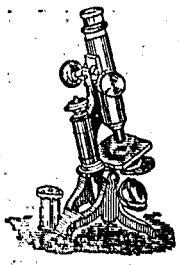
Medical Matters.

SEBORRHŒA OR RINGWORM.



Dr. Alfred Eddowes, writing in the *Medical Times*, describes three patients, illustrating the difficulty which occasionally arises in the differential diagnosis of seborrhœa or ringworm. 1. Boy, aged eight, with bald patch on scalp, no hair stumps. Surface of skin normally pigmented and not scaly. Hair at margin of patch atrophied. Microscopic examination showed the presence of organisms commonly found in seborrhœa. No trichophyton 2. The boy's father, who sleeps with him, had four circular patches on his chest, which were diagnosed by all who saw him as tinea circinata. Microscopic examination proved that it was seborrhœa dermatitis; usual organisms present but no trace of ringworm fungus found. 3. An Italian had scattered bald patches on scalp, with little crusts adhering here and there to somewhat reddened bases. On chest and abdomen several round or oval patches, more inflamed and more thickly crusted. At first sight, the patches looked something like psoriasis, but, unlike the scales of psoriasis, these crusts were friable and greasy. Microscopical examination showed the usual appearances found in seborrhœa. The last case (3) appeared opportunely to explain the differences presented by the boy and the father above mentioned, who almost certainly suffered from the same disease, though they presented wide differences in appearance. Seborrhœa, though it may advance and become so serious as to destroy the hair of the scalp in patches even in young people, does not set up such obvious inflammatory reaction as is so often seen on parts of the body covered by clothing, and therefore warmer and moister. In the subjects of seborrhœa, it is probable that what are termed by some "vest rashes" are mere luxuriant growths of a general infection. Not only do the vests keep the skin moist and warm, but by their friction, as well as by the itching which they induce and the inevitable scratching, lead to a deeper inoculation of existing germs, if not to many secondary forms of infection superadded.

It is interesting to note in this connection the theory that boils are caused by micro-organisms which find entrance through abrasions in the skin.

Nursing of Diseases of the Eye.

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AFFECTIONS OF THE MUSCLES.

As has been already said, the squinting eye, whether from disuse or from congenital malformation rarely sees well, and it therefore often remains amblyopic (*i.e*, imperfectly seeing) even though the deviation be corrected.

It is often possible by careful education to improve such an eye considerably. For this purpose the fellow eye must be occluded, or its accommodation paralysed with atropine to compel the use of the amblyopic eye. To occlude efficiently the seeing eye is by no means an easy task. The child resents the discomfort, and will pull off the source of his trouble again and again, or by displacing it will see by the side. The nurse must take care that the pad or shade is properly adjusted at once as often as it is moved. Even where the squinting eye has good vision, it is very rare for the child to be able to use the central vision of both eyes at the same time. There is very seldom diplopia, although the visual axes are directed at different objects. The peripheral vision is, however, made use of. If the extent of the visual field be taken with both eyes uncovered, this is much larger than that of the fixing eye alone, and if a red glass be placed over this eye, and a white test object be moved from the centre of the field towards the side of the squint, it is seen as white long before it has reached the outermost part of the field of the fixing eye. Attempts have been made to establish binocular vision by the stereoscope, and where the visual acuity of both eyes is good and the amount of deviation small these may be attended with marked success. There is considerable difficulty if the ordinary stereoscopic views are used in ensuring that the patients really see with both eyes and combine the two images. It is better, at all events in the early stages, to make use of dissimilar pictures which can be combined to make a whole. Thus we may have a bird and a cage. If the patient uses both eyes normally, he sees the bird in the cage; if only the bird or the cage is seen, the image of one eye is suppressed. It is often necessary approximately to correct the deviation by means of prisms or by operation before the stereoscope can be used.

In older children or adults, where the squint has persisted some years, the deformity rarely disappears under the use of glasses.

The internal rectus has become shortened by the constant spasm, and the question of operation arises. We must measure the extent of the deformity. What we wish to know is the angular deviation of the eye.

We place the squinting eye at the centre of the

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