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NOTES OF OPHTHALMIC PRACTICE.—NO. I.

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TARSORAPHY.

Mr. B., aged 60, a resident of New Hampshire, came to consult me a few weeks since. Last July his head was caught between a granite post and a heavily-loaded cart, the result being that the jaw was broken in two places, and the right side of the face completely paralyzed. The vision of the left eye was entirely destroyed. At the time of his visit to me the facial paralysis was less complete than before, but his principal source of trouble was his inability to close his right eye, owing to the loss of power in the orbicularis.

The *left* eye was externally normal and retained its normal powers of motion. The pupil acted sympathetically, but dilated and remained fixed when the other was covered. No perception of light, either qualitative or quantitative. The ophthalmoscope revealed commencing white atrophy of the optic nerve entrance.

The vision of the *right* eye remained nearly unimpaired, being affected only by a slight superficial ulceration of the lower part of the cornea, consequent on continued exposure to the air. The upper lid could be raised with ease, but was obliged to be brought down with the finger whenever the patient wished to close the eye, its unaided descent being very slight. The lower lid, without being everted, had fallen some distance below its usual level, and remained at least two lines below the upper, when this had been brought down as far as possible, leaving the globe uncovered to this extent. The conjunctiva, both of lids and globe, was reddened and somewhat inflamed. There was almost constant pain in the ball of the eye, and the ulceration of the cornea was fast progressing. The desire of the patient to be relieved from this pitiable condition was naturally excessive.

Two principal operations suggested themselves, the one being the removal of a V-shaped piece from the centre of the lid, the

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other the removal of a similarly shaped piece from the external commissure, and the diminution of the palpebral aperture by uniting the edges of the wound. The first has long been the standard method; it is open, however, to several objections. The irregular shape of the edge of the lid at the point of union is apt to interfere with the proper passage of the tears; the main difficulty, however, is that this operation does nothing towards raising the outer commissure, and, in the case of prominent eyes, the lid, shortened as it is, is apt to hug closely the lower part of the bulb and prevent the closure of the eye.

The other operation appeared open to neither of these objections, and was accordingly performed. The patient having been well etherized, and the external commissure of the lids raised from the bulb and supported over a blade of horn, a lance-shaped knife was passed in, just at the angle of the lids, over the tarso-orbital fascia, and the integument thus raised and separated from the subjacent structures over a surface stretching some five lines back from the commissure. The same splitting process was carried forward into the lids themselves, the hair-bulbs being separated from the Meibomian glands for a distance of about four lines from the angle of the lids

to the lines marked *a* and *b* in Fig. 1. From the point where this dissection ceased, the inner edge of each lid was lightly pared about three quarters of a line farther on, but behind the eyelashes. Commencing from the lines marked *a* and *b* on the upper and lower lids respectively, vertical incisions were made through the integument of the lid down to the cartilage, and these cuts carried downward and forward in a direction parallel to the edge of the lid, till they met at a point on a level with the angle of the lids, and some five lines from it. The integument, including the eyelashes, embraced between these incisions was now dissected away, and the edges of the wound united by four sutures, as in Fig. 2, a twisted suture being taken anteriorly. Care was taken, in passing

the pin for the first suture, to approximate the points where the incision in each lid had commenced, more having been removed below than above, in order to raise the lower lid into a proper position. The point at which these incisions should be commenced, and the amount of skin to be removed, must vary naturally according to the circumstances of each individual case and the effect designed to be produced.

Tarsoraphy, as the above operation has been called since its first introduction by Walther, owes the prominence it has obtained in modern ophthalmic surgery to Graefe, who (*Archiv*, Vol. IV., part 2, p. 201) describes the operation and gives the indications for its performance. It is applicable to those cases where a considerable lengthening of the lid, together with a thinning and loss of tone of the cartilage, has taken place; in marked cases of paralytic ectropion; in cases of ectropion of the lower lid dependent on cicatrices or traumatic solutions of continuity of the external commissure; in ectropion of the lower lid caused by cicatrices of the external covering of the lids or neighboring parts; and in exophthalmus. The method of performing the operation in the above case differs somewhat from that given by Graefe, and is due to Stellwag von Carion, from whose book* are also taken the two engravings.

The sutures were removed on the third day. Union by first intention had taken place, the lower lid was raised into a normal position, and with the aid of the finger the upper lid could be closely approximated to it. The ulceration of the cornea had nearly, and the pain entirely disappeared. The patient shortly left for home, and as he promised to write me in the event of anything going wrong, I have no doubt but that the relief continues to be complete.

GRAEFE'S "MEASURER OF REFRACTION,"

An Instrument designed for at once expressing the Strength of the Glass that will enable a given Patient to see distant Objects with distinctness.

With this instrument the patient is enabled to himself designate the glass he requires, without going through with the routine test of trying one lens after another. And the conscript who seeks to escape active service on the ground of myopia, if tested by means of this, must either at once conclusively establish the truth of his statement, or as quickly give results so inconsistent as to stamp him as an impostor.

An eye, possessing a normal power of refraction, and healthy in other respects, sees distant objects with distinctness. Neither convex nor concave glasses improve vision, because such an eye under such circumstances is adapted for receiving parallel, and not convergent

* Manual of Practical Ophthalmology. Vienna. 1861.