

Correspondence

ADVANTAGES OF CRYOSURGERY

To the Editor.—John M. McLean, MD, is to be complimented on his editorial "Cryosurgery in Ophthalmology" in the June 1967 issue of the ARCHIVES (77:715). The interest in cryosurgery is evidenced by the numerous reports and discussions at clinical meetings. In contrast to some writers who have magnified the dangers and difficulties of cryoextraction, Dr. McLean finds only minor objections. Two of the procedural modifications termed "drawbacks" in the editorial actually may be advantageous to the surgeon:

1. Thus grasping the lens superiorly in cryoextraction allows this procedure to be performed under direct vision.

2. Retracting the cornea more than usual causes less trauma than tucking the cornea against the cataract and instrument as required in the tumbling procedure. Striate keratitis rarely occurs after cryoextraction.

Admittedly the iris presents a problem particularly in round pupil cryoextractions. Iris freezing can be avoided by (1) adequate iris retraction, (2) careful placement of the probe on the cataract just long enough to produce an adequate adherence, followed by, (3) immediate traction upward and away from the iris.

Most ophthalmologists with practice on animal or cadaver eyes can master the technique of cryoextraction in a few weeks. The operative modifications required for cryoextraction are less difficult to learn than operating with a microscope or indirect ophthalmoscopy.

In addition to the indications for cryoextraction cited in the editorial (intumescent

cataract, friable capsule) the procedure offers advantages in subluxated lenses in which the vitreous lying in front of the lens interferes with grasping of the lens with forceps or the erisophake. It is also valuable in the highly myopic eye with degenerated and fluid vitreous because the counterpressure employed in the traditional extraction is unnecessary, thereby minimizing the possibility of vitreous loss.

It seems reasonable that if cryoextraction is valuable for the difficult cases, it should be equally beneficial in simple cataracts, especially for those who too frequently rupture the lens capsule.

JOHN BELLOWS, MD
Chicago

VISUAL DEFECTS AND LSD

To the Editor.—A 20-year-old male college student with known low-grade Gilbert's disease, but without demonstrable jaundice, was seen on Dec 31, 1966, with a one-year history of change in central vision. The history was unclear, but he did admit to using lysergic acid diethylamide (LSD) on five or six occasions. He had no recollection of staring into the sun at these times. He had once smoked but had given this up before I saw him. He was myopic (OD -1.75, OS -1.00) and saw 20/40 and 20/60 corrected. He presented on Dec 31, 1966, a good foveal reflex on the right surrounded by vague drusen-like bodies. The left macula was edematous with similar white "dots." Vitreous cells were never seen.

He was treated with prednisone, initial doses of 40 mg daily. The edema cleared but

vision worsened to 20/60 and 20/100+ (corrected) by June 9, 1967. The final picture was one of fine glistening areas in each macula, more on the left. Despite this, he was able to read fine type (poor M20) without glasses, and did well on the A. O. (American Optical) pseudo-isochromatic plates. We have then an atypical central serous picture, with paradoxically good near vision and poor distant vision, which might or might not be related to LSD.

DAN M. GORDON, MD
New York

FULL THICKNESS LID TRANSPLANT

To the Editor.—The transplantation of a full thickness graft from the opposite lid, to repair a defect created by removal of a tumor was described by Youens et al (ARCHIVES 77:226 [Feb] 1967). In their case much of a lower lid defect was effectively filled.

The procedure is not entirely original. Callahan (ARCHIVES 45:539 [May] 1951) described a similar case, in which an upper lid defect was partially closed by pulling the edges together, the final defect filled by "free-grafting a section of the entire thickness of the other upper lid." Callahan's article is well illustrated, and the cosmetic result in both eyes four months postoperatively was excellent.

MILORAD M. MILIC, MD
Steubenville, Ohio

CLINICAL EVALUATION OF THE AO APPLANATION TONOMETER

To the Editor.—I read with interest the article on clinical evaluation of the AO applanometer which appeared in the May 1967 issue of the ARCHIVES (77:646). We have re-

cently purchased an AO applanometer for use in our department at the Palo Alto Medical Clinic and I have attempted to use this. I do find, as the authors suggested, that the vertical alignment of this applanometer is quite critical and that it is very difficult to get both circles to appear at the same time, so much so that one finds oneself continually changing the vertical adjustment in order to get a good reading. Fortunately, in other rooms of our department we do have the Goldmann applanation tonometer, and the plexiglass prism-containing device which goes with this tonometer is supplied in duplicate with each tonometer. Also, fortunately, this device fits neatly into the carrier of the AO applanometer. I have thus replaced the AO plexiglass piece with the Haag-Strait piece and have been taking readings with this and find these to be quite satisfactory, in fact, much more satisfactory than those taken with the AO device.

NORMAN BALLIN, MD
Palo Alto, Calif

REPLY

To the Editor.—Doctor Ballin is correct in his two observations. The contact prisms of the Haag-Strait and AO applanation tonometers are interchangeable. It is also true, as stated in our report, that the vertical adjustment of the AO tonometer prism on the patient's cornea is "very difficult." In our experience some physicians readily master the technique of proper vertical adjustment of the AO applanation tonometer, whereas others, significantly fewer in number, experience difficulty.

CHARLES J. CAMPBELL, MD
New York

REPLACEMENT COPIES AVAILABLE

An unknown (we hope small) number of copies of the August 1967 issue of the ARCHIVES did not contain the color plate facing page 156, illustrating "Further Advances of the Study of the Macula" by A. E. Maumenee, MD. While the supply lasts the Circulation and Records Department will replace defective copies on request. Contact Robert A. Enlow, manager, at 535 N Dearborn St, Chicago 60610.