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SOME OCULAR MANIFESTATIONS OF HYSTERIA

BY WALTER BAER WEIDLER, M.D.

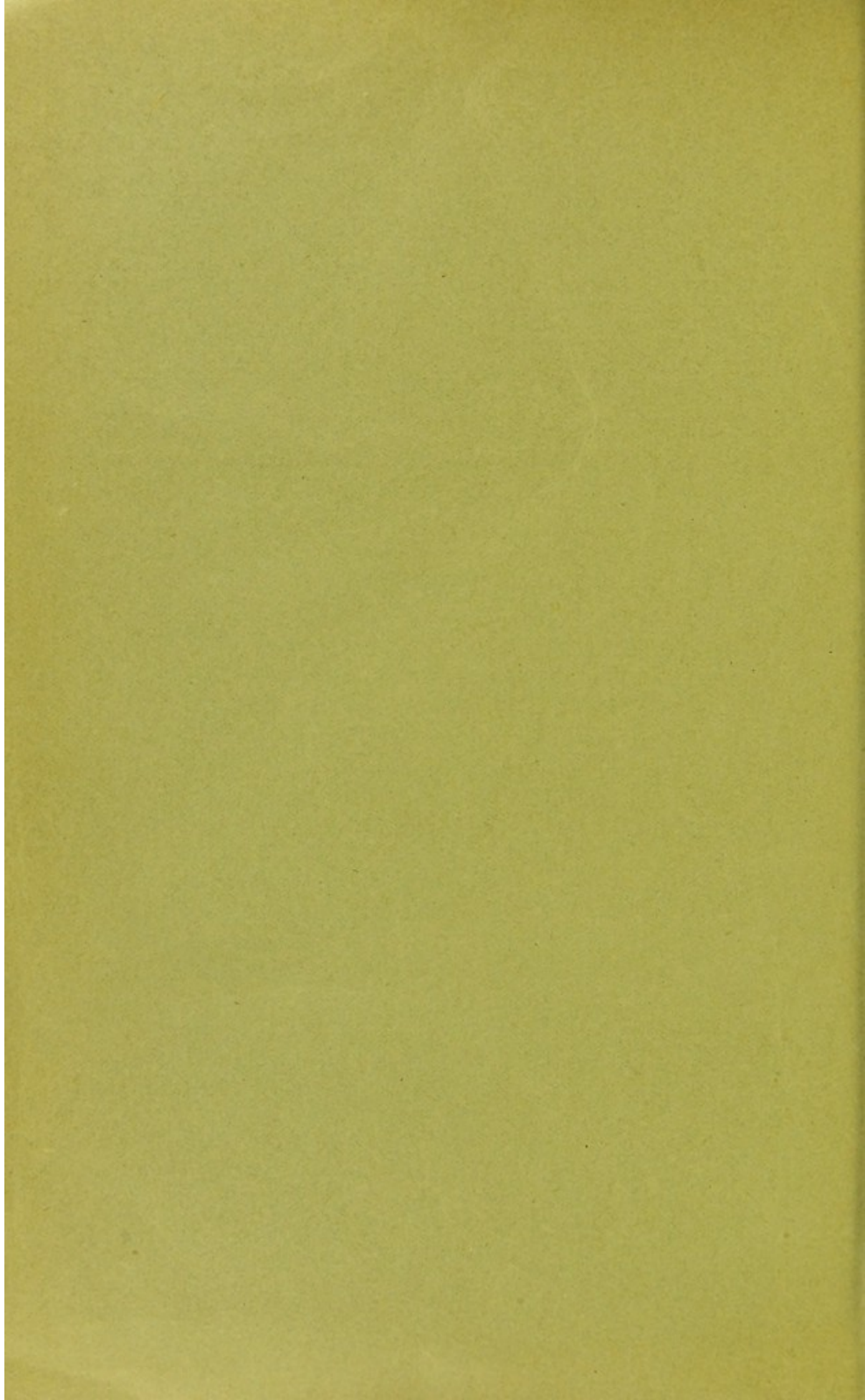
NEW YORK CITY

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## SOME OCULAR MANIFESTATIONS OF HYSTERIA \*

BY WALTER BAER WEIDLER, M.D.

NEW YORK CITY

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THE ocular manifestations of hysteria should be of great interest to the physician as well as to the ophthalmologist. Charcot was the first one to insist that our investigations and studies of hysteria should be from a physiological standpoint instead of an anatomical one. In other words, we might say that hysterical symptoms do not necessarily imply a lesion of an organ, nerve or of a nerve-centre, but rather a disturbance of function. The latter-day studies of hysteria from the *psychological* side of the question have been the means of clearing up many doubtful points in the diagnosis of this most complex disease. The more we study our hysterical patients the more we are convinced that the hysterical subject is not a clever simulator, as was formerly believed, but a sufferer from a genuine disease. Considered from the ophthalmologist's point of view, the ocular manifestations of hysteria are singularly constant and dependable, the symptoms being quite definite in many of the cases.

De Schweinitz has given a very good classification of the ocular manifestations of hysteria, but I have changed his classification to some extent in this paper. The different affections of hysteria have been placed in their anatomical order; that is to say, hysterical affections of the eyelids, of the extra-ocular muscles, of the intra-ocular muscles, *i.e.*, the iris and the ciliary body, of the retina, and the optic nerve. Let us therefore classify these various affections more in detail as follows:

1. Those affecting the movements of the eyelids and extra-ocular muscles, such as *contractures*, *spasms*, and *palsies*.

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\* Read before the Tri-Professional Society at Hotel Astor, Dec. 21, 1911.



2. Those affecting the movements of the iris, or *pupillary changes*.
3. Those affecting the movements of the ciliary body, or *accommodative changes*.
4. Painful visual sensations, or *asthenopia*.
5. Partial loss of vision, or *amblyopia*.
6. Complete loss of vision, or *amaurosis*.

7. Other ocular changes not included in the above and at present impossible to classify, such as disturbances of sensation and secretion affecting the lachrymal gland and the skin of the eyelids. This classification will readily show the wide and varied disturbances that the eye alone can present in hysteria. Hysterical affections may be spoken of as those of permanent duration, which means that they may last for years, or those which are transitory, lasting for days, weeks, and months.

*Class 1.*—There is a condition, frequently seen, affecting one or both eyelids, which we call blepharospasm. This may be of two forms, the clonic and tonic. In the clonic form we have continuous blinking of the eyelids, which may be seen as a constant vibration or trembling of the closed or half-closed lids. This condition may persist even during sleep. The tonic variety is convulsive. The skin of the lids is forcibly folded and the palpebral margins are tightly closed. It will be found difficult to open the lids with the fingers, and there is usually marked photophobia associated with the tonic form of blepharospasm. From the clinical standpoint there are also two forms of blepharospasm, the painful and nonpainful. These spastic affections of the lids may appear suddenly and disappear in the same manner, or they may last for years. Hysterical blepharospasm may be due to a spasm of the orbicularis palpebrarum muscle or to a hypersensitive condition of the retina. We may see at times pseudoparalytic ptosis caused by a cramp or spasm of the palpebral portion of the orbicularis. This condition must not be confounded with true ptosis or paralysis of the levator palpebral muscle. In pseudoparalytic ptosis the upper lid droops without much wrinkling of the skin, which condition is more or less constant in true ptosis. The lids, if raised by means of the fingers, when released fall more rapidly, and the patient may, if his thoughts be decentered for the moment, open the lids. These hysterical patients very often are able to open the eyes in the dusk or in a dull light. Landolt has



pointed out the following test for making a differential diagnosis between ptosis and orbicular spasm and between paralytic and hysterical ptosis (*International Clinique*, 1901). The differential diagnosis between paralytic ptosis and closure of the lids from spasm of the orbicularis is readily made by observing the patient's forehead. Where there is paralysis of the upper lid, the eyebrow is elevated, because the patient tries to lift the eyelid by contracting the frontalis. In spasm of the orbicularis the eyebrows follow the contraction of this muscle and descend below the normal line.

*Differential diagnosis between paralytic and hysterical ptosis:* "Suppose a patient whose upper lids are lowered is brought to me. She pretends to be unable to open her eyes. I place her in front of me and tell her to look fixedly at one of my eyes. To do so, she inclines her head strongly backwards so that her gaze may pass under the drooping lids to my eye. Then I put my hand on the top of her head and exhort her energetically to continue to look at my eye. At the same time I raise my head. I incline hers gradually forward. If the pupils of the patient remain uncovered during this procedure I have evidently to deal with hysteria, because, to affect this, the lids have to raise themselves with the eyes whilst the face is lowered; in fact, keeping the eyes open whilst the head is inclined forward is equivalent to raising the eyes and lids when the head is straight, a thing absolutely impossible in paralysis of the levator palpebræ, in which the patient ceases to see objects as soon as the head leaves the compensating position, because the lids cover the pupil immediately." Another picture presented in hysteria is spoken of as hysterical paralysis of the levator palpebræ or flaccid hysterical ptosis. This form of paralysis is denied by Charcot and Borel, but it is defended by Schmidt-Rimpler, Kiemann, and Wilbrand. They claim that the ptosis is due to a relaxation of the levator fibres. It is usually bilateral and may come on gradually or suddenly, and is often accompanied with many of the other hysterical ocular disturbances, such as amblyopia, or amaurosis and contraction of the field.

CASE I.—Miss G. B., æt. 13, white, general health good and family history negative, except for the mother, who had acute glaucoma 20 years ago. At the present time we can see the coloboma from the iridectomies which were done at the time. About five or six months ago patient noticed that the upper lid of the left eye began to droop, and she was unable to elevate it at these times. This was not continuous during this period of months. On October 15, 1909,



she presented herself at the New York Ophthalmic and Aural Institute and on examination we found a slight drooping of both lids, though much more pronounced on the left than on the right side. She was able to elevate both lids when an effort was made to do so, but whenever she fixed her eyes on an object for a few seconds the ptosis would again present itself. This condition was more constant on the left side, the opening between the lids being 5 mm. Forehead wrinkled and brows raised from the constant effort to open the lids.

202. Pupils are 4.5 mm.; irides brown, and reacting to light, accommodation, convergence, and tension normal. Vision OD. 5/5, OS. 5/9, and the accommodation is O.D. 8-54 mm., OS. 8-56 mm., Jaeger No. 1.

*Ophthalmoscope.*—O.D. Media clear, disc is oval 7x8, long axis 90. Scleral ring all around, central excavation small, vessel long axis 90°.

OS. Media clear, disc is oval, long axis 90. Scleral ring all around, central excavation small. Veins dark and full, vessels long axis 90°.

The corneas were hypersensitive and there was photophobia and marked lacrymation. There is a fibrillary tremor of the orbicularis muscle, and patient says that she is conscious of the same.

11-19-'09. Vision OD. 5/4, OS 5/4. Accommodation OD. 6-50, OS. 6-50, Jaeger No. 1. Patient inclines the head backwards so as to see through the partially closed lids. Sensation of the cornea, nasal and pharyngeal membranes somewhat plus. Temporary diplopia for near. The ptosis is so complete on the left side that it is not possible to make her open lids by any suggestion. Many psychological suggestions were tried, but failed to make her open her eyes. At different times patient walks in her sleep, but has never fallen or hurt herself in any of her somnambulistic spells.

11-30-'09. This morning, on arising, the right lid was well open and the left partially so. Later in the day the ptosis returned in its usual manner. Sensation over the skin of face and body normal. Station good, coördination fair, gait normal, the reflexes were perhaps a trifle increased.

1-11-'10. On arising the lids were both open to the normal degree and there was no manifestation of the ptosis. This has occurred quite frequently of late, but later in the day the drooping returns. Study and any attempt to use the eye cause the ptosis to appear.

When one lid is forcibly elevated with the finger the lid on the opposite side falls, covering the eye completely. Glasses were prescribed at this time, thinking that they might relieve some of the sensory irritations. She was given OD. +0.50cyl axis 90° OS. +0.25 cyl. axis 90°, constant wear.

3-11-'10. Able to open her eyes better and the lacrymation is much less. Still the diplopia, but not constant.

6-11-'10. The ptosis is very much less on the left side and, in fact, at times it is entirely absent. Now we find that the ptosis is much more pronounced in the right lid. This is a direct reversal of the paresis. A photograph that was taken at this time shows the order of things. She has greatly improved under treatment up to this time, and I have always assured the mother that the condition would eventually clear up.

2-4-'11. Patient has been under observation for nearly a year and a half and the ptosis has changed to the right side, as above stated. The ptosis would change from one lid to the other in the midst of an examination. Patient is thoroughly conscious of the fact that the ptosis changes from one eye to the

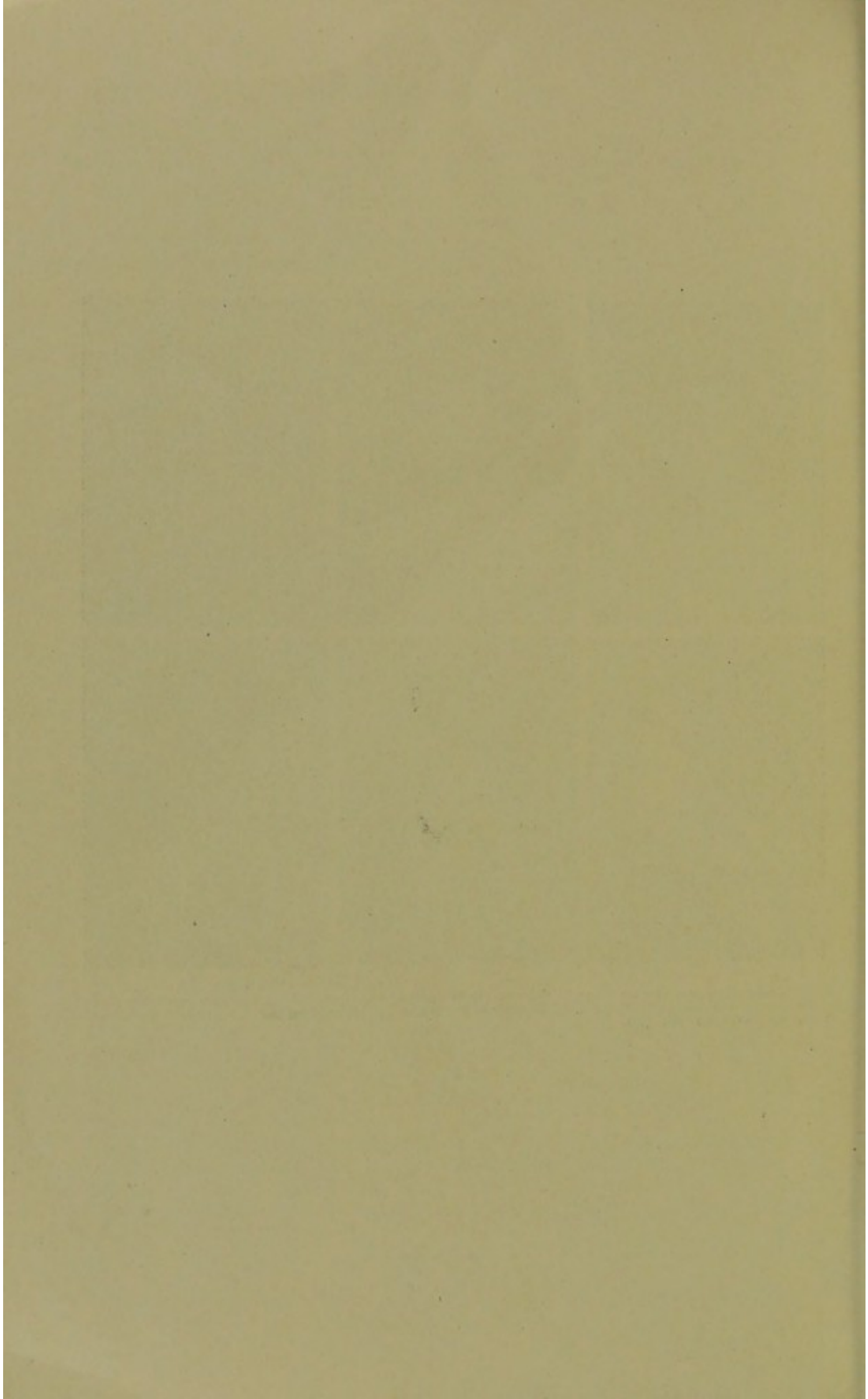


FIG. 5.



These photographs were taken at different times in groups of three. The upper row was taken three months after the ptosis (?) appeared. The lower row one year later, showing that the ptosis had changed from the left to the right eye.







other and that thinking about it always makes it worse. If her friends speak to her of the condition it is always more marked. During the treatment she has gained about twenty pounds in weight. Her general health was never better. She is a good student and her standing in her school and class has always been the very best. The presence of the ptosis has not interfered with her studies and work in any way. She is now becoming more and more conscious of the condition and is especially anxious to get well. When I first saw her she was not worried about the trouble and seemed to enjoy the novelty of the disease. She is now more anxious to get rid of the disfigurement.

The fields that have been taken through the period show great differences. This is not unlike most of our hysterical case histories. There has been the dischromotopsia. This I have been able to demonstrate a number of different

FIG. 1.

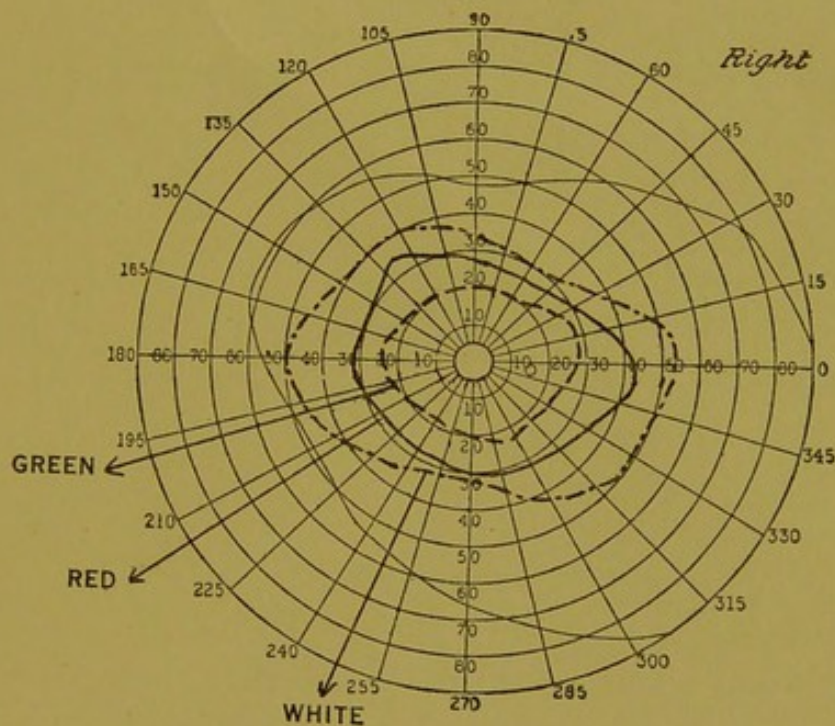


Chart shows concentric contractions, but no scotoma. 10 mm. disc. Date, 11-5-'09.

times, and the copy of the field that is shown was made 3-8-'10. The upper portion of the field was cut off by the drooping of the lids, and when they were held up the upper boundary was out beyond the normal limit of white. (Figs. 1-5.)

1-6-'11. Lids are open most all of the time. There is still some drooping of the right late in the afternoon. Patient is generally much improved since she has been under treatment of Dr. Beling, who has used hypnotic suggestion. During this examination she was told to close her eyes and remain perfectly quiet. After a few seconds of quiet I clapped my hands before her eyes and she immediately opened both of them wide. The lids of both eyes remained open for about two or three minutes. Cocaine dropped in the eyes showed no change in the palpebral openings. There is still some diplopia for near but



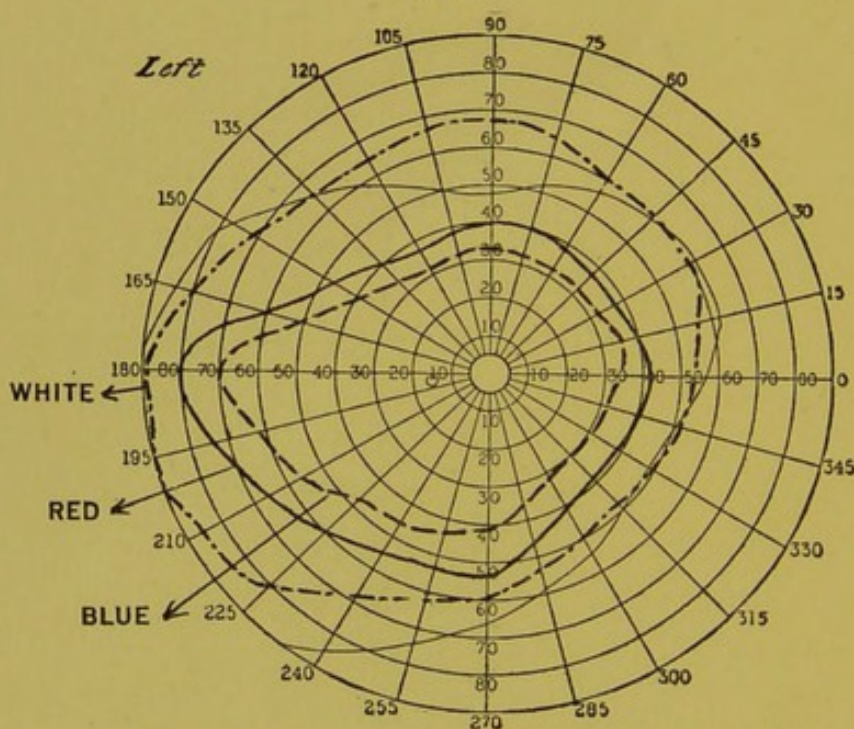
none for distance. Convergence is weak on the right side, but, on looking to the left, eye is rolled far into the inner canthus, showing no loss of the converging power of the internal rectus, except when she attempts a coördinate act in this muscle. Dischromatopsia is demonstrable at the present time.

*Report of Dr. C. C. Beling.*—January 7, 1912. Patient complains of a drooping of the right upper eyelid.

Family History: Negative.

Personal History: Her birth and growth were normal. In childhood she suffered from nightmares, somnambulism, and frequent dreams. About two and one-half years ago she says she went down to the cellar, when a boy jumped out from behind the cellar door and gave her a sudden fright. Soon after this incident she had an hysterical attack in the bathroom and a little

FIG. 2.



Reversal of colors (dischromatopsia). 10 mm. disc. Date, 3-18-'10.

later was somnambulant. Referring to this period she says: "Two or three times I had peculiar spells; when I tried to stand on my feet, my head began to swim and I could not stand." Shortly after the fright it was noticed that the left upper eyelid drooped. Six months later the right upper eyelid was similarly affected. Since then there has been an alternating ptosis in one eye or the other. Recently, however, the ptosis has been confined to the right eyelid.

Present Condition: Careful examination fails to reveal any organic disease. There are no sensory disturbances of any kind. The right upper lid is in a condition of partial ptosis, which becomes aggravated when her attention is directed to it. With it is associated an elevation of the right eyebrow, which seems to be due to a more or less continued effort to open the eye. With in-



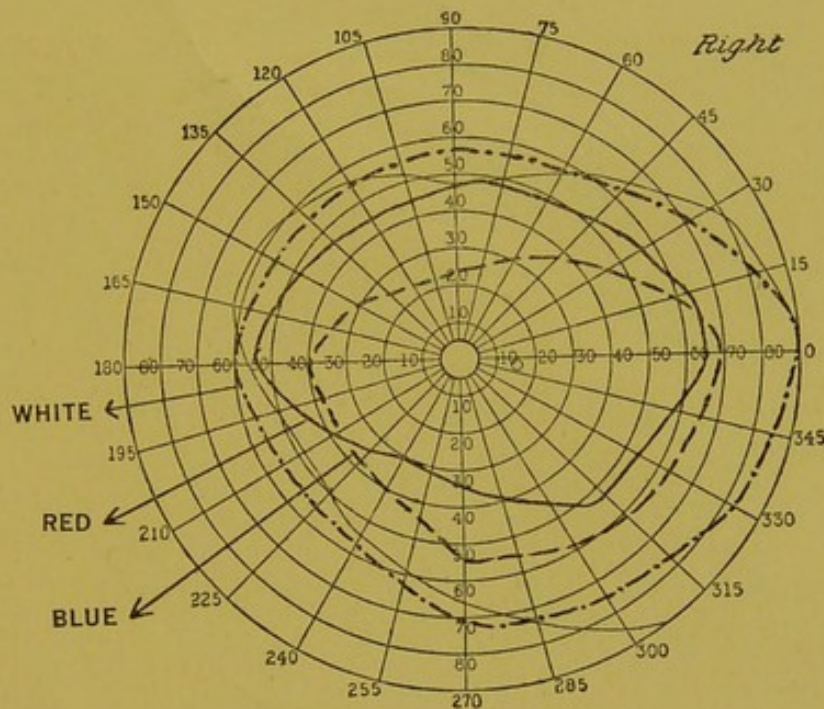
creasing ptosis the eyebrow is more markedly elevated. The left eyelid is normal. The movements of the eyeballs are normal.

Under light hypnosis and suggestion the patient opens both eyes widely and normally. Right ptosis recurs later.

The superficial and deep reflexes are all present. The knee reflexes are somewhat increased. There is a tenderness on pressure over the right temporal fossa, just above the zygomatic arch. Palpation reveals a thickening, which can be felt under a freely movable skin. The patient, however, has not complained of this.

Diagnosis: Functional paralysis of the right levator palpebræ superioris. Associated contraction of the right occipitalfrontalis (mostly voluntary). Emotional states and repeated examinations have probably tended to retard recovery.

FIG. 3.

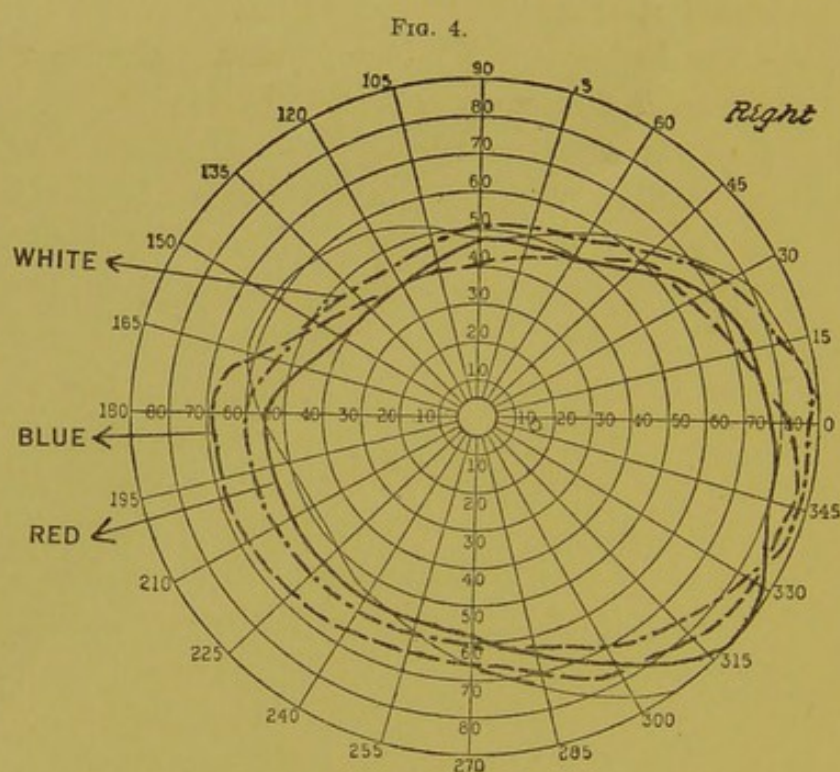


Reversal of colors (dischromatopsia). 10 mm. disc. Date, 3-19-'10.

Hysterical affections of the extra-ocular muscles may select any one or group of muscles, presenting all degrees of paresis. There may be excessive or insufficient action of any one or all of the muscles of the eyeball. Koenig states that there has never been a true case of hysterical paralysis of the external eye muscles published. These affections should be regarded as cramps or contractures, just as we see contractures affecting any of the muscles of the body. The spastic strabismus seen in the hysterical is really a contracture of convergence, and is often seen at the beginning of a grave hysterical outbreak. A permanent convergent strabismus must not be thought of



as a result of hysteria. In regard to palsies affecting individual muscles, we find a great diversion of opinion. A number of cases of paralysis of one muscle at a time have been reported by such excellent observers as Guttman, Duchenne, Borel, Wilbrand, and Parinaud. Notwithstanding the fact that Parinaud has reported a case of paresis of the abducens and the third nerve, he says: "The so-called hysterical paresis should be explained by what are sometimes described as associated ocular paralysis—that is, although the eyes cannot make certain movements in which they are usually associated,



All color limits are enlarged, with reversal of colors. 10 mm. disc. Date, 11-11-'11.

the directing power of the muscles may be unimpaired when they exercise their function in a different direction. In other words, there is a paralysis of movement and not of the muscles supplied by a given nerve."

*Class 2.*—The pupillary changes are most varied and can be put down as:

- (a) *Contractions of the pupil* or spasmodic myosis.
- (b) *Dilatations of the pupil*, which may or may not respond to light.
- (c) *Alternate contraction and dilatation of the pupil.*



These affections of the pupil have no definite duration, and they are usually bilateral, but cases of unilateral dilatation have been reported by Tourette, Mendel, and de Schweinitz. It is perhaps cortical in its origin, but a tonic cramp of the iris is a possibility without the pupil reacting to light. It is a well-known fact that it is possible to have a tonic cramp of the arm and the biceps reflex be absent. Hare and de Schweinitz have reported a case of complete amaurosis with mydriasis of the right side, the dilated pupil reacting sluggishly to light and moderately to eserine, with marked myosis on the left side and moderate amblyopia in an hysterical woman in whom the condition had existed for many years. The use of drugs in this case had been absolutely excluded by keeping the patient under the observation of a nurse all the time. Some authorities claim that it is possible to make a differential diagnosis between epilepsy and hysteria by observing the pupillary reactions. In epilepsy the pupils are widely dilated and do not react to light or accommodation, whereas in hysteria the reaction of the pupil is retained.

*Class 3.*—We may have partial or complete loss of the action of the ciliary muscle. This muscle, as we all know, is chiefly concerned in the act of accommodation. *Hysterical cyclospasm* is made evident when an attempt is made to fix the eye upon a given object, which at first may be plainly seen and then later becomes indistinct and blurred. Diplopia or double vision may be present. In hysterical cycloplegia, or paralysis of the ciliary muscle, the patient is no longer able to fix or accommodate his eye for small objects, and is therefore unable to read fine print, due to the recession of the *punctum proximum* or the near point. This is best and most easily demonstrated by the Yeager reading test type. This condition is usually bilateral, accompanied, as a rule, with paresis of convergence, as the internal recti muscles are so closely associated with the ciliary body in the act of accommodation. The size of the pupils is generally unchanged, but cases with dilatation have been reported. Unilateral hysterical accommodative paralysis is very doubtful. These ciliary muscular phenomena must be considered as a form of spasm, and may be either partial or complete.

Parinaud, in speaking of these affections of the ciliary muscle, says that the loss of the accommodation and the diplopia are due



to some changes in the lens itself, which we know is directly affected by the action of the ciliary muscle. He states, in an article published in the *Annals d'Oculistique*, 1898, that: "The disposition of the anterior portion of the lens in three segments favors the change in curvature, but at the same time, owing to their separation from one another by layers of amorphous material, each section possesses a focal point of its own, capable of producing images distinct from those yielded from the lens as a whole. The condition of spasm, by increasing the convexity of the anterior surface of the lens, serves to emphasize the diplopia arising from structural defects described." It does not seem to the writer of this paper that the crystalline lens is capable of having such great changes take place in its size, shape, and structural arrangement as to explain all the symptoms that are present in this condition. I am more inclined to believe that here again the psychical forces of hysteria are in evidence and can better explain these phenomena.

*Class 4.*—A certain number of our hysterical patients present what is known as asthenopia, or painful vision. This condition is accompanied with photophobia, lachrymation, and pain in the temples. Most all of these symptoms can be explained by a hyper-sensitive condition of the retina. The various symptoms have been spoken of as "*hysterical kopiopia*," "*hysterical ocular pain*," and "*painful accommodation*." There is, as a rule, no reduction of vision, but any attempted use of the eyes is followed by ocular pain, headache, and micropsia. Continued use of the eyes in this phase of ocular hysteria is an impossibility, and these patients often wear tinted glasses to relieve the symptoms complained of.

*Class 5.*—In the cases of *hysterical amblyopia*, or temporary reduction of vision, we usually find that the visual field is concentrically contracted. One of the peculiar changes found in the visual field is known as dyschromotopsia, or reversal of the normal relation of colors. This condition is due to an anaesthesia of the retina, in contradistinction to the hyperaesthesia which we find in the cases of asthenopia. The visual acuity is suddenly lowered in what was previously a normal eye, often without any apparent cause. We are unable to demonstrate any refractive error or any ophthalmoscopic changes in the fundus. The fields of vision may show a variety of changes from the normal. Most frequently we find concentric con-



traction of the field, according to de la Tourette's investigations. Dan says that "this is almost a constant symptom in hysterical patients and the most common of all the forms of anæsthesia." There may be many variations from the normal field found in our hysterical patients. In the normal color field *white* is first seen, then follow *blue*, *red*, and *green*, occupying a regular position and bearing a relative relation to each other. In hysteria this relation is usually disturbed, and we may find inversion of the red and blue, more rarely of the green. Cases have been reported where the red color may even take the limit of the white field. Hysterical amblyopia may come on without any apparent cause, or it may follow traumatism, affecting one or both eyes. It may last for any period of time, that is to say, for days or even for years.

CASE II.—K. F., æt. 25, was first seen by me when she was a patient in a hospital, suffering from general hysteria. She was being treated by the daily use of the actual cautery along the spine. Patient was later discharged from the hospital cured. About one year later she was working in an umbrella factory and was accidentally struck in the right eye with a rib of an umbrella. She was brought to my office half an hour later. She was in great distress of mind and told me that she could not see with the right eye.

When the vision was tested she was able to read as follows: O. D. 20-200, O. S. 20-20, accommodation normal in the left and gone in the right. Examination of the right eye failed to reveal any injury to the cornea, media, or fundus. Most careful ophthalmoscopic study gave no explanation for the great reduction of vision. Previous to the accident the visual acuity in the right eye was 20-30 (I had examined her eyes for glasses). Test was made with lenses, and on placing a  $-0.5$  spherical before the right eye the patient was able to read 20-50, but on removing this lens the vision again fell to 20-20. Placing again the  $-0.50$  spherical lens before the right eye, the vision was again 20-50; then by placing a  $+0.50$  spherical in front of the  $-0.50$  spherical, thus neutralizing the first lens, the patient could read 20-20. In three days after the accident the vision returned to normal.

In these cases the vision may be very much reduced and the field may be perfectly normal, or the fields contracted and the vision normal. This was a case of traumatic amblyopia in which we had a clear history of shock. Charcot was the first one to call attention to this group of symptoms in hysteria and to describe them under the name of "*traumatic hysteria*." This was disputed by Oppenheim and Thomson, who attempted to make these nervous symptoms a special disease to which they have given the name of "*traumatic neurosis*." In case of doubt as to the identity of hysteria



or traumatic neurosis, the eye findings will often clear up the difficulty.

These cases may become of importance from a medicolegal standpoint. In making the diagnosis, one must bear in mind the necessity not only of measuring the visual field and determining the central acuity of vision, but also of establishing the presence of those accommodative and convergence changes which we know may exist without amblyopia. Traumatic hysteria leads us to a study of the so-called reflex amblyopias and those ocular symptoms that are produced as a result of peripheral irritation. In other words, we must seek carefully in all cases of supposed hysterical conditions for a possible underlying cause that may not be at first apparent but does oftentimes exist. Some of the hystero-traumatic-amblyopic patients may even simulate the symptoms of sympathetic ophthalmia. Parinaud has put on record three of such cases occurring in men and following an injury to one eye.

*Class 6.*—*Hysterical amaurosis* is complete loss of vision, affecting one or both eyes and lasting for hours and sometimes for years. The loss of vision is complete for objects and color, but there may be a slight perception for very bright light. This condition may come on slowly or suddenly, and in these cases there is complete absence of any defects of the cornea, media and fundus. Many of the other hysterical symptoms may be present. Harlan has reported a case of amaurosis which lasted for ten years in which the vision was finally restored. The prognosis is good, notwithstanding the gravity of the symptoms or their duration.

CASE III.—Ralph G., æt. 17, student, good habits, previous personal history negative. Several members of his family wore glasses, but no serious eye trouble in any. Had his nose broken two years ago in a game of basket ball. Broken nose was not treated at the time. I was called to see him two hours after he had noticed, while tying his necktie before the mirror, the loss of vision in the right eye. Examination O. D.: Vision for objects and motion entirely absent; there was slight perception and reaction to light, but no gross changes were noticed, either externally or internally. He was sent to the hospital and the following morning the amaurosis had involved the left eye. He was not greatly disturbed, but was apparently indifferent as to the outcome of his present trouble. There was pronounced blepharospasm with the continual vibratory tremors of the lids. Upon forcible opening of the lids the pupils were found to be dilated and the eyes were rolled high up in the head. The cornea was anæsthetic—the sensation of the body was apparently normal for pain and touch.



There was, however, a curious reversal of sensation for heat and cold. He insisted that the ice-cold test-tube was red hot and that the hot tube was cold. Electrical reaction was apparently normal. After being in bed for three days and receiving electrical stimulation, massage, and increasing doses of Fowler's solution, he asked when he could return to school, and was told that he would not be able to go to school until he could see. In half an hour my patient announced to the nurse that he could see. When asked what was the first thing he saw, he said that he could see himself tying his necktie. There was no recurrence of this condition for a year and a half; after that time he passed from observation. His refraction after the restoration of his vision was O. D. =0.75 spherical, vision 20-20, O. S. —1.25 spherical, vision 20-20.

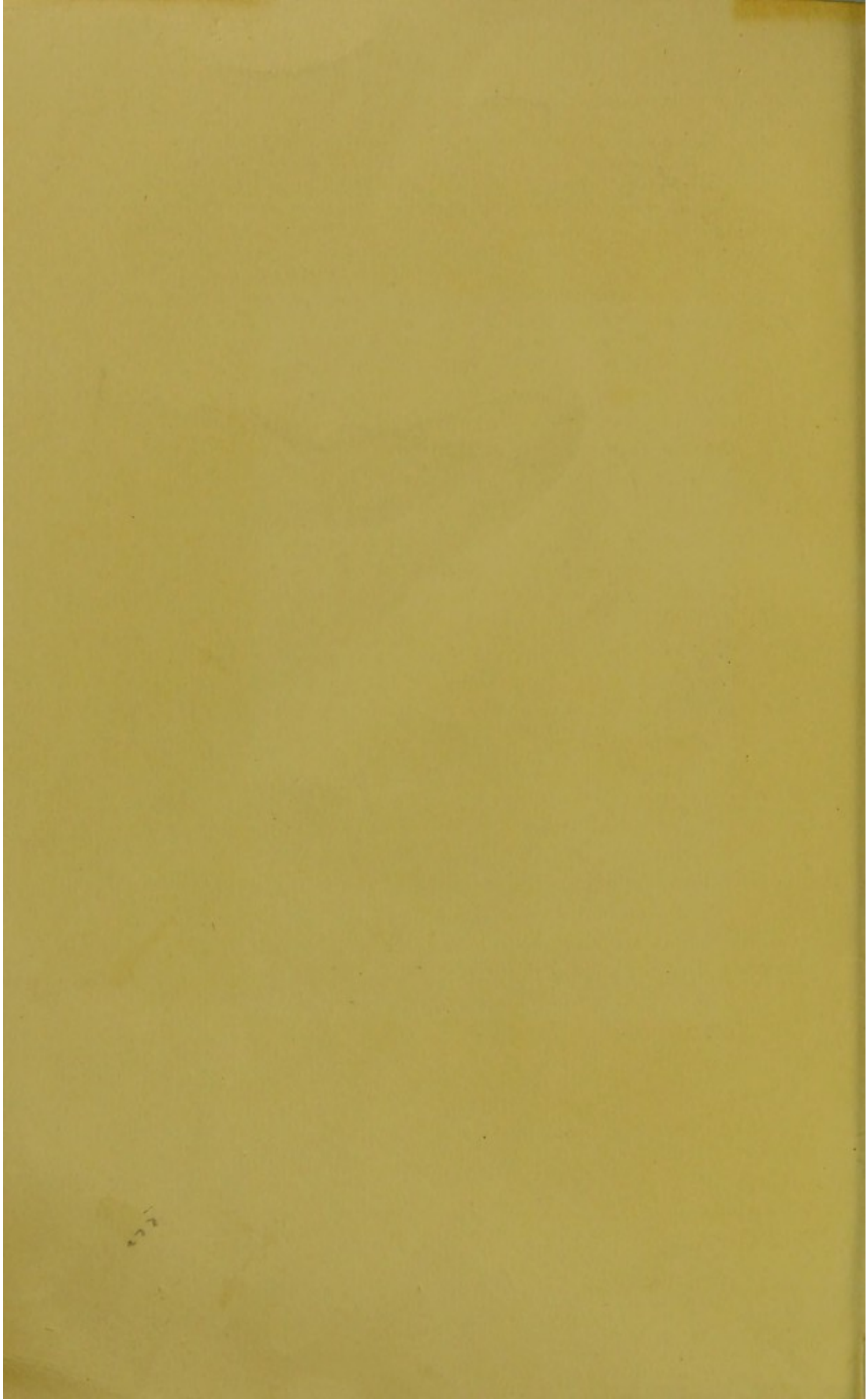
In way of explanation of this extraordinary condition, it might be said that the failure of vision is not due to any actual change in the retina itself, but rather to some change in the cortical centres. Harlan has suggested the following classification for these cases of hysterical amaurosis:

- (a) Those who deliberately simulate blindness.
- (b) Those who see unconsciously but are not capable of conscious vision.
- (c) Those who are really for the time being absolutely blind.

The case just reported seems to belong to the second group. Some investigators have suggested the possibility of a toxin which is elaborated in hysteria and which affects the cortical centres.

*Class 7.*—There are still some manifestations in hysteria which cannot be properly classed in any of the above and only need mention in this study of the disease. There may be disturbances of the lachrymal gland, such as hysterical epiphora and bloody tears. We may have hyperæsthesia of the cornea and the conjunctiva. There may be hysterical chromadrosis which consists of a blackish or brownish discoloration of the eyelids which can be wiped away or which may last for months at a time.















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