3. Reflex midway between edge of pupil and edge of cornea = 25°.
4. Reflex on sclero-corneal junction = 45° to 50°.
5. Reflex between cornea and equator of eyeball = 60° to 80°.

An inspection of the accompanying figure (taken from Hirschberg’s original communication) will render the foregoing details clear.

Examination of the corneal reflex, however, is capable of rendering still further information. A squinting eye, as well known, may or may not “fix” — i.e., when the sound eye is covered the squinting eye may or may not be capable of looking straight at an object held in front of it. Broadly speaking, the power of fixation depends upon the sight possessed by the eye, and that, again, depends upon how long the squint has lasted, and especially upon the age of onset. In order to test this point (one of some importance in view of the surgical treatment to be adopted), the non-squinting eye is covered, and the child told to fix the mirror with the other eye. If fixation be good, the reflex will at once occupy the approximately central portion of the cornea and remain in place, whereas if true fixation be absent, the eye will wander aimlessly about, a point that can be readily appreciated by the vacillating corneal reflex.

The distinction between a comitant squint, on the one hand, and a paralytic squint, on the other, is not always easy to determine in young children, although much may turn upon the diagnosis. In the former the squinting eye, of course, retains its full range of movement, while in the latter the excursions are defective in one or more directions. There is no better way of determining the point than by the corneal reflexes, especially when the paresis is trifling. The modus operandi is as follows: "Holding the ophthalmoscope in the usual way with the right hand, lay the palm of the hand on the patient’s head, with instructions to let the head follow the most gentle guidance of the hand without any resistance in the neck. Now bid the patient look at the central aperture of the mirror while the light is thrown on the squinting eye, and the exact position of the corneal reflex noted. Now slowly turn the head to the right and left, then up and down, etc., and notice if the position of the reflection is unchanged by these manoeuvres; if it is unchanged, the squint is comitant. It is true that such observations require a good deal of practice before certainty can be acquired, but the same is true of retinoscopy, ophthalmoscopy, etc." (Maddox).

One of the important clinical distinctions between paralytic and comitant squint is that in the former the primary deviation is smaller than the secondary, while in the latter the deviations are equal. This point can in no way be determined with greater readiness than by a comparison of the corneal reflexes.

Gullstrand has advocated the utilisation of the corneal reflexes as a means of diagnosing paresis of the ocular muscles. The method essentially consists in a systematic comparison of the corneal reflexes when the eyes are rotated in the various meridians of the field of fixation. But it is no part of the present paper to enter into the details of Gullstrand’s ingenious though complicated scheme, but rather to point out the simpler clinical applications of the test.

Finally, the reflex is capable of affording information with respect to the exact position of the cornea traversed by the visual axis, or, more correctly, of the line of fixation. This observation may be useful when the placing of an optical iridectomy is in contemplation or when one is engaged in attempting to estimate the effect upon sight of a blemish upon the cornea. The last application is to assure oneself that fixation (and presumably sight) is present in the eyes of a young baby.

After what has been said, it may be fairly concluded that an inspection of the ophthalmoscopic corneal images should form part and parcel of the systematic examination of children’s eyes.

Acetozone.

If acetozone is ordered in solid form it should always be mixed freely with sugar of milk and administered in a capsule. Given alone it is very likely to cause vomiting.

Garlic in Bronchiectasis.

The drug which has given the best results in bronchiectasis is garlic. It may be given chopped and mixed with beef-tea or in capsules. As much as 30 grains eight times a day have been given. A fluid extract (dose 1 to 4 fluid drachms) and a syrup (dose ½ to 2 fluid drachms) are prepared. Another preparation is the volatile oil (dose ½ minim thrice daily); this may be prescribed in capsules and taken after food.—Dr. Stanley Box.

Thyroid Extract in Migraine.

It is suggested that in certain cases migraine may depend upon thyroid insufficiency, and this view finds support in a series of cases recently reported to the Hospitals Medical Society of Paris. In seven instances the patients were cured by the administration of thyroid extract.—Lancet, June 2, 1906.