The formation of an advanced dressing station will only be required when for any reason it is impossible to get the wounded back to the dressing station, or the dressing station up to the wounded. It corresponds to the old collecting station of the bearer company. Thus at the battle of Modder River, when owing to the Boer fire and the flat nature of the ground it was impossible to get wounded back, a collecting station was formed by the bearer company of the Guards' Brigade right up behind the firing line. An advanced dressing station consists principally of personnel and as much material as can be got up, the essential things being water, restoratives, and dressings.

The wounded when treated and fed at the dressing station will be evacuated to the clearing hospital, either on foot or by improvised transport. On arrival at the latter station they will be classified and dealt with as follows: (1) Those unfit for further transport will be handed over to a temporary hospital. (2) Those who require prolonged treatment and are fit for transport will be evacuated. (3) Those who will be able to return to their units after a week or two will be retained. If the result of the action is favourable they will pass to a temporary hospital; if not, they will be evacuated to a place of safety on the line of communication.

In the case of the action ending unfavourably the assistant director of medical services will be warned beforehand that the troops will probably have to retire; he will then accelerate the evacuation by every means in his power; the staff will be asked for all available wagons. All cases that can possibly march will be sent away, and there will be no delay for rest or refreshment at the field stations. The latter will not be closed till the assistant director receives orders to do so; finally, when the order to retire does come, if some wounded remain he must ask the commander for permission to leave personnel behind.

Should the troops be victorious the object is to collect the wounded as rapidly as possible, and to bring up the field hospitals to take over the cases at the dressing stations, thus setting the latter free to proceed with the troops. If there is a pursuit one field ambulance will be sent with the pursuing troops; but should the enemy merely retire to another position a short distance in rear, then probably our troops will hold the position gained, and all the medical personnel can concentrate their efforts on the collection of the wounded. As many field hospitals as are required will be opened, and the dressing station will be packed up ready to advance.
In defensive operations the medical arrangements are similar to those for an attack; they only differ in the more deliberate manner in which they are made, and the proximity of the positions to the firing line. The divisional collecting station and clearing hospital may be further forward and more permanent in character. The dispositions of the field ambulances can be gone into much more fully, and alternative schemes prepared for possible or probable contingencies; but, as in attack, it is suggested that they be held back till the enemy's intention is revealed. Owing to the stationary nature of the fight, and the probable presence of cover, the regimental personnel will be enabled to form aid posts, and these should be reinforced by personnel from the field ambulances (para. 211, R.A.M.C. Training). These temporary dressing stations, which constitute the only fundamental difference between arrangements for attack and defence, can be withdrawn when the field ambulances come into operation.

In an encounter battle the regimental personnel will act as in attack, i.e., follow up if the troops advance, rendering first aid and collecting wounded into groups; while should the troops act on the defensive, they will endeavour to form aid posts. The field ambulances may have to act on their own initiative, but the assistant director of medical services should endeavour to give them a rendezvous and deal with situations as they arise. He should establish the divisional collecting station as soon as possible and inform the troops of its position by means of messages sent to the brigade commanders. If acting independently, officers commanding field ambulances will endeavour to get into touch with the regimental personnel by means of the bearers. Dressing stations should not be pitched until the action has developed, and altogether their policy should be to remain in the background until they are required.

No remarks on field medical organization can be considered complete without a reference to aviation; and here, owing to my thorough ignorance of the subject, I must tread warily. It would appear, however, that in two directions at least aviation is already able to render great assistance in the treatment of the wounded: the first is the sending of medical aid to detached parties, e.g., cavalry raids; and secondly, the possibility of saving valuable lives, by bringing wounded quickly and easily within the reach of efficient treatment.
NOTES ON THE MIGRATION OF ASCARIS LUMBRICOIDES.

By LIEUTENANT W. F. CHRISTIE.

Royal Army Medical Corps.

The occurrence of Ascaris lumbricoides in the human intestines has been common knowledge for centuries; Plinius named it Tinea rotunda. The parasite resembles the ordinary earth worm in appearance, having a long cylindrical body about five to ten inches in length, with tapering ends. It occupies as a rule the upper and middle part of the small intestine.

Cases seldom show more than half a dozen round worms at a time, but since one worm produces forty-two grammes of eggs annually, one may wonder perhaps at this scarcity. I have met with as many as seventy-two worms in one small intestine. One boy vomited two and passed twenty-four per rectum in three weeks. (Still.) If their numbers are considerable signs of toxic poisoning occur, often with curious reflex symptoms of nervous origin. Sigaud recorded a remarkable case of "a child, aged 6, who whilst eating his supper became unconscious, the right arm and leg were paralysed, and when after the return of consciousness santonin had been administered, twenty round worms were passed—with the result that the paralysis and the impairment of speech which had accompanied it passed off in a few days." (Gaz. des Hopitaux, June 30, 1904.) The great danger is the wandering of the parasite, fortunately not of common occurrence.

I have been able to collect the records of some eight hundred post-mortem examinations in which the worm was present in the intestines, and in only ten cases have they shown instances of migration, namely, one to the lung, one to the peritoneal cavity, one to the stomach, and seven to the liver. (Post-mortem records, Straits Medical Service, Singapore.) But cases are on record where the worm had found its way into the appendix, giving rise to an acute attack of appendicitis; into the duct of Wirsung, causing acute pancreatitis; up the pharynx and down the trachea with ensuing suffocation; and one case in which the worm passed up the Eustachian tube and gave rise to middle ear disease.

It is difficult to understand the reasons which lead them to start out on these pilgrimages—doubtless to better their position in much the same way as when they migrate from the human body before the death of their host. One must of course distinguish between post-mortem and ante-mortem wanderings; living round worms were found in the bile-duets of two of the seven post-mortem cases mentioned above where migration...
to the liver had occurred; in them there was no pathological change in the liver tissue.

The following cases demonstrate the remarkable power of migration possessed by lumbricoid worms:—

Case I.—A Chinaman, aged 36, a rickshaw puller, died from peritonitis during a severe attack of enteric fever. A perforation was found in a Peyer's patch about six inches above the ileo-cecal valve, and about eight ounces of a turbid yellowish purulent fluid were found in the peritoneal cavity. Lying free in this pus was a dead round worm four inches long, while four more were present in the intestine. Had the worm pierced its way through a diseased portion of gut, or had it passed through an existing perforation caused by the typhoid ulcer?

PLATE 1.

Case II.—A Chinese child, aged 2, had vomited round worms on two occasions, and had passed many more in her stools. After death her abdomen was opened and a condition of general septic peritonitis was discovered. Some twelve worms were present in the peritoneal cavity,
Clinical and other Notes

round each of which the peritonitis was more pronounced. One had formed a localized abscess in the region of the spleen, and three had penetrated the layers of the mesentery and had become partially embedded in it (Plate 1, N, A and B). Careful search was made along the whole length of the bowel for an opening, but no perforation could be found. Some fifty-five worms occupied the small intestine, and one, turned on itself, had completely blocked the common bile duct (Plate 1, S). The liver was the seat of suppurative cholangitis with numerous small abscesses throughout its substance, in one of which two parasites were found coiled up. The general appearance of the peritonitis suggested the probability of infection from the worms themselves, and since they had demonstrated their power of penetrating the mesentery, why should they not have a similar power of penetrating healthy gut? But there was no visible perforation. How did the parasite arrive in the peritoneal cavity?

Case III.—A Tamil, aged 22, died from acute nephritis with marked effusions into the subcutaneous tissues, peritoneum, pericardium, and pleura. Both lungs were in an oedematous condition, and one round worm was found in the left lung—presumably having wandered thither by stomach and oesophagus, trachea, and bronchi. (The commonest route is from the small intestine to the liver through the bile-duets.)

Case IV.—A Chinaman, aged 26, while in hospital suffering from acute bacillary dysentery committed suicide by hanging himself. Two macerated round worms were found in the smaller branches of the hepatic ducts, causing multiple septic abscesses in the liver radicles beyond. I had often wondered how far this liver condition would have spread, had he decided to remain in this world just a little longer. I found my answer in the following case which presented itself to me in February last.

Case V.—A Chinese child, aged 6, was admitted to hospital suffering from diarrhoea and vomiting, of which she died ten days later. At the post-mortem examination we found her small intestine occupied by sixty-six round worms of average size. Both ducts and the common bile-duct contained a round worm, and some three or four smaller worms were seen lying in the smaller branches of the bile ducts (Plate 2, D). Both right and left lobes of the liver were the seat of a suppurative cholangitis, with one large and several small bile-stained abscesses. Two of these, on the upper surface of the right lobe, had given rise to a large subphrenic abscess; this had ruptured through the diaphragm in two places (Plate 2, S), causing two abscesses in the lower lobe of the right lung. The larger of these ruptured into the pericardium (Plate 2, N), the smaller into the pleura, giving rise to a purulent pericarditis and a pyo-pneumo-thorax. Leading into the main abscess in the right lobe of the liver was the pointed end of an Ascaris lumbricoides.
Clinical Significance.

In patients known to harbour such parasites the possibility of migration should always be borne in mind. Thus the presence of ova or worms in the faeces associated with the onset of severe gastritis has occasionally ended in the vomiting of a round worm which had entered the stomach; similarly the occurrence of jaundice along with ova in the stools might suggest the possibility of a round worm in the bile duct. An increase of eosinophils in the blood is a suggestive point in diagnosis, but clinically there are no pathognomonic symptoms or signs, and diagnosis must depend on the appearance of the worm or its ova in the faeces.

PLATE 2.

Case V.—D, round worm in branch of bile duct. S, site of subphrenic abscess, having burst in two places through the diaphragm into lower lobe of right lung. N marks the place behind which larger abscess burst into pericardium. R, abscess in liver. Heart shows purulent pericarditis.

The object of this paper is to show that, in spite of the extraordinary frequency and remarkable number of lumbricoid worms which may be harboured without causing any great inconvenience, in a small percentage of cases they are responsible for pathological lesions of great severity and cause irreparable damage to tissue. Ascariasis therefore should always be considered a serious disease, calling for early diagnosis and
A CASE OF PARATYPHOID FEVER "A" WITH RELAPSE.

BY MAJOR W. R. P. GOODWIN.

Royal Army Medical Corps.

The following case of paratyphoid fever "A" is interesting as showing a typical relapse. Corporal M., East Yorkshire Regiment, was admitted to the Station Hospital, Fyzabad, on November 16, 1913, having been transferred from camp near Sultanpur, where his regiment was undergoing battalion training. He had been feeling unwell for some four or five days previously, with headache, constipation, and general malaise. On admission to hospital, beyond a coated red-tipped tongue and the general appearance of a man with fever, he exhibited no pathological physical signs of any note. Examination of blood smears failed to reveal malarial parasites. A blood culture taken on the eighth day of illness showed the presence of Bacillus paratyphosus "A." He had an uneventful illness, except for slight bronchitis, and on November 29, that is to say on the nineteenth day of the disease, his temperature became normal. The temperature remained normal and the patient steadily improved in every way until December 13, the thirty-third day of his illness and the fourteenth since the temperature had become normal, when he complained of severe headache and feeling generally ill, and his evening temperature rose to 102°F. He had been allowed light solid food on the previous day, and it was at first thought possible that this was responsible for the change, and a return to strict liquid diet was ordered, but the change had no apparent beneficial result. Blood smears again failed to show malarial parasites, and the patient had all the appearances of suffering from a relapse. A blood culture taken on the morning of December 16, that is on the third day from the recurrence of fever, gave a positive result for B. paratyphosus "A." From this time onwards the patient passed through another typical attack of paratyphoid fever, similar to the first attack except that it was much more severe. This second attack was actually shorter than the first, sixteen days as compared with eighteen, but the patient suffered greatly from severe headache and sleeplessness, and the degree of intoxication was much more intense. On the eighth day from the commencement of the relapse a roseolar rash began to appear on the abdomen, this rash increased in intensity and lasted for eight days, in appearance it exactly resembled the "rose-spots" of typhoid fever. In other respects pathological signs and symptoms were absent, there was no tonsillitis, no appreciable enlargement of the
spleen, no abdominal tenderness, and no tenderness over the gall-bladder.

The relapse lasted until December 29, that is for sixteen days, after which convalescence was uneventful and uninterrupted.

As regards the cultural reactions, Major N. H. Ross, R.A.M.C., who carried out the tests, reports as follows:

**Clinical Chart. — I.**

**CLINICAL CHART. — II.**

"First Culture.—Five cubic centimetres of blood taken, incubated in ox-bile for twenty-four hours, and then plated. The plate on the following day showed typical colonies of *B. paratyphosus* 'A.' These were put through the sugar tests, and in every one gave the indications for *B. paratyphosus* 'A.' This result was confirmed by the officer in charge of the Convalescent Depot, Naini Tal.

"Second Culture.—Carried out similarly to the first showed typical
colonies of *B. paratyphosus* 'A' next day. These 'clumped' with 1 in 10 paratyphoid 'A' serum, and not at all with dilutions of typhoid serum."

The case is of interest in showing a typical relapse after fourteen days of convalescence, the blood giving positive cultural reactions, in the occurrence of a roseolar eruption during the relapse, and in the absence of tonsillitis and tenderness over the region of the gall-bladder—so often seen early in paratyphoid fever—and the absence of enlargement of the spleen. Other points which one notes on inspecting the chart are the comparatively slow pulse-rate, even at the height of the fever, and the marked daily remissions in the temperature before finally becoming normal.

A PECULIAR CASE OF HÆMOPTYSIS.

BY LIEUTENANT JAMES C. SPROULE.

Royal Army Medical Corps.

I HAVE recently had a patient under my charge who suffered from hæmoptysis, and the interesting relationship which the condition bore to her menstrual periods appears to me to make the case worthy of record. The woman, aged 42, is the wife of a serjeant, and I was called to see her on June 27, 1913, as she was spitting up considerable quantities of blood. The patient's previous history reveals no serious illness. She had her first menstrual period at 15 years of age, when she spat up a little blood. She always had slight hæmoptysis at each period till she was 27 years old, when the hæmoptysis on one occasion was so severe that a doctor had to be called in. Slight hæmoptysis occurred at each menstrual period thereafter. The periods were always regular, lasting four days. The amount of the flow seemed to have some relation to the amount of the hæmoptysis, as when the latter was copious the former was small in amount, and vice versa. There was no abnormal pain during the period of menstruation. She was married at 32 years of age and has been pregnant twice. The first, a boy, is alive and well. The second was a miscarriage. During the time she was pregnant the hæmoptysis ceased. The patient states that there was no lactation and that the breasts enlarged very little. About ten months after parturition the menstrual flow and the hæmoptysis re-appeared. At this time she was anæmic and the periods were irregular. Sometimes she would miss two or three periods, but at each there was definite hæmoptysis. During the last few years, just previous to menstruation, she has had severe headaches and something seems to "stick in her throat" which she tries to cough up.

The family history is of no importance. The patient is the third of a family of nine and none of the sisters suffer from hæmoptysis.

On examination the patient was found to be emaciated and anæmic; he lungs normal; the breasts not enlarged although there was a dark
Clinical and other Notes

Aureola around the nipples. The heart was normal. The stomach was enlarged and succussion easily obtained. The uterus was not palpable. The patient was in a menstrual period. She told me she had been coughing up blood since the morning and showed me a receptacle with about half a pint of bright-coloured blood in it which was not frothy. She was put on a mixture containing calcium chloride gr. 10 per dose, three hourly.

On the 28th I again saw the patient. The haemoptysis was more profuse than it had been the previous day. As she was becoming uneasy I gave her a hypodermic injection containing ergotinine citrate gr. 10 and morphine tartrate gr. 3 at 11 a.m. The haemoptysis stopped about half an hour after this and remained absent till the afternoon, when she took some hot tea, after which she spat up a little blood. The stools were normal in colour and consistency.

On the 29th the patient looked much better. There had been no haemoptysis since the previous afternoon. The menstrual flow had stopped. She was out of bed and in her usual state of health two days after the cessation of haemoptysis.

I regret that I was unable to watch this case for a long period, as I was sent for duty to another station on July 5. On my return I found that the patient had left the station. A short time ago I had a letter from her in which she stated that her menstrual flow was irregular, small in quantity, and had almost stopped. She also stated that of late there had been no haemoptysis.

I think the interesting points in this case are:

1. The definite history of haemoptysis occurring and continuing through each menstrual period.
2. The cessation of haemoptysis during pregnancy.
3. The re-appearance of haemoptysis after parturition at the same time as menstruation.
4. The history of feeling something "stuck in the throat."
5. The cessation of haemoptysis when the menstrual flow was ceasing.

From the history and examination of this patient I concluded that this was a case of vicarious menstruation. I have looked up several authorities, but up to the present I have been able to find very little literature on the subject.

In conclusion I must thank Dr. Payne and Captain Walshe, R.A.M.C. (S.R.), for their many valuable suggestions concerning this case.
A CASE OF ACUTE POISONING BY BETA EUCAINE.

By LIEUTENANT L. F. K. WAY.

Royal Army Medical Corps.

Poisoning by beta eucaine being so rare I venture to report a case which occurred while I was doing a circumcision on a young healthy soldier. The solution of beta eucaine and sodium chloride had been freshly prepared and a few drops of adrenalin added. A quantity of this solution containing rather less than two grains had been injected into the body and root of the penis. As the operation was about to be started the patient became very quiet and pale, and said he felt faint. His limbs began to twitch, and the little finger of the right hand became tightly clenched. His breathing became slow and laboured, the pulse-rate was increased, and the pupils contracted almost to the size of a pin's point. He became very much cyanosed, his breathing nearly stopped, and he completely lost consciousness. Artificial respiration was carried out and strychnine injected. Under this treatment he soon revived and the operation was carried out. For the next twenty-four hours he was very drowsy and sweated profusely, otherwise he made an uneventful recovery.

The interest of the case lies, I think, in: (1) The rarity of such poisoning; (2) the indication that the patient should never be left after the anaesthetic has been given; (3) the fact of the pupil being contracted, whereas in cocaine poisoning it is dilated; (4) the small amount of the drug which caused such a sudden and severe case of poisoning, the dose being five to ten grains.  

AMBLYOPIA AND INVALIDING.

By CAPTAIN R. M. DICKSON.

Royal Army Medical Corps.

The expression amblyopia means weak or blunt sight and is used to designate a somewhat vague disturbance of vision for which treatment is of no avail. With our standard of vision for enlistment the condition is probably fairly common in the Army. I have known cases invalided as astigmatism when the real cause of the defective vision was amblyopia. An amblyopic is invariably a bad shot and his vision cannot be improved with glasses.

I wish to bring to notice nine cases of invaliding for amblyopia from India, and would emphasize the fact that many such cases have come to light and were allowed to remain in the service as the acuteness of vision was sufficient to pass the standard. These cases all conform to

1 Husband's "Forensic Medicine and Toxicology."
2 Whitla's "Materia Medica."
the nervous type of the disease for which there is no discoverable cause. The other varieties of the disease must be very rare in the Army. They may be just mentioned:

Toxic amblyopia, due to poisoning.—Quinine amblyopia is an example of an acute poisoning producing serious disturbance of vision. It is produced by repeated doses reaching a large total in twenty-four hours. Tobacco blindness is the commonest form of chronic poisoning. This must be rare amongst soldiers, as it appears to be induced only by pipe and cigar smoking.

Amblyopia due to disuse.—The common example is found in an eye which has squinted from childhood. The squint must be sufficiently pronounced to interfere with binocular vision.

Congenital amblyopia.—It is only justifiable to diagnose congenital amblyopia when other congenital abnormalities are present in the defective eye.

The details of the nine cases are shown in the table on next page.

The diagnosis involves a careful examination with the ophthalmoscope to exclude diseases of the fundus and media. The only ophthalmoscopic sign in amblyopia, pallor of the temporal half of the disc, was noted in but three cases. Retinoscopy was invariably carried out under homatropine. The majority of cases showed high refractive errors, and in no case did correcting lenses produce any improvement in the vision. Apart from the amblyopia these errors of refraction should be no deterrent to a man becoming a first-class shot when provided with suitable glasses. I may quote two high astigmatic cases in evidence.

Myopic astigmatism—

<table>
<thead>
<tr>
<th>Right eye</th>
<th>Left eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 10</td>
<td>- 4.5</td>
</tr>
<tr>
<td>- 5.5</td>
<td>- 2.75</td>
</tr>
</tbody>
</table>

Third-class shot without glasses.

Good first-class shot with glasses.

Hypermetropic astigmatism—

<table>
<thead>
<tr>
<th>Right eye</th>
<th>Left eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 5.5</td>
<td>+ 4.5</td>
</tr>
<tr>
<td>+ 4.5</td>
<td>+ 3</td>
</tr>
</tbody>
</table>

Bad third-class shot without glasses.

Marksman one month after glasses provided.

The most important and most constant symptom of the disease is concentric contraction of the field of vision, and this was present in every case. The field can be tested accurately only with the perimeter, and it is noteworthy that this symptom cannot be malingeringed. There are two points about the form of contraction which help to distinguish it from concentric contraction found in other diseases: (1) It affects both eyes
<table>
<thead>
<tr>
<th>Musketry classification</th>
<th>Vision, R. L.</th>
<th>Colour sense</th>
<th>Fields of vision</th>
<th>Retinoscopy, R. L.</th>
<th>Ophthalmoscopic examination</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Marked contraction</td>
<td>+4'5 +6</td>
<td>Temporal half of discs pale</td>
<td>Vision always bad.</td>
</tr>
<tr>
<td>2 Never qualified</td>
<td>6 6 6 6 to 6 6 6 6</td>
<td>Colour-blind</td>
<td>Marked contraction</td>
<td>+1'5 +2</td>
<td>Temporal half of discs pale</td>
<td>Vision always bad.</td>
</tr>
<tr>
<td>3 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Very marked contraction</td>
<td>+6 +6</td>
<td>Fundi normal</td>
<td>Vision always bad.</td>
</tr>
<tr>
<td>4 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Marked contraction</td>
<td>+1'5</td>
<td>Fundi normal</td>
<td>Vision always bad.</td>
</tr>
<tr>
<td>5 Third Class shot</td>
<td>6 6 6 6</td>
<td>Colour-blind</td>
<td>Marked contraction</td>
<td>+2'5 +3'5</td>
<td>Fundi normal</td>
<td>Absent from school for a year on account of bad eyesight.</td>
</tr>
<tr>
<td>6 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Marked contraction</td>
<td>Em. +3</td>
<td>Temporal half of discs pale</td>
<td>Always had difficulty in reading.</td>
</tr>
<tr>
<td>7 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Colour-blind</td>
<td>Very marked contraction</td>
<td>+175 +1'5</td>
<td>Fundi normal</td>
<td>Vision always bad.</td>
</tr>
<tr>
<td>8 Bad 2nd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Very marked contraction</td>
<td>+175 +1'5</td>
<td>Fundi normal</td>
<td>Latent internal squint.</td>
</tr>
<tr>
<td>9 Bad 3rd Class shot</td>
<td>6 6 6 6</td>
<td>Defective</td>
<td>Marked contraction</td>
<td>+4</td>
<td>Fundi normal</td>
<td>Periodic internal squint R. eye.</td>
</tr>
</tbody>
</table>
Clinical and other Notes

more or less equally. (2) It is almost uniform in degree in each meridian.

In three cases the acuteness of vision was found to vary at different dates, and this fluctuation has been noted as a feature of the disease. Two cases showed decided signs of hysteria. One man burst into tears on the range, and another became so excited that he was considered dangerous and his rifle was taken from him. In every case the colour sense was affected as tested with Holmgren’s coloured wools.

If an amblyopic fails to pass the standard of vision the only resort is invaliding. It is difficult to know what is to be done with the man who reads $\frac{2}{5}$ or even $\frac{4}{15}$, who is a very bad shot and cannot be improved with glasses. A third-class shot suffering from amblyopia would be less useful on service than is indicated by his musketry score. Nearly all his points are made at short ranges; and after straining the eyes, especially if exposed to the sun, his shooting becomes rapidly worse until he can see neither the target nor the sights of his rifle. Much trouble and expense would be saved if these cases could be prevented entering the service; but after six months’ experience as medical examiner of recruits, I realize the impossibility of diagnosing amblyopia or any fundus trouble at enlistment.

There are two periods in the life of a recruit when his eyesight could conveniently be tested:

(1) Under three months’ service, if a low standard of vision is noted in his medical history sheet. It is an advantage of this period that the recruit can be rejected as unfit without any waste of time or trouble, besides the saving of expense to Government.

(2) After three months’ service, if he has failed to qualify in Table A. Six months appears to be the average service of a recruit when he fires this course. It is a disadvantage that the question of the examination would be left in the hands of the regimental officer. I know of several young soldiers who were allowed to come out to India who failed to qualify in this recruits’ course on account of defective eyesight. Authority for the examination is found in Musketry Regulations, preliminary training—“some men lose their power of definition when straining the eye. In serious cases the soldier should be medically examined with a view to discharge or the provision of proper glasses.” The examination would require to be done by a specialist and recruits with defects of vision which would prevent efficient shooting could be rejected at once. It would be a means of still further reducing the invaliding returns, and I hope to see the matter taken up by those having authority.