Headaches of Ocular Origin.

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It is a constant matter for surprise to the ophthalmic surgeon to note how little the power of properly-adjusted spectacles in the relief of headache is recognised by the general public, although it has been a fact of common knowledge to ophthalmologists, and has been published by them in all possible ways for many years.

A large number of people are condemned to suffer not only severe pain, but also more or less complete disablement from work, because of the lack of this knowledge. Their headaches are treated by drugs, from which they obtain temporary relief; but they do not know that by the use of correcting lenses they might once and for all be rid of their trouble.

I must not be understood to say that glasses are omnipotent or that they can drive away all pains in the head, but I am more and more convinced that the large majority of "occupation headaches"—those, that is to say, which are brought on or increased by work—are, if not entirely cured, at least largely relieved by the accurate correction of errors of refraction. An incalculable amount of distress has been avoided, and an equal increase in efficiency has been ensured, by the use of glasses in recent years; but there is no doubt that a larger and more general knowledge will bring about a still larger employment of spectacles, and a further diminution in the number of people who are prostrated by headaches.

Not all headaches, even when combined with symptoms which call attention to the eyes, are due to errors of refraction. Increase of intra-ocular tension or cerebral tumour also occasions pain. We must, as far as possible, therefore, differentiate the characters so that we can recognise more or less certainly to what cause it is attributable. In the cases under consideration the degree of pain varies, from mere smarting of the eyes to severe neuralgia involving a great part of the head. Usually it is confined to the frontal and temporal regions, but this is not absolutely universal, and it may in exceptional cases be vertical or occipital. At the same time if the headache is occipital, it is wise to give a guarded prognosis as to the effect of glasses It is usually bilateral; occasionally one finds true hemicrania with all the characteristic appearances, such as teichopsia, removed by the use of spectacles.

The character of the headache is variably described by the sufferers; most speak of a dull, heavy pain, which seems to them to lie deep in the head; occasionally it is acute and superficial, and the skin may be tender over it.

It is not uncommon to find a secondary exciting cause. Thus, many nurses become subject to headaches after a year or more of hospital life, when the depressing surroundings have reduced the vigour to a considerable degree; after an exhausting illness, also, we may not infrequently hear that headaches have appeared as soon as the patient begins to use his eyes for any near work.

It is generally a characteristic of these pains that they disappear, for a time at least, if the sufferer rests or takes a holiday, and as long as the improvement of general health lasts, so long is the interval of reprieve. When the temporary benefit of the holiday wears off, the headaches once again become habitual. Usually they have the very definite relation to work that has just been mentioned, occasionally they assume an almost regular paroxysmal character, so that the sufferer may be free from pain two days, and be prostrate on the third.

If in a case such as this we examine the eyes we will often be struck by the slight amount of error they disclose. It is, in fact, a recognised truism that a small degree of astigmatism is more likely to cause distress than a very high degree of refractive error, and the reason of this would seem to be that the ciliary muscle by irregular and uneven contraction is able to neutralise slight corneal astigmatism by producing a corresponding degree of lenticular astigmatism, but only at the expense of a great nervous effort and consequent exhaustion.

In high degrees the vision is frankly bad, and there is no effort made constantly to overcome the error.

In the former case vision may be normal or more than normal, and the sufferer will probably scornfully resent the idea that anything can be amiss with his eyes. This error can only be discerned after the use of a cycloplegic, and the first step that the surgeon must take is to secure paralysis of the ciliary muscle by the use of atropine or homatropine. The former is the more sure, but, at the same time, the more inconvenient because of the long duration of its action. In children there can be no doubt that it should always be used, in adults the grave loss that may result from ten days or a fortnight's complete disability must weigh with us in the choice of the mydriatic. Often the error found will be only half a dioptre of astigmatism, but however apparently insignificant it is, correction must be ordered, at first to be worn constantly; later it may be possible to leave off the glasses except where the patient is engaged in any close work.

This is the most common cause of ocular headache; it is not, however, the only one.

Any over use of accommodation may give rise to pain. Thus, when the power of accommodation is weakened from any cause, such as age, or some exhausting disease, headaches often follow use of the eyes.

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