

Nursing of Diseases of the Eye.

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AFFECTIONS OF THE MUSCLES.

Many varieties of procedure have been devised. All have for their object to stitch the tendon of the weak muscle to the sclera close to the cornea, in advance of the original attachment.

The choice of operation will vary with the surgeon. The instruments required are practically the same in all cases—speculum, strabismus hook, fixation forceps, and straight scissors; most surgeons will add Prince's forceps for holding the muscle. One or more needles are required, either threaded singly on silk, or with two needles on the same thread. One of the simplest methods of operation is that devised by Richard Williams. The muscle is exposed by a horizontal incision through the conjunctiva, about midway between its upper and lower borders. It is freed by slight dissection, and held up by a hook; the conjunctiva is loosened above and below. A single thread is passed through the conjunctiva close to the margin of the cornea near the vertical meridian, and takes hold of the episcleral tissue, then on subconjunctivally to the wound. Here it pierces the muscle, and is again passed subconjunctivally to pick up a little of the sclera below the cornea and make exit at a point corresponding to the point of entrance.

Thus the whole suture is subconjunctival; when the muscle and its opponent are divided and the suture tied, the cut edge is dragged forward close to the margin of the cornea, where it is held until it has acquired a new attachment.

The after-treatment of this operation is simple: it is well to keep both eyes at rest by a bandage for a day or two until the new attachments have more or less consolidated. The immediate result is not very beautiful; large folds of conjunctiva are pulled over the cornea, but these disappear very rapidly when the stitch is removed on the fourth or fifth day.

In young children the operation requires general anaesthesia, but in older patients it is little painful and can be performed under cocaine.

Divergent squint is less common but usually requires advancement to overcome it. A simple tenotomy is rarely sufficient.

The nurse should never forget to make a note which eye is affected. In children, when an operation is required, it is impossible to tell after the anaesthetic has been given which is the squinting eye, and the fixing eye may become the subject of the operation, if no careful note has been made beforehand. It is not a bad plan to mark with ink the forehead or cheek on the side affected before the anaesthetising commences. Division of a muscle belonging to the fixing eye is most unlikely to have

any permanent evil effect, and, indeed, is often done advisedly under certain circumstances by the surgeon; at the same time it is a mark of carelessness not to have noted which was the affected eye.

Paralytic squint is not so important for our immediate purpose, since it is rarely seen in the ophthalmic wards. It may follow many causes, but is most commonly the result of some affection of the peripheral nerve, from some general disease, or of an affection of the brain centres. The ocular movements are commonly affected in an early stage of tabes. General treatment is indicated. Not very uncommonly one may see a congenital loss of power of one or other muscle. No treatment is of any avail.

THE EYELIDS.

It must appear strange to all nurses who are familiar with modern surgical practices that the ophthalmic surgeon when he is operating on the globe of the eye seems persistently to disregard many of the principles that have proved so successful in other departments. I have already pointed out why this is. The fundamental rule of all practice is to avoid doing harm; the employment of methods of cleansing or antiseptics sufficient to procure sterilisation of the conjunctiva would lead unavoidably to extensive damage and even loss of many eyes. It being known that their efforts cannot be entirely successful, without being dangerous, the somewhat lengthy routine of cleansing which I have described in a former lecture is shortened or even entirely abandoned by many surgeons, who are yet able to show good results. When we pass from operations on the eyeball itself to operations on the lids, the case is different. Here aseptic surgery is as feasible and as desirable as in any other part of the body. It is obvious that when we perform an operation on the lids for cosmetic reasons, it is most desirable that the wound should heal by first intention; under these circumstances the minute linear scar, which is all that should in most cases remain, becomes after a short time practically invisible.

Operations on the lids are required for a variety of conditions, amongst others for inversion, which turns the lashes against the cornea and gives rise to serious damage thereto; or eversion, which, apart from the deformity, exposes the cornea to injury, and allows the tears to run over the face. The first of these conditions, entropion, is due, in the case of the upper lid, most commonly to the contraction consequent on trachoma—as has been already described. A number of operations of various forms have been devised to replace the lashes in their normal position, but of these, two only are generally useful: it is true that there are many modifications of each method, which are sometimes elevated by their originators into separate operations; at the bottom, however, there are but two methods. The one aims, by altering the

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