Nursing of Diseases of the Eye.

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EYE OPERATIONS.

There is also another object gained by a previous iridectomy—when the cataract is not "mature" (when the cortex is not broken down) the extraction of the nucleus often leaves much lens matter behind, which will become opaque and necessitate a second operation. This, of course, adds to the risk—especially since the presence of lens matter in the aqueous chamber often causes pretty acute iritis. Even with immature cataract, however, vision may be so far defective as to render any work impossible. It is important, therefore, to restore useful vision as early as can be done with safety. If a preliminary iridectomy be made, the clear cortex will become opaque more rapidly, and the mature cataract may generally be removed a few weeks or months later.

The objection to operating on immature cataract is much less serious since the introduction of antiseptic or aseptic methods into ophthalmic surgery. The fragments of lens matter and aqueous form a very favourable culture medium, in which micro-organisms may grow. Hence accidents were more common if much lens matter remained behind.

There is a general consensus of opinion, also, that the average result is rather better with an iridectomy than without; although the result of a perfectly successful simple operation is more brilliant.

The instruments required are: a speculum, fixation forceps, Græfe's knife, iris scissors and forceps, cystitome curette, lens vectis, and a small spatula for replacing the iris.

Even though the simple operation be chosen, all these should be at hand, as the prolapse of iris may necessitate an immediate iridectomy.

The steps of the actual operation are the corneal incision, the iridectomy, and the removal of the lens, and the adjustment of the wound.

The surgeon always stands at the head of the couch, making his incision with the left hand on the left eye, with the right on the right. Instruments are rather more convenient if placed on the side of the operation. The table bearing them should be almost on a line with the surgeon, beyond the head of the operation couch. An assistant will stand by the patient on the same side.

During the operation, especially if the patient is nervous, the nurse or any assistant may be asked to steady the speculum. In this event the speculum should be raised by grasping it at the hinge, so that the blades lift the lids away from the globe: the object is to prevent a sudden contraction of the orbicularis driving the speculum against the eye after the incision has been made. Such pressure might force the vitreous out of the wound, and seriously imperil the success of the operation.

If from any cause the vitreous presents in the wound, the surgeon will take out the speculum and remove the lens by the vectis: an assistant will have to separate the lids to allow the wound to be seen. In doing this it is most important that no pressure be made on the globe, since this would occasion further loss of vitreous. The lids must be separated, as has been described earlier, by making tension on the skin over the long white margins.

When the extraction is completed, the surgeon will usually close both eyes with a pad and bandage. There is seldom much after-pain. Sometimes a small injection of morphia is necessary to secure a quiet night, but commonly, if the operation be performed before mid-day, this is unnecessary. If the patient is restless, trional is one of the best hypnotics. The first dressing may remain thirty-six hours undisturbed, unless there is any uneasiness. In this case the pads may be changed and the lids bathed with a little boric acid solution; but there should be no attempt made to open the lids. A drop of sterile atropine solution may be instilled if the surgeon thinks well.

At the first dressing care must be taken to observe the state of the lids, when the pad, &c., has been removed. The upper lid should not be reddened or œdematous; these appearances may be the first sign of septic infection of the wound. The pad will probably be stained with a small quantity of bloody serous fluid—no pus or muco-pus should be present. If the lids be gently opened after thirty-six hours there should be slight injection of the conjunctiva only, and the cornea should be clear and bright. The iris should be seen of a normal colour; not very uncommonly there is a small clot in the anterior chamber. This is of no importance.

In a normal course the edges of the wound adhere in a few days, and the anterior chamber refills. The pupil should be kept slightly dilated with atropine.

There should never be any considerable discharge.

For the first two days it is well to keep the patient on fluid diet; during this time he should not move from the dorsal recumbent position. On the third day it is usually convenient to give a slight aperient to prevent any straining. After this the diet may be more liberal. As a rule I keep the patient in bed for about a week. Sometimes when one is dealing with feeble persons, whose good health confinement to bed might damage, this rule is inadvisable, and may be relaxed. I have allowed patients to sit up on the second day without any evil result. A healthy man, however, needs reminding that the operation must be treated seriously, and for him confinement to bed is advisable. About the fourth or fifth day

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