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External Eye Diseases — Case Reports

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INDEX

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William A. O'Brien, M.D.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
March 19 - 24, 1945

No. 63

Monday, March 19

9:00 - 10:00 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff; Todd Amphitheater, U. H.

9:00 - 11:00 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Interns Quarters, U. H.

Tuesday, March 20

9:00 - 10:00 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Eustis Amphitheater, U. H.

11:00 - 12:00 Urology Conference; C. D. Creevy and Staff; Main 515 U. H.

12:30 - 1:30 Pathology Conference; Autopsies; Pathology Staff; 104 I. A.

4:00 - 5:00 Physiological Pathology of Surgical Diseases; Physiology and Surgery Staffs; Todd Amphitheater, U. H.

4:30 - 5:30 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Station 54, U. H.

4:00 - 5:00 Pediatrics Grand Rounds; I. McQuarrie and Staff; W-205 U. H.

4:30 - 5:30 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

5:00 - 6:00 Roentgen Diagnosis Conference; Solveig Bergh, and T. B. Merner; 515 U. H.

Wednesday, March 21

9:00 - 11:00 Neuropsychiatry Seminar; J. C. McKinley and Staff; Station 60 Lounge, U. H.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Pneumococcic Meningitis; Common Duct Stone; E. T. Bell, C. J. Watson, O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

12:30 - 1:30 Pediatrics Seminar; The Problem of Hirsuitism in Children; Dr. Beach, W-205 U. H.

12:30 - 5:30 Physiological Chemistry Literature Review; Staff; 116 M. H.

Thursday, March 22

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff; Todd Amphitheater.

4:00 - 5:00 Pediatric Journal Club; Review of Current Literature; Staff; W-205 U.H.

4:30 - 5:30 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

Friday, March 23

9:00 - 10:00 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U.H.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff; E-214 U. H.

10:30 - 12:30 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Otolaryngology Department, U. H.

1:00 - 2:30 Dermatology and Syphilology; Presentation of Selected Cases of the Week; Henry E. Michelson and Staff; W-206, U. H.

1:30 - 3:00 Roentgenology-Neurosurgery Conference; H. O. Peterson, W. T. Peyton and Staff; Todd Amphitheater.

Saturday, March 24

8:00 - 9:00 Surgery Journal Club, O. H. Wangensteen and Staff; M-515 U. H.

9:00 - 10:00 Pediatrics Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, U. H.

9:15 - 10:30 Surgery Roentgenology Conference; O. H. Wangensteen, L. G. Rigler and Staff; Todd Amphitheater, U. H.

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff; M-515 U. H.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff; E-221 U. H.

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Tuesday, March 20

8:00 P.M. Minnesota Pathological Society; Experimental Endocarditis; B. J. Clawson: The Islets of Langerhans in Alloxan Diabetes; Arthur Kirschbaum; Medical Sciences Amphitheater.

II. EXTERNAL EYE DISEASES -

CASE REPORTS

Erling S. Hansen

Introduction

Case reports illustrated by kodachrome projections are used in the teaching of ophthalmology. A selected series of 10 cases is presented today.

Case 1. Depigmentation of eye-lashes.

, farmer, 25, first entered the University Hospitals February 10, 1925. Complaint was impaired vision of both eyes of 2 weeks' duration. Patient gave a history of having been exposed to exhaust gas of a gasoline motor for 2 hours while working in his garage on the day previous to the onset of his symptoms. Also gave a history of previous similar exposure. Accompanhing the loss of vision patient complained of yellow spots in the field of vision which later changed to dark blurred areas. One day previous to admission he was registered in the University Out-Patient Department where the following findings were noted. There was slight tenderness over the eyeballs on palpation. Tension was normal, and there was some injection of the bulbar conjunctiva. There was inequality of the pupils. Pupils reacted to light and convergence. Intraocular media was clear. Funduscopic examination revealed blurred disc margins, slightly contracted retinal arteries and relatively engorged veins. The visual fields showed contraction with sector defects for red and blue. No scotoma was present and no enlargement of the blind spots. He was unable at this examination or at subsequent ones to distinguish green color. Vision in the right eye was 20/200, in the left 10/200.

General physical examination on admission to the hospitals showed the lungs, heart, kidneys, and abdomen negative. Neurological examination was also negative. Blood analysis, including urea nitrogen, creatinine, sugar, hemoglobin, red cell count, and white cell count were all within normal limits. Blood Wassermann was negative. Spinal fluid was clear with normal pressure. Cell count was 214, Nonne +, Wassermann negative. Carbon monoxide hemoglobin with sodium hydroxide test was positive. Two days later spectroscopic test for carbon monoxide hemoglobin was negative, and sodium hydroxide test for carbon monoxide hemoglobin was also negative.

Ocular examination while the patient was in the hospital is as follows: Bulbar and palpebral conjunctiva moderately injected, external ocular muscles normal, no ptosis nor nystagmus. Pupils are irregular, the right pupil larger than the left with sluggish reaction to light; intraocular media clear. There is bilateral papilledema, contraction of retinal arteries, and dilated veins. The retina presented diffuse gray-white opacity which extends uniformly throughout the fundus and is but slightly elevated. There is a retinal edema present. His vision is failing rapidly, and he is able to distinguish moving objects but is unable to recognize individuals. When he left the hospital one week later his vision was reduced to the perception of hand movements before the right and left eyes.

A few weeks after the patient left here he was examined by Dr. Frank Burch, who found retinal edema and large massive vitreous exudates. Vision at that time was perception of light. On May 15, 1926, 15 months after the onset of the involvement, this patient was reexamined by Dr. Burch and also by Dr. Murray. Ophthalmoscopic examination showed extensive chorioretinal lesions throughout the fundus without the presence of pigment deposit. There were also vitreous opacities noted. The vision in the right eye equalled 10/200, left eye equalled 2/200.

This patient was next seen at the University Hospitals August 27, 1942. At this time the patient presented the following picture. The patient is a very dark-complected individual with poliosis. The patient stated that his eyelashes turned white shortly after the

onset of the original trouble in 1925. The patient also had a combined nerve and conduction type of hearing disturbance. The patient's vision at this time is light perception only in each eye. The patient stated he had had no useful vision since the vision failed in 1925. He had had light perception only since January, 1942. The lids and conjunctiva are normal with the exception of the white eyelashes. The intraocular tension is normal in each eye. Both pupils are small and irregular and fixed and there is a dense membrane over the pupillary area. The pupils are bound to the lens in each eye by many posterior synechiae. The iris pattern in each eye is atrophic. Neither pupil could be dilated with mydriatic drugs. The impression at this time is chronic iritis in both eyes, inactive; cataracta complicata, both eyes. It was also thought that there is a probable old optic neuritis. The patient had very poor light projection at this time.

The patient stated that since the onset of the eye condition in 1925 there had been no acute phase until January, 1942, at which time the eyes had been red and sore for a period of one month. Since that time the eyes had been quiet. It was decided that the outlook was poor but that some surgery was worth trying, so on December 22, 1942 a preliminary iridectomy was performed upon each eye. These were broad-based iridectomies. None of the synechiae on the remaining iris were disturbed.

Following this operation the patient was quite happy because he said his vision had improved enough to enable him to get around. However, the vision was still light and motion. Both lenses were seen to be quite cataractous in the area where the iridectomy had been done.

November 23, 1943 in intracapsular cataract extraction was performed upon the left eye. Postoperatively this eye healed very nicely and the media remained perfectly clear. On examination of the retina following this operation it was found that there seemed to be very little normal retinal tissue left but that large patches of white sclera could be seen throughout the fundus. There seemed to be no pigment deposits. The patient was refracted on December 6, 1943 and at this time the vision in the left eye could be corrected to 20/200. The patient was given this correction.

He was last seen at the University Hospitals on January 6, 1944. At this time there was no further change in the eye condition.

Comment:

This case represents a syndrome in which the most important feature is a chronic destructive uveitis with plastic exudate in the pupil, secondary complicated cataracts and severe chorioretinitis. There is accompanying hearing loss of the nerve type, vitiligo, alopecia, and poliosis.

The cause is not known. It has been variously ascribed to a number of toxic agents, to endocrine disturbances, and to an allergic reaction to uveal pigment. More recently some have thought that it was due to a virus infection. The findings parallel many of those of sympathetic ophthalmitis, which is now considered to be due to a sensitization to uveal pigment, following injury to an eye, especially in the region of the ciliary body.

Case 2. Bilateral symmetrical infiltration over the superior rectus muscles in lymphatic leukemia.

, 48 years old, white male, was first seen in the University Hospitals January 6, 1942. He complained of slight weakness, fatigue, and excessive sweating for the past 2 or 3 months. The patient had been seen by his family doctor who had made a diagnosis of leukemia and had sent the patient to the University Hospitals. The past history revealed that the patient had had scarlet fever and about 6 episodes of rheumatic fever flareups.

Physical examination: heart is slightly enlarged, with a blowing systolic murmur at the apex. The breath sounds are impaired. The spleen is markedly enlarged. X-ray of the chest is essentially negative. There is thought to be

some chronic interstitial fibrosis of the lung. The white count on admission is 110,000, with 12% neutrophils, 87% lymphocytes, and 1% eosinophils. The hemoglobin was 68%. Other laboratory work is essentially negative. Diagnosis of lymphatic leukemia is made.

The patient was referred to the Deep X-ray Department for X-ray therapy, at which time he was given treatments to the spleen. Following this the white count dropped to 30,300 on 1-20-42, and on 1-21-42 it was 19,750. On 1-23-42 the white count was 13,800. On 2-2-42 the white count was 7,000.

The patient was first seen in the Ophthalmology Out-Patient Department on Oct. 5, 1942. At this time the patient complained of 3 white elevated plaques beneath the conjunctiva of the left eye. There was one plaque at the inner angle of the eye and one at the outer angle of the eye, and the third plaque was above in the region of the superior rectus muscle. A diagnosis of leukemic infiltrate was made. These infiltrates were treated with Beta irradiation of two 150 millicurie minutes of Beta ray and promptly cleared up. The white count at this time was 32,650. Aside from the subconjunctival infiltration the eyes were perfectly negative.

Patient was treated from time to time during the year of 1943 with deep x-ray and had no return of the eye condition until February 3, 1944, at which time the patient was again seen in the Ophthalmology Clinic. At this time there was a pink meaty subconjunctival infiltrate in the region of the insertion of the superior rectus muscle of each eye. The lacrimal gland of the right eye also seemed to be enlarged and could be easily palpated. There were no other positive eye findings. The fundi were normal and there was no evidence of leukemia in the fundi. At this time the white cunt was 45,000. Diagnosis of subconjunctival leukemic infiltrates was again made. These infiltrates were treated with 600 roentgens of x-ray to each area. The infiltrates promptly cleared up and the patient has had no recurrence. The patient's white count on 6-29-44 was 6,950. White count on 11-14-44 was 21,850, at which time he was admitted to the hospitals and treated with body irradiation. The white count on 11-22-44 was 13,900. On 11-25-44 the white count was 8,950.

Comment:

Simple lymphomata may occur anywhere in the palpebral or bulbar conjunctiva, as well as in the skin, or deeper in the orbit. They are seen most often in lymphatic leukemia, but also in other types of hemopoietic disease. Occasionally they occur without evidence of constitutional disease.

As seen in the illustration, they are reddish, brown swellings, sometimes nodular, and correspond to the multiple tumor-like nodes seen in the skin. They are usually painless and relatively slow in development. They follow the rule of being radiosensitive and respond to local treatment, as does the general disease to irradiation.

Case 3. Chloroma - 3 year old male.

History: Parents had noted a "squint" in the left eye one month before admission on May 19, 1939. Two weeks ago left eye began to swell and appeared more prominent.

Examination: Exophthalmos, left eye, displaced downward and slightly inward, with limitation of lateral and downward movements and no upward rotation. Skin of upper lid is thickened and red with prominently dilated veins. A firm nodular mass is palpable below the upper orbital rim. Fundoscopic: congestion and tortuosity of veins, elevation of disc about 3 diopters, detachment of upper portion of retina down to optic disc.

First blood examination, hemoglobin 54%, erythrocytes 3,200,000; leucocytes 16,400, neutrophiles 53%, lymphocytes 42%, monocytes 3%, eosinophiles 1%, and basophiles 1%. Subsequent smears show increasing numbers of myeloblasts and leucoblasts, promyelocytes and basket cells. Sternal puncture showed acute or subacute myelogenous leukemic changes.

X-ray shows no bone destruction around orbits; sutures slightly separated and convolutional markings increased.

Subsequent history: Treated with deep X-rays with regression of tumor. Ten days after admission a firm, tender swelling appeared over right mandible, with rapid increase in size. Roentgenograms showed a destructive lesion through the mandible on both sides with cystic areas of rarefaction. Expired June 10, 1939.

Comment: Clinically a case of chloroma although no biopsy was done and no autopsy allowed. The name is derived from the dirty green color of these tumor masses. They tend to invade bone as shown here in the mandible. They show a regression in size after deep X-ray treatment, a blood picture of myelogenous leukemia and a rather rapid fatal termination (7 weeks from onset of symptoms in this case.

Case 4. Lymphosarcoma

, 11 year old female, first came to Out-Patient Department on 12-27-43 for radium therapy.

History: Mass began growing on inner angle of upper lid, left eye, about August 15, 1943. It was painless. Gradually increased in size. Local physician removed it September 1, 1943. Recurrence. Second removal two months later. Tissue sent to Pathologist (E.T.Bell). The diagnosis was basal cell carcinoma and radium therapy was advised. Given X-ray on 12-27-43 and 1-11-44. Admitted to the University Hospitals on 1-11-44. Three 5 mgm. radium platinum needles into tumor area 24 hours. Recession of tumor. Discharged from hospitals 1-15-44. Readmitted 1-28-44. Rapidly increasing proptosis, left eye. Pain, nausea and vomiting at intervals for two days. Complete exenteration of orbit. Tumor mass extensive, adherent. Small dehiscence in floor nasally; may have been extension through floor but ethmoid cells seemed uninvolved. X-ray treatment course following exenteration. Frozen section and later study of removed tissue: Partly filmous connective tissue arranged in distinct bundles; rest made up of small cells showing no definite arrangement. Cells stain intensely, some show mitotic figures. Some of cells round, others spindle in shape.

Conclusion: Transitional cell carcinoma of the orbit. At this time review of original slides; also probable transitional cell carcinoma of orbit perhaps from lacrymal sac. April 5 - Out-Patient Department: Socket clean, not quite ready for skin grafting. Still some reaction from X-ray. Seen by Pediatrics service for extreme nervousness and slight weight loss. April 29, 1944. Admitted with terminal meningitis. Had recurrence in orbit with rapid growth. Biopsy had been sent in. Section by Pathologist (J.C.McCartney) 4-27-44. Report: Very cellular tumor with no definite arrangement into bundles; numerous mitoses. Cells are fairly uniform, most of them round. Appearances those of lymphosarcoma rather than transitional cell carcinoma although difficult to make a distinction between the two. Probably lymphosarcoma.

Expired 5-5-45. Autopsy; meningitis probably by extension from orbit. No metastasis in brain.

Comment:

This case is shown to call attention first to the difficulty of making a diagnosis from tissue sections in this type of tumor, at first seemingly basal cell carcinoma, secondly transitional cell carcinoma and finally lymphosarcoma. Next, the rapid growth of the tumor mass and its resistance to X-ray and radium was striking. Third, meningitis apparently developed from infection and death resulted from this rather than from metastatic growths or extension. In reviewing the case, there seems to be some possibility of meningeal irritation three weeks or more before the final admission when there was some complaint of nervousness and irritability, personality change and some weight loss.

These cases are relatively rare; the tumor rapid in growth, with a high local malignancy and a tendency to spread by way of the lymphatics.

Case 5. Essential Shrinking of Conjunctiva.

E.B., Female, age 22. Seen in Out-Patient Department on 1-22-42. Diagnosis of referring physician "Superficial Keratitis".

History: April, 1941. Watering og eyes, blurring, sandy feeling. Next day eyes swollen. Hospitalized. Temperature 104°. Intense itching of skin. Two days after admission broke out with water blisters, first on arms and legs. Then over whole body. Blisters lasted three weeks or more. Skin peeled off these areas after treatment with soda solution and mercurochrome spray. Left hospital after 5 weeks. Had no idea of the cause of her trouble.

Present complaint: Eyes itch and burn; sandy feeling, watering; sticky discharge; always red; unless ointment is used lids tightly stuck together; marked photophobia.

Eye examination: Both upper lids show scarring and redness. Pannus on cornea, more marked on right.

Impression note: Second stage of trachoma.

Treatment: Sulphanilamide grs. 50 daily. Seen by Dermatology Division. Note says Ectodermosis erosiva-pluriorificialis.

Eye note: 1-28-42. To go on second series of sulphanilamide now.

Subsequent findings: On September 23, 1942 is developing adhesions (atrophic bands) in conjunctiva.

It was later learned that this patient had been given sulphanilamide treatment for specific infection. A month later she was again given some sulpha drug with the aforementioned reaction beginning within a half hour.

Case 6. Pemphigus.

, Female, age 20.

Seen at request of her local ophthalmologist while employed in the city. History of chronic inflammation in both eyes for one year. Periods of remission and exacerbation.

Lids show pseudoptosis; there is marked photophobia. Lower lids show adhesions between palpebral and bulbar conjunctiva. When upper lid is everted there is seen a greyish exudate which is a stringy mucous secretion. The conjunctiva is thickened and scarred. When the two lids are spread apart a band-like adhesion is shown stretched across near the inner cauthus. Has had small ulcer on cornea.

Comment: These two cases represent a group to which Von Kries gave the name "Essential Shrinkage of the Conjunctiva". The second case had been called ocular pemphigus and is the typical picture of this disease. Apparently there are some of the less severe cases of pemphigus in which other lesions are minimal and the ocular involvement is the major lesion. Most of the acute cases do not survive but in these the eyes partake of the generalized involvement of the skin and mucous membranes. Some become chronic with successive crops of blisters appearing as others disappear.

The conjunctiva in these cases shows these successive crops of blisters which rupture easily leaving a raw surface. The subconjunctival tissues become indurated, scar tissue forming and contracting. Raw surfaces become adherent and sometimes result in bridges of connective tissue from globe to lids.

As a rule the cornea is not involved early, but as time goes on there may be a pannus like formation of new-formed vessels over the surface. If the shrinking goes on to a marked degree, so that the cornea is exposed by fixation of the lids, xerosis of the cornea occurs, with loss of vision in the extreme cases.

The first case I would tink was one of Erythema Exuditivum multiforme or rather erythema vesiculosum, which may

occur as a drug or serum reaction.

The clinical picture of the 2 cases is almost identical and it is difficult for me to believe that there is not a common factor in the development of all these cases. Many observers have reported etiological factors in the causation of pemphigus, but no uniformity exists. I would think that they are probably toxic in origin, just as are those with similar ocular findings in erythema exuditivum multiforme, vesiculosum or bullosum, erythema nodosum, dermatitis herpetiformis and other toxic dermatosis.

Case 7. Vernal conjunctivitis.

boy of 15. Admitted to hospitals December 17, 1942 for study of asthmatic condition. Known asthmatic since 1940. Showed marked skin reaction to cat and rabbit fur, horse dander, house dust, ragweed and wormwood sage group as well as to some grasses.

Referred August 6, 1943 for eye opinion.

Present complaint: Itching; photophobia; irritation both eyes, worse in the morning. Eye symptoms began fall of 1942.

Examination: Bulbar conjunctiva injected, mucous secretion, conjunctiva of upper lid, cobble stone, bleb like and edema.

Beta radiation 150 r. to everted lid, 8-6, 9-4, 10-12, 10-26, 1943.

Comment: Symptoms given are typical; intense itching, photophobia, lachrymation and stringy mucous secretion. Smears from conjunctiva show no organisms, but often large numbers of eosinophiles.

This case is unusual in that symptoms began in the fall. As the name implies, it is usually worse in the spring and summer, recurring annually for several years. Most cases are in children and young adults.

There are 2 types of lesions, the one seen here, palpebral and a limbal type in which there is formation of one or more discreet lesions around the cornea. The cornea itself is only rarely involved.

Treatment is mostly symptomatic, but in more severe cases radium is the most effective way to control the palpebral lesions. In the worst cases, it is necessary toremove the larger vegetations surgically, or to even excise the conjunctiva and tarsus.

Case 8. Conjunctivitis and Blepharitis.

, male, age 70. Sent from Minneapolis General Hospital for treatment. Shown only because there was no response to local treatment. Cleared up promptly on removal of infected focus in mouth, by extraction of teeth.

Case 9. Epidemic Kerato-conjunctivitis (Shipbuilders conjunctivitis).

Shows redness of skin of lids and surrounding skin; pseudoptosis due to edema of upper lid, lachrymation. Complaint of foreign body feeling in eye and marked tearing. Preauricular lymph node palpable. Later had more mucous secretion, never any pur nor any bacterial findings. The cornea is not involved as in at least 50% of the cases.

Case 10. Osteoma of orbit.

., age 65.

Shown only because of extensive involvement with osteoma of the orbit with preservation of vision in eye, though markedly displaced, because of the slow development of the tumor.

III. GOSSIP

The following letter was received from a Minnesota graduate: "Ever since you invited me to discuss post service training courses for returned medical officers, I have been going over the subject in my mind. As a matter of fact, I have given this subject considerable thought for over 4 years--ever since I left practice and followed the army. Keeping the medical officer well orientated and abreast of the medical times has always been a neglected subject and a rather sore point with me. Particularly so far as those in field service are concerned and not those assigned to hospitals. It would appear that no one in the higher realm of military medicine has considered it important to keep the medical officer medically smart, and little if any attempt has been made to improve a bad situation by a scheme of rotating assignments as the British army does. On the other hand, I have seen little effort or thought on the part of organized medicine or those interested in medical education to interest themselves in the rather sterile plight of the temporary medical officer. For after all, we are only militarized civilian practitioners. On our return to civilian life we will definitely dilute--or concentrate the volume of medical thought. So all of us are pretty much interested in what will be offered in the way of post service courses and the manner and means in which they will be offered. The returned medical officer will constitute somewhat of a problem to himself and everyone else. In some ways he will be difficult. I have seen his problems long enough to know that this will be so. It will take some imagination and more than a passing interest to make the projected courses successful--or rather, to make them valuable for the retainees.

Many people are of the opinion that the military doctor will have gained much in medical thought and dexterity that will be of value in civilian practice. This does not follow, and in many cases it is untrue. However, in many cases returned medical officers will do much to foster this belief in civilians, for he would like to believe it himself--and plunge directly into a medical practice for which he is not quite sharp enough to handle. He will wish to begin at once to make up for his lost years, to repair his financial deficit and to assume immediately the place he would have occupied had there been no war. He will look with a friendly, tolerant and somewhat jealous eye on the well paying practices of his fellow doctors, and he will want to get right in with both feet.

The graduate of a medical school is a proud and sensitive person. He does not like to admit, even to himself, that through his war service, his mental activity in medical things has tarnished. Though he knows that through no fault of his own, his assignment as battalion, regimental, or corps surgeon has not given him much medical work to do. He has learned much about his fellow men. He has learned much about psychosomatic complaints and considerable about some therapeutic measures, method and procedures. He has learned a lot about public health, too. Indeed many of us have much to give, as well as a great desire to get the results of newer medical thought.

However, most of us, no matter what our war-time assignment has been, feel a sense of loss. A loss in prestige and a lingering feeling of inferiority as we again make contact with those who have remained on the job here at home. The medical world has moved on and left us stranded. Our minds need constructive stimulation and this must be administered in the proper way--or it might be resented. We want to learn again, but not be told too much how we need it. It should be the function of the medical school to present this needful instruction in a practical, concise, understanding and helpful way.

So it appears to me the methods of presentation and subject matter of these courses will require considerable thought. Future security and good standards of the medical fraternity will be in the hands of many of these returnees and the methods of presentation of these courses--and their subject matter will influence many a man on his return to practice. Many men will have to be "sold" such a course in a diplomatic manner. But he should be "sold". Many of us no longer have the patience to sit thru a long abstract theoretical lecture. They must be short, alive, and full of meat. The returnee is critical and quick to lose interest in subjects too academic. I am interested in the problem and know what these men are thinking and what their attitudes are. The University has a great opportunity to improve medical practice, and it must not be fumbled."