

where the meridians of the cornea had obviously changed after the correcting glasses had been worn comfortably for considerable periods of time; not only the degree of the astigmatism having increased, but the axis of the correcting cylinder formerly at  $60^\circ$  had changed to  $45^\circ$  or even to  $30^\circ$  in one case. There was marked asthenopia, uveal disease and the corneal ring and cloud as above described. The corneal nutrition had been impaired, the cornea softened and unable to resist the normal intraocular tension.

Many examples have been found in children, as I pointed out last May in a paper on "The Genesis of the Myopic Eye," presented by request to the Ohio State Medical Society. In many of these cases of increasing refraction the distension of the globe does not occur as posterior staphylomata, but as a stretching of the anterior segment, or thinning in the anterior scleral region, and they, almost without exception present the ring and granular cloud associated with the uveal disease, which is the significant underlying factor in the syndrome of increasing refraction.

So far as I know this observation is new, and I bring it before the Section in this very incomplete statement, not wishing at this time to give a detailed study of the numerous examples from case records.

### **CORRECTION OF IRIDODIALYSIS BY OPERATION.\***

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Few of the textbooks on ophthalmology have anything to say concerning the correction of iridodialysis by operation, and those that offer any suggestions recommend removal of the bridge of iris, thus making an iridec-tomy with a broad base and leaving a large coloboma. Operations for the re-attachment of the torn iris, or the fix-

ing of the iris in a corneal wound at the limbus, have been condemned by numerous authors, tho I am pleased to note that Wood, in his *System of Ophthalmic Operations*, as also in the *American Encyclopedia of Ophthalmology*, admits being satisfied with the results of incarceration of the torn iris in a corneal wound.

Just why this procedure, which is known by the name of iridenkleisis, should have fallen into disrepute and be considered as a risky procedure is not quite clear, except that it is generally thought that iris entangled in a corneal wound is apt to set up irritation, glaucomatous conditions, and even-purulent inflammations. In the light of our present knowledge we must assume that the inflammatory symptoms are due primarily to the entrance into the iris tissue of some infectious germ, and such a complication in a large measure has been overcome by our modern aseptic methods of handling injuries. If the wound is a solid one, and closed to outside infection, there can be little danger of inflammatory reaction, and this is evidenced by the fact that many cases of prolapse of iris following injuries or operations, with incarceration of the iris tissue in the wound, have made uneventful recoveries and remained free from irritative or inflammatory reactions for long periods of time. It would seem, therefore, that it is folly to offer any objections to the operative correction of iridodialysis by incarcerating the iris in a corneal wound, on the ground that it is not a safe procedure.

I have had occasion to operate three cases of traumatic iridodialysis to correct defects that were very annoying to the patients thru double vision, movement of the torn iris, or objection to the double pupil from a cosmetic point of view.

In the first case, operated a number of years ago, the patient had a large iridodialysis occasioned by a sharp blow upon the eye, and this was corrected by making a relatively large opening at the limbus, thru which the bridge of iris was drawn, and to

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insure its permanent incarceration in the wound it was anchored by a stitch which also enclosed the conjunctival flap without leaving any iris exposed. In this case recovery was uneventful, and, while the pupil was drawn upward to a considerable extent, yet the result was very satisfactory to the patient as well as to me. The eye remained perfectly quiet for a period of some three or four years, after which the patient was lost to observation.

The second case was a similar one, but the iris was not anchored in the wound in connection with the conjunctival stitch and it went back into the anterior chamber, but was replaced later with satisfactory results, so far as known, tho the patient was lost sight of soon after the operation.

The third case was of more recent occurrence, and in this case, with a large iridodialysis due to trauma, an effort was made to incarcerate the iris in the smallest possible wound at the limbus that would permit the introduction of iris forceps. Liebrecht iris forceps were used, the bridge of iris was seized on its torn edge and drawn into the wound sufficiently so that there was but the slightest amount of prolapse visible. No stitch was introduced. The wound was touched with pure tincture of iodine, the eye dressed with sterile vaselin, and the resulting effect was exceedingly gratifying in that it left the pupil but slightly deformed, and corrected a condition that was very annoying to the patient,—a young lady of twenty years of age. The operation was performed on May 17, 1919, and within ten days the eyeball was entirely free from inflammation or even irritation, and it has remained so up to the present time.

To my way of thinking this operation should be more generally used for the correction of extensive traumatic iridodialysis. It is preferable to the complete removal of the bridge of iris which leaves a very large coloboma with its disfiguring effects as well as irritation thru the passage of too much light into the eye, and when performed under our present methods of surgical technic it offers little or no evidence

of being what many authors term "a risky procedure."

The point I would make is that the opening at the limbus should be on the scleral side; it should be no larger than necessary for the entrance of a closed pair of Liebrecht's iris forceps; and the bridge of iris drawn into the wound should not prolapse beyond the conjunctival flap. I am under the impression that the application of pure tincture of iodine to the wound with its incarcerated iris has a tendency to prevent irritation, while at the same time it stimulates the reparative process.

### CASE OF ACUTE TENONITIS

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**HISTORY:** While driving a motor car at a rather high rate of speed very early in the morning, patient noticed that he had difficulty in moving his eyes from side to side. A few minutes following this he felt as tho his lids were swelling, and stopped the car to have the occupants look at them. The owner verified the patient's fears, and placing him in the rear seat, himself drove to the city, where the writer saw the case within two hours after the first symptom had appeared.

**EXAMINATION:** Very marked chemosis of both lids of either eye, extending across the bridge of the nose, firm and hard to the touch. Patient was at this time unable to voluntarily open the palpebral fissure. Upon raising the lids, with horn retractors, the globe of each side was red, swollen so that the conjunctiva extended over, and obliterated all but 5 mm. of corneal surface, and the external ocular muscles apparently fixed, as the voluntary movement was limited to excursions of about 4 mm. in any meridian. Ophthalmoscopic search of the fundus revealed nothing abnormal. The reaction of the iris was sluggish. Monocular vision was slightly below normal, probably due to the fact that it was taken while the lids were held apart mechanically. Binocular vision was not possible due