Nursing of Diseases of the Eye.

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DISEASES OF THE CONJUNCTIVA.

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Phlyctenular ophthalmia is essentially a disease of childhood, though occasionally it may be met with in old people, and more rarely in adults.

In children it is extremely common, so that it is comparatively rare to see any case of catarrhal ophthalmia in a child without some indication of phlyctenulæ.

The typical lesion of the disease is a rounded, raised papule some 1 or 2 mm. in diameter, seated on the sclero-corneal margin, to which runs a leash of vessels. This papule is the phlyctenule. It is rarely single; often we may see the whole corneal limb studded with fine elevations, which are early papules. These increase in size until they reach the diameter mentioned above, and then often break down on the surface into small ulcers, in whose floor fine nerve filaments are exposed.

Much discomfort results to the little patient, as these ulcers are irritated by the discharge from the conjunctiva; and the eyes are kept tightly closed to avoid exposure to light and air. Photophobia is always marked, but even in darkness the eyes cannot be opened voluntarily in many cases, showing that it is not so much dread of light as dread of exposure to the air. It has been demonstrated by the microscope that the leucocytes which form the papule track along the nerve fibres as they pass through the cornea. This position, no doubt, gives rise to the photophobia.

The phlyctenule is rarely single, and though in the early stages it is most commonly confined to the corneo-scleral junction, the remainder of the epithelium seldom is entirely and perpetually exempt. Sometimes we find the whole surface of the eye studded with minute elevations, as if fine grains of sand had been sprinkled over it. Sometimes the patches are confined to the scleral conjunctiva, and then in many instances they are larger than usual, even 5 mm. in diameter, and have gained a special name, "pustular conjunctivitis." Such large lesions rarely attack the cornea.

It is, however, quite rare for the palpebral conjunctiva to show the typical lesion.

The little ulcers usually heal in a few days, but frequently a new crop have arisen before the first are well, and so the disease may drag on for a considerable time. In the later stages the ulcers tend more and more to invade the cornea and creep over it, dragging a train of superficial vessels after them. Such an ulcer is usually crescentic in shape, with its convex edge towards the unaffected cornea, preceded by a patch of grey infiltration. When the ulcer heals, the vessels may or may not disappear. Most commonly they are obliterated, but leave a grey band of nebula, extending from the margin of the cornea to the point which the ulcer reached; a "comet-shaped" nebula is entirely characteristic of previous phlyctenulæ. Not uncommonly, however, the vessels do not disappear and then remain running irregularly in the superficial part of the cornea. If there have been many attacks of the kind, the whole membrane may be left hazy with numerous vessels, and the diagnosis between former phlyctenular and interstitial keratitis is by no means an easy matter. When the acute attack is progressing there is practically no difficulty in diagnosis.

A large scleral phlyctenule simulates in the early stages a mild episcleritis, but is much more superficial than this. The colour of the injection is not so purple, but rather bright red, and finally, if the two be watched, the former gets well in a few days, the latter may require weeks and even months before the treatment results in cure.

When the disease is left unattended to, the irritation of the eye often brings about a condition of spasmodic contraction of the orbicularis (blepharospasm), which may cause partial inversion of the lids, and the lashes may be turned into the conjunctival sac to irritate the cornea increasingly; at the same time the spasm renders the closed palpebral fissure a watertight joint, retaining the ocular secretions within the lids, and thus forming a vicious circle, which tends more and more to augment the photophobia. The lids, as a result of the blepharospasm, become swollen and œdematous, and often acquire a form of eczematous ulceration, especially at the outer canthus, at the bottom of the wrinkles caused by the tight closure.

On the other hand, the degree of photophobia may have no relation to the conjunctival lesion. Often when the photophobia is so extreme that the child cannot be induced to open his eyes at all, a careful examination will show the conjunctiva but very slightly injected, and no apparent lesion of the cornea beyond slight

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