

## The More Common Diseases of the Lids, Conjunctiva, Cornea, and Iris.\*

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*Iritis*, or inflammation of the iris, may be divided into three classes:—(1) Idiopathic iritis, or iritis due to some general disease; (2) traumatic iritis, or iritis following a wound or an operation; (3) sympathetic iritis, or iritis following an injury of the other eye.

Idiopathic iritis is in three-fourths of all cases due to syphilis. Of the remaining number almost all are due to rheumatism. It is characterized by sharp neuralgic pain in the eye and temple, ciliary injection, photophobia, lacrimation, and changes in the colour and mobility of the iris. The colour of a blue iris changes to a dirty green, and a brown iris gets a deeper, muddy brown. By comparing the affected eye to the sound eye the colour can be more correctly judged. The pupil soon becomes immovable, and, if treatment is not instituted promptly, the iris will stick fast to the lens, forming what is known as posterior synechiæ (adhesions to the cornea being anterior synechiæ). Posterior synechiæ are always bad, as they tend to keep the iris irritated and so to develop new points of adhesion. If the entire margin of the pupil is adherent to the lens, the consequences are apt to be serious. The treatment of idiopathic iritis is local and constitutional. The treatment of the constitutional disease must, of course, be started at once and kept up until the eye is free from redness. The most important element, however, is the use of atropine, which is used in a solution of gr. iv. to ʒ i., usually. The atropine acts by dilating the pupil and so drawing the iris away from the lens; and, further, by paralyzing the inflamed muscle, it keeps the iris quiet. Often when the pupil is dilated the sharp pain stops. Applications of hot water as described under "Keratitis" are also used to relax the iris and quiet the pain.

Nursing.—Iritis is often so sharp and severe that we must cut off all possible sources of irritation in order to gain control of the case. If the eye is very red and watery and the pain severe, the patient should be in bed. The room should be darkened, or else the patient should wear a double shade, pulled well down over the eyes to exclude the light. The digestive tract should be carefully looked after, and the diet should be simple and light. If the pain becomes severe during the night, as it is apt to, the application of hot water will often relieve. If this fails,

\* From lectures delivered to nurses on Ophthalmic Nursing at the Eye and Ear Hospital, Manhattan, U.S.A.

we must resort to some sedative, usually morphine. Often the pupil refuses to dilate under atropine and the pain keeps up. Under these circumstances a leech often does great good. It is applied to the temple near the external canthus. The skin is first carefully cleansed and a drop of blood drawn by the prick of a needle or the scratch of a sharp knife. The leech is made to take hold and is allowed to hang as long as it will. It usually falls off in about five minutes, and if the patient is full-blooded we may allow the blood to flow for a few minutes more, after which it should be controlled by a firm pressure bandage. The leech acts by taking the blood from the eye, and so decreasing the irritation. Often after the leech has been applied the pupil will dilate under atropine and all the symptoms will begin to decline.

*Traumatic iritis* is very similar to the idiopathic disease, but is apt not to be so severe, unless infection has taken place, in which case a collection of yellowish-white, purulent-looking material collects in the anterior chamber (hypopyon).

The treatment and nursing are the same as previously described, except that we use ice-cloths constantly instead of hot water. The object of the cold is to keep blood-vessels contracted, and so ward off the inflammation. If hypopyon appears, we wish to absorb it, and we stop the ice-cloths and use hot water, as before described. Usually the hypopyon will be absorbed, but in some cases it goes on increasing, and must be let out by a paracentesis.

*Sympathetic iritis*, or irido-cyclitis, is caused usually by a wound through the ciliary region of the opposite eye or by the presence of a foreign body in the interior of the eye lying near the ciliary body. The ciliary body extends back from the root of the iris, or from the junction of the sclera and cornea. Thus it will be seen that a wound through the sclera just outside of the corneal margin will pass through the ciliary body. Such a wound almost invariably sets up an inflammation of the ciliary body and iris, and in the course of time a similar irido-cyclitis appears in the sound eye. For this reason the region immediately outside of the cornea is known as the "dangerous area" of the eye, wounds being so much more serious there than in other localities. Similarly, a piece of steel or other foreign body lying in the vitreous near the ciliary body will most probably set up an irido-cyclitis and sympathetic trouble in the other eye, even though the foreign body may not have wounded the ciliary body. The wounded eye goes through the usual course of a severe iritis, and in all probability will eventually shrink up into a sightless stump, a condition known as

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