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De Schweinitz, G. E. 1858-1938.
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Publication/Creation

[London] : [John Bales, Sons & Danielsson], [1900]

Persistent URL

https://wellcomecollection.org/works/u9hzpb82

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BLINDNESS FROM SYMPATHETIC OPHTHALMITIS—RESTORATION OF VISION BY CRITCHETT'S OPERATION.*

BY G. E. DE SCHWEINITZ, M.D.,

PHILADELPHIA.

Doubtless we all agree with the late Mr. George Critchett's advice not o attempt operative interference during the progress of sympathetic phthalmitis. As he says: "It is only when the disease has run its ourse, and finished its work of destruction, so that the eye has not only ecome perfectly quiet, losing all vascularity and sensitiveness to light, ut when this condition or quiescence has existed for some time, that t may become expedient to commence operative measures."†

Iridectomy, iridotomy and various forms of extraction having proved nsatisfactory or disappointing, Mr. Critchett proposed and practiced the llowing operation: The patient is placed under the influence of an anes-hetic, a speculum is introduced, the globe is fixed, and a fine cutting eedle is introduced through the cornea, its point being directed to he center of the capsule. This structure is penetrated by making a apid rotary movement, on the principle of a gimlet. A second needle introduced from the opposite side and the points separated from each ther, the result being a rent in the center of the capsule and the escape f the soft lens matter. The operation must be repeated at proper inter-als until a clear pupil has been obtained.

The following is a case in point:

Benjamin C., aged 53, born in Philadelphia, married, an engraver and rinter by trade, was admitted to the ophthalmic wards of the Philadel-hia Hospital on August 17, 1898.

History.—His family and personal history in detail is unimportant; e has enjoyed good health; he has spreed occasionally, but is not steady drinker; he smokes and chews tobacco excessively; he is not yphilitic.

In March, 1898 (he does not remember the exact date), his left eye as injured by a blow from a walking stick. He remained one night in he Polyclinic Hospital, and then returned to his work, occasionally visit-

*Read before the Ophthalmic Section of the College of Physicians, Philadelphia, Jan. 16, 1900.

†*Royal Lond. Oph. Hosp. Reports*, Vol. X, Part 2, 1881, p. 144.

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ing the Howard Hospital and also the office of an eye-surgeon for advice and treatment, which he seems not to have followed with regularity. About six weeks or two months after the injury of the left eye, which probably caused an irido-cyclitis, although this is not quite clear from the patient's statement, sympathy began in the right eye, which "got red as if he had taken cold in it." He was advised "to have an operation" (probably enucleation), but declined. He then wandered to the Homeopathic Hospital, where he was admitted and treated for three months, and where his left eye was enucleated.

After his admission to the Philadelphia Hospital (August 17, 1898), he first came under the care of my colleague, Dr. Oliver, who found typical irido-cyclitis and secondary cataract, the eye being still much injected; V. = movements of the hand. Under treatment the inflammation began to subside, and by October 29, 1898, vision had risen to counting fingers at two feet.

On November 3, 1898, I divided and resected a small band of cicatricial tissue which united the central region of the socket with the upper lid, but which, however, was not connected with the stump of the optic nerve. No operation was attempted upon the right eye until January 4, 1899, when I made with some difficulty, owing to the friability of the iris and its close attachment to the capsule of the opaque lens, an iridectomy upward and slightly outward. In a short time this coloboma closed, and its position could only be surmised by a somewhat irregular scar-line. Vision was now movements of hand; good light field. General medical treatment—iron, quinine, arsenic, and at times mercury, with atropine and scopolamine locally—was continued until June 26, 1899, when my chief assistant, Dr. Veasey, while temporarily in charge of the wards, attempted irido-cystectomy. This met with slightly better success than the previous iridectomy, because although the incision closed, a small area of lens-surface, about two millimeters in length and one millimeter in width, remained uncovered by adherent iris. This space afforded the opportunity of performing a modification of Critchett's operation, which I did as follows on December 6, 1899:

The eye having been cocainized, a Bowman's stop-needle was introduced so that its point rested upon the small area of exposed lens-capsule, which it was made to penetrate by a twirling or gimlet-like movement. Almost immediately semi-liquid, grayish-white lens-matter began to escape alongside of the needle and fill the anterior chamber. The needle was withdrawn after the opening had been enlarged by slight vertical and lateral movements, and the eye was dressed with a light compressing bandage.

In twenty-four hours the anterior chamber was clear and the patient could uncertainly count fingers. On December 13, 1899, a Knapp's knife-needle was introduced and the capsule carefully cut and thrust aside. This manœuver created a clear oval pupil, somewhat below the center of the iris, to the upper margin of which the remains of the lens-capsule is clinging. There was no reaction, and in ten days the patient's vision was 5/60 with $+12^{s}$. Two months later V. with $+12^{s}+6^{c}$ axis 75 was 5/25, and with $+4^{s}$ added he could read D. = 0.75 at 20 cm.

Operations of this character, according to the author of the surgical procedure, and also according to J. B. Story, who has written upon this subject and advocated the measure, are best suited to young eyes. That they may also prove successful in old eyes—my patient was 53—is evident from the present report. It is essential that the eye shall be free from "vascularity and sensitiveness to light" for some time before the operation is undertaken. This necessary condition of affairs was secured in the present instance by months of careful medicinal treatment.