry vision whenever she looked down—for example, in reading. Examination of her glasses, together with questioning, showed that the temples of the glasses were just a trifle loose and that the patient in consequence was from time to time putting her fingers up against the lower parts of the lenses so as to push the glasses higher. For that reason the lower parts of the lenses were almost always blurred. She was a highly educated woman, but had not been able to make the necessary simple observation for herself.

Tightening the temples effected an immediate cure.

The same procedure often helps patients who find bifocals just right for distance but blurry (therefore apparently too strong) for near.

*629 East First street.*