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CATARACT EXTRACTION IN REFRACTORY PATIENTS AND THE OPERATIVE TREATMENT OF IRIDO-DIALYSIS

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WHEN in practice one tends to settle down to cut-and-dried lines in the performance of various ophthalmic operations, it is sometimes a relief and affords some pleasure to be forced to try something slightly different, and possibly not quite orthodox. There is a natural reluctance to depart from well-proved procedures, but when one does and gets good results, the effect is very stimulating.

Some months ago I had a patient—a farm labourer of about sixty-eight years with a double cataract, on whom I had performed a preliminary iridectomy. It was quite useless to expect him to stay in bed—all his life he had got up at five in the morning and persisted in doing so even in Hospital. When he arrived in for the actual extraction, I was frankly puzzled to know what to do to make things as safe as possible. In the end I decided that if the incision could be kept as small as possible the risk of his daily five o'clock leap out of bed might be faced with more equanimity. To effect this, the capsule was torn and the lens thoroughly stirred

up with a Ziegler knife, and the eye was then left alone for about a week or ten days, by which time the lens matter had thoroughly "fluffed up." A keratome incision was then made above, and most of the lens matter washed out. It was found that the nucleus had some difficulty in passing through the small keratome incision, and this was widened very slightly by a snip of the scissors on either side. With a little patience and gentle pressure below and above the wound, the nucleus was coaxed through, and a final irrigation left a clear pupil.

As the wound showed no tendency to gape, the patient—after the usual atropine and argyrol, and with only the operated eye bandaged—walked back to the ward, and continued to be an ambulant case until he went out eight days later with a good result.

I was so struck with the post-operative lack of anxiety that I have since tried it on six other cases with good results, modifying the procedure by breaking up the lens first and then proceeding later to do the iridectomy and extraction through the keratome incision. The method is not so clear cut as the straight-forward extraction, and perhaps a little more patience is required in getting the nucleus through—I think it might be possible in some cases even to break up the nucleus with forceps, thus keeping the size of the incision to the very minimum—but the sight of a firmly shut little wound, and not the lax gaping of the full size cataract extraction, is very comforting, and the nursing is infinitely more pleasant from the patient's point of view, as he need not stay in bed at all. In my last case I managed to break up the nucleus itself with a Ziegler knife into five pieces, which were delivered through a very small incision.

Whilst on the subject of slightly out-of-the way operative methods, the question of treatment of iridodialysis may be worth mentioning. Some time ago I was faced with an iridodialysis in a boy aged sixteen years, in which the iris was torn away at its root for over half its circumference. There was no wound of the globe and the eye settled down cleanly and quietly, but the iridodialysis made a very obvious disfigurement. I had never seen any treatment for this condition and the text books I had did not throw any light on how to deal with it. I decided that it would be worth trying to do something.

A very narrow keratome was inserted about a millimetre and a half behind the corneosclera and pushed in obliquely until its point just appeared in the anterior chamber. The incision was as "flat" as possible, *i.e.*, similar to the incision for an iridencleisis. A very fine iris forceps was then gently pushed in and the root of the iris seized. This was then gently drawn into the wound, which was pressed by the tip of the handle of the keratome, and

the forceps released. Forty-eight hours later the eye was clean and quiet, and the portion of the iris root in the wound was still firmly held there. At the end of another few days, the same procedure was carried out further along the iris root, and again the portion remained firmly fixed. This was repeated a third time and was again successful, the eventual result being that the whole of the iris root was replaced by these three small operations, and has remained so ever since. The eye showed no reaction and the disfigurement was entirely done away with.

One small point which would not be overlooked in future was in the case of the first operation, where, being very anxious to make sure that the iris root remained in position, it was pulled out a little too far and formed a small filtering cicatrix, and the small iris protrusion had to be cauterized two or three times to flatten it out. It was found with the other two wounds that it was only necessary just to draw the iris root into the inner lips of the wound.

In an American book on ophthalmic surgery, which came into my hands after this, I looked up the treatment of iridodialysis, and was slightly abashed to find that what I thought was a new procedure had in reality been described by Wheeler of New York. It can certainly be advocated as a most simple method for dealing with the disfigurement and visual impairment due to an iridodialysis.

P.S.—Apparently after a week or more of soaking in aqueous, the cortex comes away fairly easily and—especially after irrigation—the nucleus can be made out quite distinctly. With this in mind it might be possible not only to crush it up in forceps, but possibly actually to cut it in two or three parts with a pair of fine scissors. Furthermore, with an iridectomy, which is only just a little smaller than the incision, prolapse is practically impossible. How much value there may be in the whole procedure is difficult to assess, but it may have its place in certain circumstances, or might even lead to further developments in more skilful hands than my own.

Much to my surprise the replacement of the iridodialysis is remarkably easy, as there does not seem to be any tendency for the root of the iris to pull away from the wound after replacement, which is what I thought would be the main difficulty.