

Behari is far removed from that degree of intelligence that Captain H. Smith, I.M.S., ascribes to the Punjabi cultivator.* Over and over again, here in Behar, I have examined a man with commencing cataract, and advised him to wait a few months and come again for operation, at the same time ordering his name and address to be taken. After a few months I have found that the man has had his eye "couched." In the same way if he is not operated on at once he thinks operation is refused. Another reason for the coucher getting patients is that he comes to a village and gathers a crowd, in the usual quack style, and operates on a villager with cataract. The man sees immediately, and all with any defect of vision then come forward to be cured. The subsequent loss of vision of those operated on is known only to the friends of the patient, and even by them is not always put down to the couching. Then occasionally, no doubt, vision is not lost after couching in a very tolerant eye. Personally I have only seen one such case.

The staple diet of the district is rice. The pulses and *kesari dal* are largely used by the lower orders. Diabetes is common among clerks but not common among the cultivators, who suffer largely from cataract.

The simple operation, without iridectomy, a $\frac{1}{3}$ " of the upper segment of the cornea forming the flap, is the operation I adopt. The capsule is usually lacerated, although in hard ripe cataracts, I do not think it makes much difference as the capsule comes away with the cataract. In fluid, Morgagnian cataract I think it is much better not to lacerate the capsule. If the capsule is not lacerated, the little bag containing the nucleus and milky fluid is easily delivered, and a clear black pupil left. The capsule is always more or less opaque in these fluid cataracts.

Recently I have used Captain H. Smith's suggestion,† of using lid retractors in sunken eyes, or when the patient is unruly, instead of spring-lid-elevators with great advantage. More room to use the knife in making the flap is obtained by this method.

Asepsis and Antisepsis.—All the instruments (except the knife, which I disinfect in a bottle of pure carbolic acid, and then put in boracic lotion) are sterilized, and then placed in a dish of carbolic lotion 1-20. Before use they are dipped in Boric lotion (4 gr to 3i). The eyebrows and lids are cleansed with carbolic 1-20. The conjunctival sac is syringed out with the boracic lotion. Absorbent boracic cotton-wool is used for swabs. The eye is dressed with the light pad of absorbent wool. Both eyes are bandaged. The bandage is not removed until the fifth day unless there has been pain. After that the dressing is changed daily. On the eighth day a green shade is given.

Anæsthetic.—*Atropine* (gr. iv to 3i) is instilled into the eye on the day of operation. At the operation cocaine (gr. xvi to 3i) is used practically always.

Complications.—Most complications occur from the stupidity of the patient, or from the operation being performed on diseased eyes, that furnish some hope of success. I operate on many anæmic, debilitated subjects, on whom it would be far better to operate when they were

in a better state of health. When, however, there is no prospect of their health being improved, one has to operate. The patients will not stay in hospital long enough to allow of their being fed up and their health improved, while if you let them go away, their condition is miserable in the extreme, as they are suffering from want of proper nourishment from the failure of their vision, depriving them of the means of making a livelihood, and they will surely get a coucher to operate on them. Many of these cases do very well.

The stupidity of the patient at and after the operation damages many eyes. It is not that they feel pain or fear the knife. Sometimes it is almost impossible to make a patient look down. He thinks something difficult is required of him and will strain, corrugate his brows, sit up, open his mouth and do every thing but look down. Then it is very difficult to get other patients to keep their eyes fixed. After the operation, the patient will often feel some itching sensation on the second day. Up goes his bandage and he indulges in a good rub. With a healthy eye and an ordinarily intelligent patient our results will compare with any. It is the stamp of patient that makes our results appear poor.

In a series of 65 cases, I have notes of loss of vitreous in nine cases, seven recovered with good vision, and in two the result did not look promising at the time of their discharge.

The method of testing vision is the roughest, as long as he can see to work is all the patient cares about. When spectacles are applied for, I test the vision with lenses and the result is usually $\frac{6}{9}$.

EYE OPERATIONS AT AZAMGARH DISPENSARY.

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CATARACT operations performed during the last five years with their results and other particulars.

CATARACT.

- A. (a)**
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| 1. Total number of operations performed | ... | ... | 1,523 |
| 2. Percentage of success | ... | ... | 74.55 |
| 3. Forms of cataract—Senile, mostly hard. | | | |
| 4. Age of patients—Mostly between 55 and 70 years. | | | |
| 5. Sex—Both males and females. | | | |
| 6. Staple diet—Barley and dal (arhar). | | | |
- (b)**
1. Nature of operations—Mostly without iridectomy and with laceration of capsule. Some with iridectomy.
 2. Site of incision—Corneal.

* *Indian Medical Gazette*, March, 1901, p. 116.

† *Indian Medical Gazette*, July 1900, p. 241.

3. Asepsis Antisepsis—Eye first washed with corrosive sublimate lotion 1 in 5,000 and then with boric lotion 1 in 20. Instruments first boiled and then put in boric lotion 1 in 20.
4. Anaesthetic used—Cocaine lotion gr. viii—oz i.
5. Method of dressing and protecting eyes. Eyes dressed with boric lotion 1 in 20. Corrosive sublimate gauze and salalem-broth wool.
6. Bandaging eye, &c.—Both eyes bandaged with an ordinary bandage. Eye opened on the fifth day. Before they used to be opened on the fourth day, but keeping the bandages for a day more gives better results.
7. Operation for maturation.—None.

(c) 1. Complication of diseases or during operation—Granular ophthalmia treated before operation if bad.

2. Prolapse of iris prevented by the use of atropine after operation and raising the head of the patient after operation by putting extra pillows under his head. The patient is, as far as possible, allowed to remain on table after operation at least for about an hour and not disturbed. Cough and constipation are sometimes causes of prolapse after operation. They are relieved if detected. It is more common in cases without iridectomy, if there is the least straining on the part of the patient whether from constipation or cough.

3. Loss of vitreous.—It happens in very few cases. If the loss is not much, it has no effect on the union of the flaps of the wounds or the vision of the patient. The loss of vitreous is prevented by removing all pressure from the eyeball which has even the least increased tension or the eye-ball looks very prominent. Even the pressure of the speculum is minimised.

4. Pterygium if present is excised before operation, otherwise the wound gapes, and very great difficulty is experienced in keeping the two edges in opposition.

5. Atropine is invariably used after operation. Eserine was dropped in at first in a number of cases, but atropine gives better results. It is put in before operation too.

(a) Method used to test results, especially in illiterate, &c. The patient is asked to count dots measuring $\frac{1}{4}$ -inch in diameter with + 10 D glasses from a distance of 10 feet. If he can see these dots clearly and count them, the vision is put down as $\frac{1}{10}$ or 1; if he sees them from less distance, the vision is put down as $\frac{\text{distance}}{10}$.

Most of the patients are provided with cataract glasses of the strength of + 10D.

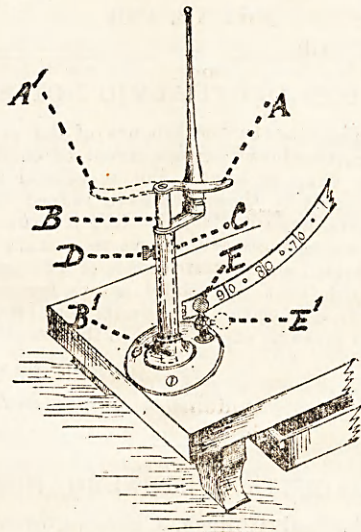
(b) Most of the bad results are due to suppuration and iritis—very few due to hæmorrhage.

A MODIFICATION OF PRIESTLEY SMITH'S PERIMETER.

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THE registering perimeter invented by Mr. Priestley Smith* is well adapted for use in India, by reason of its simple construction and moderate cost.

After some experience in the use of this instrument, I have modified it by the addition of a metal chin-rest and a clip, as shown in the accompanying sketch.



The chin-rest A is attached to a metal tube, BB', on which it rotates horizontally (A¹) so as to be utilized for the examination of either eye. The tube BB' telescopes into the hollow metal pedestal C, and has a vertical range of movement of 4 inches, within which it can be fixed at any point by a screw D with a milled head.

The clip E is hinged and is constructed to hold the free end of the arc of the perimeter when the instrument is being carried about. It can be turned down to E', so as to be out of the way when the visual field is being examined.

I have had these modifications in use for the past three years and have found them to be advantageous. The chin-rest assists in fixing the head, and diminishes the fatigue and discomfort caused by the constrained position during examination. The clip will be found especially useful when travelling, as, by fixing the arc, it checks the vibrations which tend to throw it out of gear.

I am indebted to Messrs. Lawrence and Mayo, of Calcutta, for having carried out my suggestions so efficiently.



* Ophthalmological Society's Transactions, Vol. III (1883), p. 294.