Nursing of Diseases of the Eye.

By HAROLD GRIMSDALE, F.R.C.S.,
Assistant Ophthalmic Surgeon, St George's Hospital.

DISEASES OF THE CORNEA.

If the base of the ulcer continue grey and uneven, covered with small tags of slough, the use of eserine is indicated; two or three drops daily will often cause a marked improvement in the condition of the ulcer. There is every reason not to omit the atropine during this application. It is most desirable to maintain the dilatation of the pupil, and the eserine will not be able to overcome this, if the mydriatic be employed throughout.

When the ulcer is healing, if it has been large it is advisable to support the eye with even, gentle pressure. The ordinary pad is hardly sufficient for this, as the inner and outer canthal regions are almost unsupported. Masses of wool must therefore be arranged here so as to form an even basis for the overlying dressing. Unless this be done, the scar tissue may be unable to resist the intraocular pressure; the cornea will yield, bulging unevenly. For a large peripheral ulcer, which would almost necessarily be followed in this way by a staphyloma, it has been suggested to graft a flap of conjunctiva into the healing surface. This has been done with great success in some cases.

The healing of an ulcer, unless it has only involved the epithelial layers, necessarily leaves a scar, which shows as a whitish patch on the cornea. Such scars have received names according to their density and condition. A faint scar is usually called a nebula, a dense one a leucoma. As we have just said, when the scar tissue bulges, owing to the intraocular tension, it is called a staphyloma.

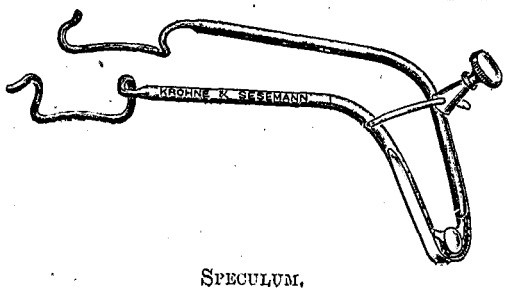
These opacities are, in the adult at least, permanent, or at most renew their transparency slowly and imperfectly. In the young child this is by no means the case. Even large opacities left from the ulcers of ophthalmia neonatorum will clear, and the cornea become so nearly normal that careful examination will yield the faintest trace of the previous opacity.

The visual defect caused by any scar varies in amount with the position, density, and alteration of surface curvature. This last is often the most important of the three factors. A cornea with considerable opacity but little deformity, such as is often seen after interstitial keratitis (which will shortly be described), may allow better vision than a cornea possessing a small facetted scar from a former ulcer, even though it be situated not absolutely centrally.

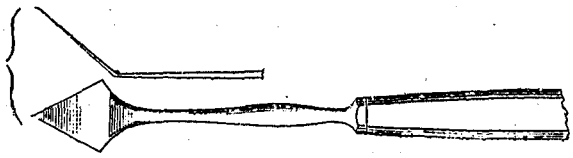
The treatment of the nebula, &c., following ulceration, is very unsatisfactory. All kinds of remedies have been recommended from time to time; none have really shown any great success. Massage of the cornea with yellow oxide of mercury ointment has seemed to me as efficient as any other remedy.

If the opacity hides the pupil completely, it is very tempting to perform an iridectomy, to place an artificial pupil behind some part of the cornea beyond the scar; but the expectation of great improvement is rarely fulfilled. In a few instances where the scar was very dense and limited I have obtained good results, but usually the curvature of the cornea is so irregular that no glasses correct it.

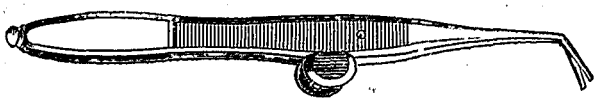
In some cases, however, there is no other possible treatment. For the operation are required a speculum, fixation forceps, keratome, iris forceps and scissors, and repositor. The previous preparation of the patient will be dealt with in a later lecture; cocain will give a sufficient anæsthesia. In operating in such cases the surgeon's object is to place a small artificial pupil behind clear cornea without uncovering the edge of the patient's lens. A very peripheral iridectomy is therefore inadvisable. The clear area of the cornea that most nearly approaches the centre is chosen as the seat of the artificial pupil, and the incision in the corneal edge is made opposite this; the iris is then either divided *in situ* with the scissors, or drawn out of the wound and cut off. In the first proceeding, devised by Mr. Brudenell Carter, the scissors, which should be of some such pattern as De Wecker's, are introduced closed through the wound, the blade lying flat on the iris.



SPECULUM.



KERATOME.



DE WECKER'S SCISSORS.

They are then allowed to open slightly; a small fold of iris springs up between them and is cut off by a single closure; however small the gap, it will dilate considerably on the use of atropine. In this way the excision can be limited to the pupillary margin. The fragment of iris usually can be withdrawn with

previous page next page