that proper methods of isolation have been established, to prevent the acceptance of any child suffering from trachoma into a school containing healthy children, the workhouse schools of London have been almost free.

The disease may have a somewhat acute onset; there are the signs of conjunctivitis, red and velvety lids and muco-purulent discharge, but though in the older epidemics trachoma seems to have run a course as rapidly destructive as true purulent ophthalmia, I have never seen anything approaching to this condition; and in some instances I have known the progress so gradual that the disease has gained a firm hold before it has been recognised.

To the ordinary signs of conjunctivitis is joined a hyperplasia of the lymphoid follicles, which are normally present in little scattered masses in the subconjunctival tissues, so that each follicle stands up as a rounded semi-transparent body; these granules tend to congregate chiefly in the upper cul de sac.

This choice of position aids us greatly in diagnosing between trachoma and so called follicular conjunctivitis, a much less serious disease, in which there is simply hyperplasia of the lymphoid bodies in the lower cul de sac.

To examine the superior fornix of the conjunctiva, we must evert the upper lid. This little manœuvre is also required if we desire to apply any medicinal treatment to the conjunctival surface of the lids.

To evert the upper lid, we must stand in front of our patient and direct him to look down, then with the pulp of the forefinger raise the upper lid—an action which draws it slightly away from the globe. The lower lid is then pressed up with the thumb under the upper, which is drawn down over it, so as to allow the margin to be grasped between the thumb and forefinger.

The patient still looking down, we depress the upper margin of the tarsal cartilage, either with the forefinger which holds the lid or with a probe, and, raising the fissural edge with the thumb, turn the lid round its transverse axis so that the conjunctival surface becomes anterior. The process is only slightly uncomfortable to the patient, and can be, after a little practice, performed in a moment.

If it be desired to examine the whole upper cul de sac, this may be shown in many cases by depressing the globe with the lower lid, and pressing the upper lid upwards and backwards. The folds of the fornix will usually turn out, and can be examined at leisure; sometimes, however, this cannot be done, and then the everted lid must be seized in forceps and again turned round its own axis. This is much more uncomfortable to the patient, and can rarely be done without an anæsthetic. It is, however, the more efficacious method, and allows a fuller examination.

A further point in the diagnosis between trachoma and follicular conjunctivitis is in the aspect of the conjunctiva itself; in the follicular conjunctivitis it preserves its transparency over the nodules, as elsewhere; every tiny injected vessel can be seen clearly underlying the epithelium. In trachoma this transparency is lost, and with it the view of the finer vessels. The surface has a ground-glass-like appearance, which is very difficult to describe in words, but fairly readily recognised clinically.

The correct appreciation is of importance because follicular conjunctivitis is of no danger, while in trachoma the danger is great.

At the same time it is only right to say that though the majority of ophthalmic surgeons are convinced of the distinctness of the two conditions, some well-known authorities even now contend that the two are identical.

It must not be taken from what is written above that the diagnosis is in all cases easy. Far from this, one may have to delay until the course of the disease under treatment enables one to separate the two.

Though in trachoma the granules invade the superior fornix first, they do not remain localised here, but the whole conjunctiva, both palpebral and ocular, becomes implicated. We have seen in the anatomical description how the tarsal cartilage is firmly connected with the palpebral conjunctiva; here, therefore, is very little lymphoid material, and the hyperplasia at first cannot run riot, as in the cul de sac, but eventually the granules appear and form well-marked papillæ, which may attain a diameter of several millimetres. They are usually somewhat flattened on the surface owing to the pressure of the lids against the globe. The thickened, clumsy lid, drooping over the cornea, has in many instances a characteristic appearance, which is made more noticeable by an increase in curvature.

The new tissue laid down on the deep surface of the lid becomes fibrous and contracts, bending the lower edge of the upper lid backwards, so that in advanced cases the lashes turn into the cul de sac and rub against the cornea—a condition called entropion—or in milder cases trichiasis. The corneal epithelium shares in the general affection apart from this. One finds that the upper segment becomes dull; on careful examination it is seen that the dullness is due in part to vessels which run into the cornea from the conjunctiva, quite superficially, lifting up the epithelium over themselves, in more or less parallel lines, in part to changes in the corneal epithelium, which is invaded by lymphoid

previous page next page