IRIDENCLEISIS—A MODIFICATION

By D. PRIESTLEY SMITH

THREE months ago a woman of 80 came to see me. Both eyes were hard and both lenses opaque. One eye was stone blind, but the other had fairly good projection, and she chose to face cataract surgery on this eye, though realising that the risks were high.

One had, of course, to relieve the glaucoma first; and this meant making a filtering scar that would not be deranged by the subsequent cataract wound. One way would have been to do the glaucoma operation below the cornea; but in that situation it is permanently more exposed to infection. So I decided on iridencleisis above the cornea as usual, but further still from the limbus if possible; and the question arose how to minimise the difficulty of striking the angle of the anterior chamber from so far away.

The procedure which I adopted was as follows. First, I lowered the vitreous pressure by a scleral puncture with a Graefe knife 45 degrees to the temporal side of the vertical meridian and 6 mm. from the limbus. This is my usual first step in glaucoma operations. Next, with a rather narrow parallel-sided keratome, I made an incision as for an ordinary preliminary iridectomy, but entering the sclera about 5 mm. above the limbus. With an iris hook I then pulled a loop of iris into one angle of the wound and snipped off the tip of the prolapse flush with the surface. By stroking the wound from the opposite end I freed one pillar of the loop so that it slipped back into the anterior chamber, leaving the other incarcerated. I do this as a routine in iridencleisis, to reduce the amount of iris tissue left in the wound, one pillar being enough in my experience.

The iris inclusion had now to be provided with a proper covering of conjunctiva. I made a scissor-cut through the conjunctiva parallel with (and rather longer than) the keratome wound and about 5 mm. above it, and tunnelled under the strip of conjunctiva.

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lying between the two. With two pairs of fine forceps I then picked up the lips of the conjunctiva over the keratome incision and pinched them together, hoping that they would adhere, which they did, the elastic pull from above having been abolished by the scissor-cut. This cut served another purpose also: it provided a temporary outlet for the aqueous, so that the lower conjunctival wound was not forced open again, but had time to unite.

The scar filtered well, lowering the tension nicely, and in a few weeks I extracted the cataract, somewhat hampered by two inconveniences. The previous operation had warned one of the first, namely, that the sclera was very tough, as it so commonly is in eyes with glaucoma of long standing. The second is, fortunately, not so common; as I was, with difficulty, making my counter-puncture, fate decided that this was the moment for the patient to be seized with cramp in the leg. It gave everyone a bad forty-five seconds, but her great self-control prevented it from wrecking the eye. I cut out at the limbus, foregoing a conjunctival flap, so as to give the filtering scar a wide berth, opened the capsule with forceps and expressed the lens.

Recovery was uneventful. The redness lasted rather long, but at the time of writing, four weeks after the extraction, it has nearly all gone, the filtration has not been upset, the tension keeps normal (to palpation) and the corrected vision is 5/8. (Vitreous haze. Disc cupped).

The above method of performing iridencleisis enables one to make the scleral incision through undisturbed conjunctiva instead of under a fold. This lessens the difficulty of directing the knife accurately, and so allows one to introduce it well back from the limbus without undue risk. This consideration comes to the fore especially when one contemplates subsequent extraction of cataract; but it applies also in ordinary cases of glaucoma. And the procedure is simple.