EXTRACTION OF CATARACT IN A CASE OF
SYMPATHETIC OPHTHALMIA*

BY

F. W. G. SMITH

MARGATE

THE summary in Ophthalmic Literature of an article by A. Franceschetti¹ has prompted me to report this case.

In October, 1946, Mrs. A., aged 79 years, with bilateral cataracts, underwent a left extra-capsular extraction without any obvious operative complications, but two days after operation an acute iridocyclitis developed. The usual treatment was undertaken, and both eyes observed carefully with the slit-lamp. Enucleation was advised after five weeks, as the left eye had a marked flare, many plastic keratic precipitates and new vessels in the iris. The tension was low, and she had recurrent attacks of ciliary pain.

The day after the left eye was enucleated typical sympathetic ophthalmia developed in the right eye, which, after much treatment and many distressing symptoms, settled down, but showed a slight flare, many K.P., posterior synechiae, and the pupil occluded by exudate. The tension became low. By mistake a section of the enucleated eye was not carried out, but clinically all the signs of sympathetic ophthalmia were present. The case had been examined several times with the slit-lamp before operation, and there had been no evidence of previous iritis.

As the projection of light was good in the remaining eye it was felt that some risk might be taken owing to the age of the patient. Nineteen months after the onset of the disease, extraction was undertaken with the usual akinesia, retrobulbar anaesthesia, bridle suture and, in this case, a Stallard's corneal suture. A large corneal section was made, and retraction of the cornea by the suture allowed the excision of a large portion of iris and capsule with a capsule forceps. The lens was lifted out, without vitreous loss, by two Ziegler needles inserted into its substance. 20,000 units of white penicillin in 1 c.c. *aq. dest.* were dropped on the eye before, during and after operation. The removal of the lens was easier than in the case described by J. Herbert Fisher,² where the cataract was extracted seven years after the onset of the disease.

The eye settled down quickly, and one month later an opening was made with a fine Graefe knife in the thick but soft membrane remaining. The corrected vision was reduced to 3/60 on account of a white plaque in the macular area, which might have been the result of a coalescence of Dalen's spots, but the peripheral field was full, and the patient was able to get about and undertake household work.

I have found the above method of extraction useful in complicated cataract with many iris adhesions. One Ziegler needle with slight external pressure on the lower pole, or two needles without external pressure, can be helpful in extracting the lens, and also when the capsule has burst in an intra-capsular extraction. A fine straight, non-toothed iris forceps instead of a corneal suture retracts the cornea. I have ceased to use the latter in routine cataract extractions.

The fixation forceps in the illustration are a type used by Dr. Frank Burch (Senior) of St. Paul, Minnesota, and they have many practical advantages. Their 20 into 19 teeth provide excellent fixation, whether the conjunctiva is normal, friable or oedematous,

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Conjunctival Fixation Forceps.

and the breadth of grip helps to prevent rotation of the eyeball in a Graefe section if the knife is not quite perfect.

It is suggested that, where cataract has developed in cases of sympathetic ophthalmia, fairly early operation might be undertaken when the slit-lamp does not show undue inflammation and the acute recurrences have subsided, despite the presence of keratic precipitates and a slight flare. The irido-capsular membrane may be softer and an opening made more easily to lift out the lens. The same would seem to apply to the after-cataract.

REFERENCES

- FRANCESCHETTI, A. (1948).—*Ann. d'Ocul.*, **181**, 530.
 FISHER, J. H. (1933).—*Brit. Jl. Ophthal.*, **17**, 35.

SIMPLE CAMERA SUPPORT FOR THE OPERATING THEATRE

BY

GY. P. HALBERG, M.D.

ARGENTINA

THE usual photographic tripods are often inconvenient and cumbersome when used in the theatre for the photography of eye operations. For this reason a simple *unipod support* has recently been designed. A short illustrated specification is given below.

The unipod consists of a vertical iron rod, and a horizontal flat iron tongue, supported at 90° by a simple diagonal bar. The vertical member is $\frac{1}{2}$ in. solid rod, 36 in. in length. The horizontal portion is flat; 24 in. long, $1\frac{1}{4}$ in. wide and $\frac{1}{4}$ in. thick. Two slots