

Summary

This report deals with 2,478 eye injuries in 30 collieries in Scotland extending over a period of eighteen months, and 11,953 eye injuries in 30 factories in Scotland in six months.

First aid treatment was essentially the use of 10 per cent. albuclid soluble (sodium sulphacetamide) as eye drops.

Of the total injuries in collieries, 96 per cent. returned to work with no loss of working time.

In factories and shipyards, there was no loss of working time in 98.87 per cent. of the cases.

These eye drops have already been recommended by the Ministry of Fuel and Power for use as first aid treatment in Collieries throughout the country.

The excellent results after six months trial in factories fully justify the recommendation that the new eye drops be adopted in all forms of industry where there is any danger of injury to the eyes.

REFERENCES

- (1) and (3) DICKSON, R. M.—Traumatic Ulcer of the Cornea with special reference to Coal Miners. *Brit. Jl. Ophthalm.*, December, 1942.
- (2) GARROW, ALEXANDER.—A Statistical Enquiry into 1,000 Cases of Eye Injury. *Brit. Jl. Ophthalm.*, February, 1923.
- (4) MINTON, JOSEPH.—Industrial Eye Injuries and their Prevention. *Brit. Jl. Ophthalm.*, p. 673, 1936.

A NOTE ON IRIDENCELEISIS

BY

P. JAMESON EVANS

BIRMINGHAM

THE operation of iridencleisis has in the past fifteen or twenty years gradually gained popularity for the treatment of glaucoma and, in some parts, has come to be preferred to trephining in the majority of cases.

It is in fact at the request of an enthusiastic convert to this operation that I offer this short note on a modification of the classical technique.

Perhaps I should first make it plain that iridencleisis finds its best application, in common with all the fistula operations, in cases of non-congestive glaucoma, either chronic or sub-acute: in acute congestive glaucoma all manipulations of the iris or ciliary body are contra-indicated if other procedures are possible. Secondly the usual technique which I adopt for iridencleisis is the total section

of the temporal pillar of the withdrawn iris and its reposition into the anterior chamber, while the nasal pillar is retained for inclusion through the lips of the incision.

The modification which is now described is particularly applicable to such cases in which the iris is still elastic and the pupil still responsive to eserine; in cases where there is marked rigidity

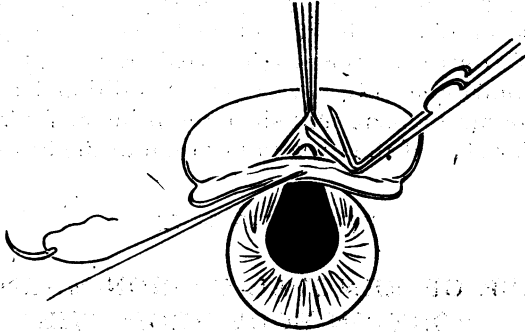


FIG. 1.

of the iris and poor pupillary response I prefer the classical procedure. If the iris, then, can be easily withdrawn it is possible to secure a peripheral iridectomy by an oblique incision of the withdrawn iris. The scissors are applied with the heel touching the globe and the points slightly raised, and about two thirds only of the thickness of the iris is cut, but to a sufficient length to provide a tongue which will easily reach the subconjunctival pouch through the lips of the incision. (Fig. 1).

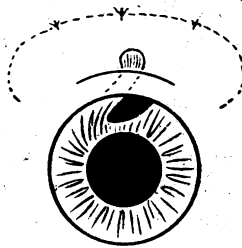


FIG. 2.

The replacement of the iris is effected by gentle external pressure over the corneal limbus and the temporal half of the wound while retaining a grip on the tongue of the iris. (Fig. 2).

It is preferable, whenever possible, to include the nasal pillar

of the iris in the wound and to replace the temporal pillar into the anterior chamber. The final result gives a better cosmetic effect and retains the sphincter action of the pupil, and has been found to provide an adequate fistula at the same time.

Gentle massage and drops of pilocarpine $\frac{1}{2}$ per cent., or of pilocarpine and adrentalin, are required as post-operative measures for one to three months, as in the case of most iridencleisis operations. Indeed I prefer to institute a permanent post-operative routine of the daily use of pilocarpine in all such cases as a precautionary measure of control of the whole uveal tract, since any type of fistula can contribute only a very small additional fraction to the total drainage mechanism, and since the primary fault lies perhaps in the vascular tone of the uvea rather than in the filtration of fluid.

A CASE OF REMOVAL OF NON-MAGNETIC FOREIGN BODY FROM THE CILIARY REGION

BY

DERMOT PIERSE

LONDON

THE suggested techniques and instruments for the extraction of non-magnetic foreign bodies from the vitreous chamber are many. Much ingenuity has resulted in such various methods as Cruise's telephone probe, Thorpe's endoscope, biplane fluoroscopy and so on. Equally noticeable, however, is the paucity of actual details of cases successful or unsuccessful.

Where the foreign body lies free in a clear vitreous, Spaeth recommends that either the endoscope or biplane fluoroscopy be used, but says that if it lies in contact with the retina or ciliary body, some form of flap sclerotomy following accurate localisation is the proper procedure. Savin in his Hunterian lecture earlier this year, mentioned that he was able to find only one successful case recorded in the literature. It was on his account of Spaeth's technique that this operation was based.

Case Report.

J. B., a male aged 38 years was watching a fellow worker turning a brass bolt, when the tool slipped and he felt a sharp pain in the right eye. On examination a few hours later it was found that a small foreign body had perforated the right cornea just above its centre and travelling downwards, had driven through the root of the