

THE
BOSTON MEDICAL AND SURGICAL JOURNAL.

VOL. LXVIII.

THURSDAY, MARCH 26, 1863.

No. 8.

IRIDECTOMY.

By J. H. DIX, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

THE operation of iridectomy has been too recently correctly described in this and other journals to make it necessary to repeat it. There are, however, one or two points connected with it, a further consideration of which may lessen the repugnance of the general practitioner to enter upon this portion of the field of surgery.

First, the instruments essential to its performance are to be found in the dressing case of every practitioner; viz., a lancet, a pair of forceps and scissors. The lancet should have a broad shoulder in order to effect a sufficiently wide opening without bringing its point too far forward in the anterior chamber for the safety of the cornea. It should not have been thinned by repeated sharpenings, and of course should be in perfect order. The forceps need not absolutely be very small, provided that they are *pointed*. The scissors, if large, must be first ascertained to cut with precision close to their points, and curved are preferable to straight scissors.

A thorough etherization of the patient is very desirable, as also that he should not be liable to vomit from a recent meal. If by the fingers of the operator and of a clever assistant holding the lid, the globe is not rendered nearly immobile, a common tenaculum or hook passed through the conjunctiva and twisted half round answers very well as an ophthalmostat. With these instruments, if those to which I am accustomed are not accessible, I should not hesitate to operate.

The first step in the operation, as described by some, suggests a difficulty and perplexity, even to one tolerably conversant with the minute anatomy of the eye. It is directed to enter the sclerotic a half line back of its anterior margin. Now all operations with which we have heretofore been familiar by sclerotomy

VOL. LXVIII.—No. 8

(through the sclerotic) have been posterior to the iris, and it is necessary in this connection to bear in mind the fact that although the sclerotic appears to terminate where the iris commences, it does not, but advances front of the plane of the iris. It is intended to enter the anterior chamber, and to take hold of the iris on its anterior face. The initiative incision is, therefore, to be made in front of the iris, but as near to it as is practicable, and it is in fact made not through the sclerotic alone, but through the sclerotic and the cornea; through a portion of the sclerotic which overlaps the cornea and a portion of the cornea which underlies the sclerotic.

The second step in the operation, the seizure of the iris by the forceps and pulling a portion of it out, does not involve a plunging of the forceps into the anterior chamber. With the evacuation of the aqueous humor, the iris has already fallen towards, and presents itself at and sometimes through the opening.

In the last step, the cutting off of the iris, it is important to remember that in glaucoma and other conditions for which it is necessary to lessen intraocular pressure, it is desirable to remove a considerable portion of the iris, and especially that nearest its outer circumference. The iris must be cut off as closely as possible to the globe.

On these points the *American Journal of Ophthalmology* gives, among other valuable hints, the following from Dr. Arlt:—"The iris must be cut off to its periphery in order to give entire satisfaction. The section of the iris must at least comprise 2^{mm} of its substance, and for that purpose the outside wound of the cornea must have 6^{mm} to 8^{mm}, the inside one 3^{mm} to 4^{mm}. The iris hook (Tyrell's), is so dangerous for the capsule that its employment ought to be dispensed with. The cutting off of the iris after it is drawn out of the wound must be done *à deux temps*: the first half of the flap is cut, and then this part is drawn upward before the rest is snipped off. This method allows to cut up to the margin of the corneal wound."

Previous to the remarks here quoted, Dr. Arlt had expressed his preference for an initiative opening through the cornea only, near the sclerotic, instead of through the sclerotic. In cases in which the pupil is not much dilated, this may be allowable; and to an unpractised operator would certainly be convenient. But when, as in glaucoma, for the relief of which a general practitioner would oftenest find occasion to perform iridectomy, the pupil is largely dilated, sometimes to the extent of complete mydriasis, the readiest access to the iris, and especially its periphery, will be found to be at the overlapping of the sclerotic upon the cornea, in accordance with general usage.

Of the inestimable value of this means of relieving intraocular pressure, and of the imperative necessity in glaucoma of an early

resort to it for the salvation of sight, a continued experience has convinced me, and I delay the report of several cases of interest, only to be assured of the permanence of the apparent result.

OBSCURE SOURCES OF DISEASE.

By JAMES R. NICHOLS, BOSTON.

[Communicated for the Boston Medical and Surgical Journal.]

THERE are many instances of disease brought to the notice of physicians which are exceedingly perplexing in their character, and the sources of which are very imperfectly understood. They belong to a class outside of, and distinct from, the usual forms of disease resulting from constitutional idiosyncrasies, or accidental causes, within the knowledge of the patient or medical attendant. The obscurity of their origin and persistency under treatment, render them peculiarly trying to the patient and the skill of those who have them in charge, and after the trial of the usual remedies without effect, the patients are sent into the country or to the sea-shore, as the case may be, with the expectation that a change of air or residence may prove beneficial.

We cannot, in a majority of cases, regard these affections as altogether imaginary, or as resulting from some casual derangement of the nervous system; they are instances of true disease, and should be studied with the view of bringing to light the hidden source from whence they originate. I am led to believe that a considerable number arise from some disturbance in the sanitary conditions of dwellings or their surroundings, and that however improbable this may seem from a superficial or even careful examination of suspected premises, a still more thorough and extended search will often result in the discovery of some agent or agents capable of producing disease.

The chemical and physical condition of water used for culinary purposes has much to do with health, and is perhaps the oftenest overlooked by the physician in searching for the cause of sickness. We must not suppose that water is only hurtful when impregnated with the salts of lead or other metals; there are different sources of contamination, which produce the most serious disturbance upon the system. Some of these are very obscure and difficult of detection. The senses of taste and smell are not to be relied upon in examinations, as it often happens that water entirely unfit for use is devoid of all physical appearances calculated to awaken suspicion. It is clear, inodorous, palatable, and there is no apparent source from whence impurity may arise.

A few instances which have come under my observation may serve to illustrate the view presented, and as suggestions to those