WEBSTER (DAVID)

Two Cases of Destruction of Vision by Foreign Bodies;

Restoration of Sight in One out of Four Eyes by Operation.

BY

DAVID WEBSTER, M. D.,

Professor of Ophthalmology in the New York Polyclinic and in Dartmouth Medical College; Surgeon to the Manhattan Eye and Ear Hospital.

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The two following cases are of extraordinary interest, inasmuch as the father lost the sight of both eyes from injury with bird shot, the gun having been fired by his son, while the same son lost the sight of one eye permanently and of the other temporarily by a cannon explosion less than a year later. The acuteness of vision restored to one of the son's injured eyes by the removal of the traumatic cataract is worthy of remark:

Case I. *Both Eyes of the Father Put Out by Bird Shot.*—James O. P., aged forty-eight years, of Tariffville, Conn., was accidentally shot by his son in both eyes, a No. 10 shot in each, on August 13, 1869. His son thus describes the catastrophe: "We were hunting woodcock in the bushes. My father was about five rods from me when I shot. I did not see him. The bird was flying. My gun was elevated from where I stood as much as five rods over his head. There were only two shots struck him—one in each eye."

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When Mr. P. came to consult Dr. C. R. Agnew, on May 29, 1874, nearly five years after the accident, the condition of his eyes was as follows: There was no perception of light in either eye by the usual tests, but the patient said he could see the sun with both eyes. The crystalline lenses were mostly absorbed. There was total posterior synechia of both, and both irides were arched backward. A cicatrix at the center of each cornea showed where the shot had entered the eye. Dr. Agnew was of the opinion that no operation would restore any sight, and advised him to have nothing done for his eyes.

Case II. *Both Eyes Injured by a Cannon Explosion; One Lost; the Sight of the Other Restored by Operations.*—J. C. P., aged twenty-three years, the son of the above patient, and the man who did the shooting, was brought to Dr. Agnew's office at the same time with his father.

On the 4th of July following the accident to his father—*i. e.*, July 4, 1870—he had both eyes injured, one lost, by a gunpowder explosion. He thus describes the accident: "I went up to the mountain to fire the cannon. It was a very large one. We put eleven pounds of powder in it, and drove turf in with a sledge hammer, and the second time the fuse that we set it off with turned over and struck in the vent hole, and it was loaded so—drove in so hard—that it did not go off. It all blew backout of the vent hole right to the left of my head. I was within two feet of the vent hole. My foot was on the cannon. If my head had been four inches to the left it would have been blown off. The powder did not burn that went into my face. I was covered from my waist up, and it burned my clothes off."

Upon examining him we found that he had *phthisis bulbi* of the left eye. In the right eye there was traumatic cataract. There were adhesions of the iris to the anterior capsule of the lens, and there were particles of powder and possibly of dirt in the substance of the lens. Still, he retained vision enough to enable him to get about alone. Dr. Agnew advised that the eyes be not operated upon unless the vision became worse.

June 6, 1878.—The patient counts fingers at four inches when they are moved before his eye. He can no longer see sufficiently well to go about alone.

10th.—I administered ether, and Dr. Agnew enucleated the left atrophied eyeball at the Manhattan Eye and Ear Hospital.

Several needle operations were done on the cataractous lens by Dr. Agnew at proper intervals of time, and the vision was considerably improved. He came to the hospital on July 17, 1885, with a dense membrane in his pupil and with vision only $\frac{4}{200}$ with the best glass. Dr. Agnew being absent, I performed a discission on the same day. The result was vision $\frac{10}{200}$ while the pupil was dilated with atropine; but it was evident that the clearest part of the pupil would be covered by iris when the effects of the mydriatic should have passed off.

On July 22d, five days after the discission, I made an incision with an iridectomy knife at the temporal side of the cornea, just over the border of the dilated pupil. I then passed in a small, sharp hook, and, engaging it in the membrane, withdrew the latter from the eye, leaving quite a large mass of opaque lens-matter in the supero-temporal portion of the anterior chamber in contact with the iris. I then dropped in atropine and bandaged the eye. There was very little immediate inflammatory reaction. Some days later the patient had considerable pain in the eye. Iced cloths, atropine, and eserine were applied locally; one or two hypodermic injections of morphine were administered.

August 8th.—The eye is no longer painful, but still somewhat red. Vision $= \frac{30}{200}$ with $+ \frac{1}{4}$.

15th.—The redness has passed off. Vision $= \frac{20}{30}$ with a convex glass.

June 23, 1894.—Vision $= \frac{20}{30}$ with his glass. Vision $= \frac{20}{15}$ with + 10 D. s. $\bigcirc$ + 2·75 D. c. axis 50°. There is still, nine years after the last operation, a movable mass of organized lymph attached to the iris, supero-temporally, and waving about in the aqueous humor as he moves his eye.

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