THE

Journal of the American Medical Association.

EDITED FOR THE ASSOCIATION BY N. S. DAVIS.

PUBLISHED WEEKLY.

Vol. VIII.

CHICAGO, FEBRUARY 19, 1887.

No. 8.

ORIGINAL ARTICLES.

THE AFTER-TREATMENT OF CATARACT EXTRACTION AND IRIDECTOMY ACCORDING TO DR. MICHELL'S METHODS.

BY T. E. MURRELL, M.D.,
OF LITTLE ROCK, ARK.

Dr. Charles Michell's method of dressing an eye after extraction of the lens and after iridectomy, together with the non-exclusion of light from the eye at any time subsequent to the operation, was brought before the general profession of the country for the first time in St. Louis last May, in the Section of Ophthalmology of the American Medical Association. As might be expected, it created no little surprise. Opinion was divided as to the propriety of such seemingly extreme measures. Dr. Chisolm said, for one, he would test it. How many others have made a test of it I know not, but it is somewhat surprising that so little literature on the subject has thus far appeared. Evidently few have ventured to put the matter to the test else, I think, more would have been written in commendation of so valuable an acquisition, to ophthalmic surgery. In the *American Journal of Ophthalmology*, June number, Dr. Chisolm reports sixteen cases in which he used Dr. Michell's after-treatment with most flattering results. Again, in a more lengthy report in the *N. Y. Medical Record*, of July 31, he further comments on the after-management of extractions, and adds other cases from which he draws conclusions more firmly confirming his faith in the safety and advantages of the innovation. Dr. Michell very modestly gives an account of how he came to adopt this dressing, and to allow the patient abundant light after extractions, in the third number of the *Archives of Ophthalmology* for 1886. He has been too modest in bringing this matter before the world; besides, I regard it so valuable as to have made it his duty long since to have done so. As for myself, I am willing to subscribe to Dr. Chisolm's strongest commendations, having used no other after-treatment in extractions and iridectomies since last May, when Dr. Michell very kindly gave me in person all the details of the treatment. Nothing can be more simple, and nothing more sensible.

As would be expected, claims of priority are now coming in. One writer asserts that for fifteen years or more Dr. Levis, of Philadelphia, has discarded

bandages. He is not alone in this. Some of the English and Continental surgeons have been in the habit of dressing the eye after extraction with strips of adhesive plaster, but they were very careful to keep the patient in a *dark room*. See "Wells on the Eye," third edition, p. 268; "Haynes Walton on the Eye," third edition, pp. 788-89, and other works that might be cited; some preferring the compress bandage, some the adhesive strips. As I understand, Dr. Levis' dressing consists of a piece of black court-plaster completely covering both lids, leaving only a small opening at the inner canthus to allow the escape of tears. I don't know whether he uses a dark room or not, but he could not more effectually exclude the light than by the above dressing. In the August issue of *Progress*, Dr. Dudley S. Reynolds, of Louisville, Ky., puts in a claim in the following words: "The use of the bandage after extraction of cataract has long since been abandoned by the writer. Instead of this useless and sometimes dangerous form of dressing, a little dry absorbent cotton, secured by strips of adhesive plaster drawn from the cheek to the forehead, answers a better purpose." He makes no mention of a dark room, but had he not regarded the light, he would not have omitted putting in his claim here also, since it is one of the strong points in Dr. Michell's methods. Dr. Reynolds' dressing defeats two important features in the after-treatment under consideration, viz.: the filling in of the orbital space with cotton heats the eye, excludes the light, and precludes the daily inspection of the lids without disturbing the dressing; and second, the play of the facial muscles would certainly disturb the equilibrium of the dressing through traction on the adhesive strips. These, the two strongest claims yet put forward, speak for themselves, while whatever honor may come of this valuable measure certainly belongs to Dr. Charles E. Michell.

In my former experience after extraction I had much trouble with slow convalescence, and long-continued photophobia oftentimes; and, in addition, quite a large percentage of iritis of a mild grade, which usually made its appearance after the fifth day. None of these have troubled me with the new after-treatment, and I now feel quite sure that the majority of iritic inflammations were the result of exposure of the eye to a bright light at the time of the first examination. It was always painful and caused a flow of tears. Well do I remember how I used to go through the eye wards in Baltimore and in New York with the surgeon to dress the eyes op-

erated for cataract, with candle in hand, to see how to change the dressing. And when I began practice I followed in my preceptor's tracks, and carefully excluded every ray of light. I came to notice, however, in the course of time, that the more effectually the light was excluded the more intense and the more persistent the photophobia; hence I came gradually to be less careful of utter darkness, until I had come to using a well lighted room for the patient, and only using the cotton and bandage dressing over the eyes. I always directed, if the light was too bright, to put a piece of black goods over the bandage, but I found they seldom called for this. On hearing, therefore, of Dr. Michell's after-treatment, I felt prepared to try it at once. To show what I founded my faith on, I give, by way of illustrating the effects of this simple treatment, a few cases from my record book:

Case 1.—Miss W., æt. 23. Old irido cyclitis, with exclusion of the pupils and opacity of the lens in each eye. V= perception of light. Extracted the right lens, leaving a thick calcareous capsule. Dark room and bandage. Ten days later removed the bandage permanently and put on a shade for the eyes. There was some iritis at this time, which soon subsided, but the most intense photophobia continued for fully a month, and it was after two months or more that she could tolerate full daylight without discomfort. Some months later I extracted the left lens in its capsule, which was also treated with bandage and dark room, and was followed by a like train of iritis and long continued photophobia. These operations were performed last winter and spring. In September of this year I extracted the calcareous capsule from the right eye. It was a dense hull of lime salts so thick that it crushed like egg shell. A large corneal section was made and the mass seized with forceps and withdrawn. Both eyes were dressed with a narrow strip of isinglass plaster just long enough to catch well on the two lids and hold them together. The room in which she stayed had two large east windows without blinds, curtains or shades, and I directed that none be put up. The walls being white, the light in the room was very bright. The morning sun shone in her face and she found it more comfortable to put a screen between her face and the window until the sunshine had gotten off of her bed. No other discomfort was complained of. On the fifth day the left eye was turned loose, and on the seventh day the right. She was at once given the liberties of the house, and on calling to see her the next day I found her walking in the yard barehead, with a bright sun overhead, utterly indifferent to the light. There was no iritis or photophobia at any time.

Case 2.—Mrs. R., æt. 81. Hyper-mature cataract in the right eye, dislocated downwards fully one-third its diameter; fluid vitreous.

July 22, made an upward iridectomy. Lids closed with narrow strips of isinglass plaster and full daylight allowed in the room. Six days later liberated both eyes and let her go where she pleased. A mild conjunctivitis ensued, but there was no photophobia whatever. The result of the iridectomy was not satisfactory as regards vision on account of a filmy

opacity above the periphery of the lens; so on September 29 I removed the lens and its capsule. The after-treatment was the same as before. No pain at any time. On the eighth day removed the plaster and gave her the liberties of the house. There was union by first intention, a clear black pupil, and not the slightest trace of iritic engorgement. The effect of full daylight was not at all disagreeable from the first exposure of the eye. Ophthalmoscopic examination revealed a fluid vitreous with floating opacities from former choroiditis, and of course there was but moderate vision.

Case 3.—Mr. S., æt. 76. Cataract in both eyes. August 2 I extracted the right lens and dressed both eyes in the usual way, allowing the light in the room just as they had been accustomed to having it. On the fifth day I removed the strip of plaster from the left eye, and on the seventh day from the right. Perfect healing, no iritis, no photophobia or lachrymation, no discomfort of any kind. He was out in the bright sun in less than two weeks, and remarked that daylight seemed brighter to him than it ever did in his life, much like being near an electric light; but it was not at all disagreeable, and caused no irritation of the eye. He soon went to work at his trade—type setting.

Case 4.—Mr. Y., æt. 60. Is nearly blind in his left eye from old choroiditis, and has immature cataract in his right eye, with which he can still count fingers readily at four feet. I determined to operate. On September 12 I extracted the right lens, taking pains to remove as nearly as possible all the cortical substance. Closed the eyes with a strip of isinglass plaster on each, and directed that the window blinds be left open and the curtains kept up. Before leaving the room I noticed that the lids of the right eye had not been drawn closely together, sufficient space intervening for me to see the cornea. I did not interfere, however, as Dr. Michell had told me he frequently left a small space between the lids on purpose to allow the easy escape of the tears. When I called the next day the patient exultingly told me how he lay in bed and counted the bars in the window frame, and his fingers at arm's length, and saw across the street with the eye that had been operated on. As all was going well, I did not disturb his recreations.

On the sixth day I turned his eyes loose, and on the eighth day he walked to my office, underwent a thorough ophthalmoscopic examination and test for glasses, and took the train for home, one hundred miles distant. I received a letter from him a few days since, saying his eye had never given him a particle of trouble. I never saw so little restraint after operating for cataract as in this case, nor did I ever see smoother healing.

Case 5.—G. W., Negro, æt. 70. Cataract in both eyes, mature in left. November 6 operated at the Medical College before the class, removing the right lens. Operation smooth. A narrow strip of plaster to close each eye. After the operation he walked down stairs and sat by a stove nearly an hour, waiting for some way to get home. Finally a wagon called and he got in and rode to his home, more than

a mile distant, over very rough streets. I directed that the light should not be excluded from the eyes, but his prudent wife carefully sealed all cracks and hung quilts over all windows. On calling the following day I found a pitch-dark room, and in addition found the old darkey lost in a wilderness of blankets and comforts wrapped about his head. I at once stripped all the windows and uncovered his head, and enjoined him and his wife not to repeat it. On the fifth day from the operation I found the old man with both eyes wide open, enjoying himself in looking about the room. Finding the corneal wound nicely healed, I did not put on the strips again, but let him go free. About two weeks later I saw him driving a wagon on the streets. Not long since he called at my office and received a formula for glasses, with the effect of which he was delighted.

It is not worth while to report other cases, including iridectomies, as those already given are sufficient to demonstrate the effect of not placing the patient in the dark after an extraction or iridectomy. The foregoing cases have not been selected from the most favorable. In the second case there was fluid vitreous and a very hazardous eye to operate on, and which I undertook with considerable misgivings. Those who have attempted removing a dislocated lens with a fluid vitreous can appreciate my feelings. And in case 3 there was an incurable stricture of the nasal duct, chronic abscess of the lachrymal sac, and a lachrymal fistula. I should have greatly dreaded bandaging this eye, covered with cotton, and yet with free escape to the secretions and careful daily inspection of the lids and soaking away the secretions from the inner canthus with absorbent cotton, it healed without an untoward result.

I have not yet ventured to treat iridectomy as an office operation, as does Dr. Michell, but my experience with case 5 goes far toward proving its safety. I leave to others to draw their own conclusions from experience, as I have done, and in conclusion will say, I shall use no other method of after treatment of extractions and iridectomies until something better offers, which, in the nature of things, I cannot now conceive of.

111 E. Fifth St., Little Rock, Ark., Dec. 20, 1886.

INTUBATION OF THE LARYNX, HISTORY OF FOUR CASES.

BY L. H. DUNNING, M.D.,
SOUTH BEND, IND.

The unusual interest manifested by physicians in the treatment of pseudo-membranous croup by the O'Dwyer method, induces me to report the following cases:

Case 1.—Nov. 18, 1886, I was asked by Dr. Kettring to see a child of Mr. Galata, of this city. I responded at once and found a well-marked case of pseudo-membranous croup that had been in progress six days. It had commenced lightly and gradually grown severe until now it threatened to prove speedily fatal. I advised intubation of the larynx or tracheot-

omy, giving preference to the former procedure. The family consenting, Dr. Kettring was called and concurred in my diagnosis, and agreed to the plan of treatment. We proceeded at once to introduce the tube, using the size for a child 2 to 3 years of age, our patient being 2 years and 4 months old. A marked improvement in respiration occurred in two or three minutes after the thread was removed. Stimulants were ordered, and drachm doses of a saturated solution of potass. chlor. every three hours. At 4 P.M., five hours after intubation, the patient was resting and breathing easily. Continued the same treatment.

19th. Patient rested well last night, but did not sleep much. She is now breathing easily. Temp. 100, pulse 115 and resp. 24 per minute. The child objects to medicine and nourishment, so everything has to be forced, and family are not willing to give either. The same orders were given as yesterday.

20th, 8 A.M. Patient rested but little during the night, but breathed easily. This morning is quiet. There is considerable cough and profuse expectoration, in which occasionally appear shreds of pseudo-membrane. The patches of membrane have nearly all disappeared from the fauces. The bowels moved several times during the night. Temp. 99.5, pulse 105 and resp. 20 per minute. Has taken but little nourishment. Same treatment. 5 P.M. Same condition as in the morning, except that there are sonorous and sibilant râles to be heard all over chest.

21st, 8 A.M. Bronchitis somewhat more pronounced. The breathing is easy and regular, and the pseudo-membrane has all disappeared from the fauces. The expectoration is profuse. The patient is very weak, and this is due largely to its refusal to take nourishment. Believing the danger from croup had nearly or quite disappeared, the tube was removed, Dr. Hitchcock assisting. It was quickly removed upon first effort, and came away clear of obstruction. After its removal there were but slight indications of croup. From this time on the case was uneventful, passing on to complete recovery in a few days.

Case 2.—Essie B., aged 2 years and 4 months. She had been ill of bronchitis several days. Upon November 26 she became very hoarse, and there was a slight croupy cough.

Nov. 28, 7 A.M. During the night the child had had several slight paroxysms of dyspnoea that yielded readily to emesis.

Dec. 1. Despite the most energetic measures, there has developed a most alarming case of membranous croup. There is continuous labored breathing and severe and prolonged attacks of dyspnoea. Dr. Kilmer had seen the case with me a number of times. He was called again, and after consultation we decided to intube the larynx, as in this procedure or tracheotomy we saw the only hope of recovery. At 1 P.M. the tube was introduced, and considerable difficulty was experienced in securely placing it in position. The difficulty was in pushing it down into place. There was considerable resistance, and when left in place was inclined to rise out of the larynx. After the second effort it was left well in position.