

anaesthetic ointment (*e.g.*, cocaine and boracic acid) to secure a speedy healing. If, however, the ulcer has been infected, we find in a few hours the pain and injection increased, and a grey haze of infiltration round the original injury. Probably the most speedy method to produce a cure is the actual cautery. If the glowing point be applied to the grey centre of infiltration the heat will destroy the invading micro-organisms, and the resulting scar will not be large. It is well to apply some mydriatic in such cases.

If a longer time has elapsed, there may be seen a whitish-yellow line or crescent at the bottom of the anterior chamber, obscuring the base of the iris; this is a collection of lymph or pus, and is called an "hypopyon." The presence of this would necessarily set up iritis, even if it were not the product of an already inflamed iris. As the ulcer heals, the hypopyon will be absorbed. It is rarely necessary for the surgeon to do more than attend to the ulcer. The actual cautery will be the best curative agent.

If the galvano cautery be used, heated, as is most usual, by a storage battery, the nurse must see that the battery is in working order and that all binding screws are firm. When put away the regulator must be turned so that no current passes, or the battery will run down. The wound may be dressed with iodoform and atropin ointment.

The extent of an ulcer can be readily mapped out by using a solution of fluorescein, in bicarbonate of potash. This substance stains the corneal tissue, wherever the epithelium is removed, bright green. The stain lasts a few minutes only.

If the wound of the cornea be deeper, and penetrate to the anterior chamber, the aqueous humour will escape. It is important to prevent any adhesion of the iris, and prompt measures must be taken against this accident. Should the wound involve the centre of the cornea, the iris will be dragged away from it by the use of atropin. If, however, the periphery be wounded, atropin might cause further prolapse, and the employment of eserine is indicated.

Often, however, this will not suffice, and the surgeon will replace the iris, or, if necessary, remove the prolapsed portion by iridectomy.

A wound of the lens at once make the prognosis far more grave, as it of necessity means a traumatic cataract, which will almost certainly involve the whole of the lens.

It is true that a mere puncture of the capsule may be made in some few cases without a complete cataract resulting, but this must of necessity be a very rare accident.

If the wound be occasioned by a flying splinter, this may be retained in the eye, and add seriously to the gravity of the injury.

A retained foreign body, as a source of irritation, varies in potency with its nature and position. If

the fragment be aseptic at the time of the injury the subsequent reaction will naturally be less than if it were loaded with bacteria. Any small aseptic foreign body may remain embedded in the cornea and covered over with epithelium for an indefinite period; but if it have passed through this membrane its chemical nature has important bearing. Glass, which is not acted on by the contained fluids, is less able to excite inflammation than metals.

Except in very occasional circumstances, however, an eye with a foreign body in the vitreous is in so dangerous a position that, unless the intruder can be at once removed, the eye should be enucleated to prevent the risk of sympathetic ophthalmia. Recently Professor Haab, of Zurich, has constructed a very powerful electromagnet, by whose means small splinters of iron or steel can be drawn from a wounded eye with the least possible disturbance.

A direct blow on the eyeball may rupture the globe. The accident is not a very frequent one; the bony orbital margins offer great protection against direct violence, but when it happens the eye is so disorganised that it is rarely of much value as an organ of vision, and, if the other is healthy, should be removed. If the fellow be very defective, it becomes a question whether to operate or not; on the whole, most surgeons will be inclined to advise the patient to run the risk of retaining the injured eye for a few days, so as to give it a chance of recovery. When, under such circumstances, it is resolved to attempt to save the eye, the patient must be kept in bed, and the inflammatory processes limited in every possible way. A sub-conjunctival injection of mercuric cyanide (five drops of a 1-1,000 solution) should be administered, which will reduce the risk of sepsis.

Should the iris be prolapsed the surgeon will replace or remove as he thinks best. As a rule, it is easier to remove, and more satisfactory, as the prolapse often returns; and it is of great importance to secure speedy healing.

Atropin will usually be ordered, and cold pads may be used with great advantage. The patient should be kept at rest, with the uninjured eye shaded or bandaged.

If the wound shows signs of sepsis, quinine drops, frequent irrigation with antiseptic lotions, and perhaps the galvano cautery will be required. If the eye becomes quiet under these measures within a few days, we may leave it even though sightless in the orbit. An artificial eye is a constant source of worry and expense to a patient. If, on the other hand, we decide to remove it, the form of operation will vary with the case. For cosmetic purposes nothing is so successful as the operation of Mules, which was described in a former lecture. Recent injuries are not, however, very favourable cases for this procedure. Where time is of great importance to the patient, simple enucleation is th

[previous page](#)

[next page](#)