through the sclero-corneal junction on opposite sides and plunged into the capsule so as to perforate it by a single opening. By separating the points a hole will be torn in the membrane without any strain on the ciliary processes. In this operation a speculum is hardly necessary; one should be prepared, however, in case of need, and two stopped needles.

If the opacity be thicker it must be cut by a knife or scissors. I am inclined personally to prefer the latter, because no tension is made on the ciliary processes; on the other hand, their use necessitates a rather large wound, which might lead to the loss of vitreous. The instruments needed for the operation are speculum, fixation forceps, keratome or irid-desis knife, and spring scissors (Carter's or de Wicker's).

The prognosis of the operation for cataract is, as a rule, very good; about 90 per cent. of uncomplicated cases regain vision, amounting to $\frac{6}{36}$, and in probably 50 per cent. at least $\frac{6}{12}$.

The presence of general disease, and specially of diabetes, however, is a serious matter. In diabetes cataract occurs, both as directly caused by, and as accidentally accompanying, the glycosuria. Even when it is a mere accident, the course of healing and convalescence is greatly affected. But too commonly an apparently insignificant iritis persists, obstinately resisting treatment, and eventually leading to loss of the eye.

It will be seen that local nursing after cataract extraction, as after any of the operations on the globe, as a rule consists in a policy of masterly inactivity. If the patient is comfortable, and makes no complaint, it can do no harm to leave the original dressing undisturbed for forty-eight hours. To remove the pad and drag the eye open at the end of a few hours may very possibly interfere with the healing of the wound, and there is some evidence to show that the sudden fall of light on the eye, by inducing contraction of the wounded iris, may set up an iritis which will be difficult to subdue. If the patient is uncomfortable within twelve or twenty-four hours, the pad may be changed and the lids bathed externally with a little sterile boric acid, but unless there is an excess of discharge, or œdema of the skin of the lids, there is no occasion to examine the eye.

It is to be noted that some few old people suffer from traumatic delirium after operation, and are apt to pull at their own bandages. This must be guarded against.

The nurse must be on the look-out for a form of spasm of the orbicularis palpebrarum, which produces an inversion of the lashes, so that they are rolled into the lower fornix, there to set up great irritation. This is a common accident in old people whenever the eye is bandaged for any length of time. Should it occur the nurse will find that drawing down the skin of the lid with the finger, without any pressure backwards, will suffice, and bring the upper margin of the lid back into the normal position, and it may often be held here by painting the surface with contractile collodion right up to the roots of the lashes and down on to the cheek. Great care must be taken that none of the fluid reaches the conjunctiva. The ether is an intense irritant, and might do much harm. If this is not at hand, a piece of indiarubber plaster may be fixed to hold the lid in position. Whichever method is adopted, the skin must be dried thoroughly first, or else the collodion or plaster will fail to stick.

Whichever is used it will have to be renewed whenever the lid inverts again. Should these simple means fail, the surgeon may elect to put sutures through the lid, to hold it more permanently in a proper position. For this two needles should be threaded on a piece of stout silk. They are introduced consecutively through the skin about one-eighth of an inch apart close to the lashes, and carried down simultaneously for about three-quarters of an inch, and are brought through the skin again on to the surface. When both ends of the silk are drawn on the lashes are everted. The ends are tied over a piece of drainage tube. Two such sutures may be necessary to evert the whole length of the lid. They are left in as long as the surgeon thinks well. The introduction is somewhat painful, and the pain is not much relieved by the subcutaneous injection of cocaine.

The policy of local inactivity, however, involves a considerable amount of general nursing. The patient must do nothing for himself without the surgeon's permission, and the nurse must do everything for him.

Inasmuch as the patient is almost helpless, with both eyes tied up, it will be necessary to feed him.

The food should be easily digestible, and should not require much mastication, but I do not think it necessary to keep the patient entirely on fluid diet for some days in the way that was customary for many years. In old people the diet must be ample and stimulating, as they often bear confinement badly and not infrequently develop hypostatic pneumonia. For this reason, also, aged patients may be allowed to sit up sooner than is often considered advisable. It is usual to give a slight aperient on the third day after the operation, if necessary; castor oil is perhaps the most convenient drug, but a small enema is often preferable, especially when the patient is habitually constipated.

If, however, there are any untoward signs at the first dressing, if there be excessive discharge, or if the lids are red and œdematous, the nurse must suspect the possibility of sepsis, and should immediately summon the surgeon, who will take such measures as have been already described. If for any reason the surgeon is inaccessible, and the

previous page next page