

Simultaneous rupture of the choroid and parietic mydriasis without paresis of accommodation / by Alexander Duane.

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Duane, A. 1858-1926.
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Publication/Creation

[Chicago] : [R. R. Donnelly and Sons, printers], [1901]

Persistent URL

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SIMULTANEOUS RUPTURE OF THE CHOROID AND PAR-
ETIC MYDRIASIS WITHOUT PARESIS OF
ACCOMMODATION.

BY ALEXANDER DUANE, M. D.

NEW YORK.

The publication of Dr. de Schweinitz's interesting case in the May number of the RECORD has impelled me to report a quite similar case from my own practice.

John H., aged 13, came to my office June 6, 1889. Two months before had been struck in the left eye by a corn cob, thrown at him by another boy. The blow was so severe that he fainted, and when he came to he had to be kept in bed and in a dark room for two days. The eye was much suffused at the time. The pupil was dilated; according to his father's statement, more so than now.

At the present time, both pupils large; left slightly larger than right. On exposure to light, right contracts to 3 mm. Contraction of left pupil, whether produced by light (direct or consensual reaction) or by convergence, is imperfect, the pupil always retaining a width of not less than 6 mm.

V, $\frac{1}{2}$ —each: rejects all glasses. Accommodation normal in each eye.

Muscles normal in all respects.

In left eye two faint ruptures of the choroid, close to the disc and concentric with it; one, below the disc, running nearly horizontally, the other, to the upper temporal side of the disc, running obliquely. The two areas of rupture intersect near their ends, forming an obtuse angle. No pigmentation in their vicinity, and fundus otherwise normal.

The points of similarity between this case and that reported by Dr. de Schweinitz, are:

1. The coexistence of a rupture of the choroid with a parietic mydriasis, both evidently produced by the same traumatism.
2. The peculiar bifurcated form of the rupture.
3. The retention of normal vision in the affected eye.

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In my case no notching of the sphincter border could be made out. The contusion may, however, have caused a laceration of the sphincter too minute to be discoverable and yet sufficiently great to impair the contractility of the muscle. This, I think, more likely than that the oculomotor nerve-endings in the iris were paralyzed by the blow. A contusing force sufficiently great to produce actual permanent paralysis of these nerve-endings would be apt to leave some paresis of accommodation as well. The accommodation, however, here was intact.

That, nevertheless, a temporary parietic mydriasis may be caused by a concussion which does not produce a laceration of the sphincter, I can confirm from my personal experience. Some years ago, while playing tennis, I was struck in the eye with a ball flying with great force. The immediate result was severe pain, marked mydriasis, and considerable blurring of vision. All these symptoms passed away in the course of a few hours, leaving the iris as mobile as ever. Whether this transitory paralysis of the sphincter was associated with an equally transitory paralysis of accommodation I could not tell, as the sight was too much affected for me to settle this question satisfactorily.