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TREATMENT OF ACUTE IRITIS IN ADULTS.

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At the Eye and Ear Infirmary, Toronto, out of a total of 2,122 eye cases, 39 are recorded as cases of iritis. Although occurring with far less frequency than catarrhal or phlyctenular diseases of the conjunctiva, or superficial phlyctenular disease of the cornea, acute inflammatory diseases of the iris run a much more rapid course, and, when neglected, are much more destructive both to vision and to the integrity of the eye.

A slight attack of inflammation of the iris, if overlooked, may result in adhesion of its posterior surface to the anterior capsule of the lens (anterior synechia), which, however slight, may be sufficient to cause recurrent attacks of iritis,—resulting in total closure of the pupil (annular synechia).

When recognized early, however, there is probably no pathological condition that responds so readily to treatment, and none that can be so effectually kept under control. In this paper, however, I except from consideration those forms of iritis that result from injury, sympathetic irritation, or from inflammation extending forward from the interior of the eye.

The plan of treatment that I have found most satisfactory (I might almost say, uniformly successful), though not new, is, I fear, not yet generally adopted in Canada.

I believe, with Von Græfe, that the great sheet anchor, in the treatment of acute iritis, is the local use of atropine. Atropine causes dilatation of the pupil, allays nervous irritation, and places the iris in a state of absolute rest. It is also believed to exert a controlling effect on the size of the calibre of the vessels.

In these cases it may be advisable, on other grounds, to place the patient on constitutional treatment (a syphilitic patient for instance); but in perhaps one-half the cases, if the treatment is commenced early, the local disease can be brought to a successful termination by the local treatment alone. The following is a good illustrative case. One Sabbath morning, as I was about ready for church, our cook asked me to look at her eye, saying that it had been painful that morning, and that the sight was somewhat misty. On examination, I discovered nothing unusual in the appearance of the eye, with the exception of a very slight pink blush around the cornea. Suspecting the possibility of iritis, and not having time for a more careful examination, I applied a four-grain solution of atropine, and left her. After church, I found the pupil slightly dilated, but irregular in shape. There were three points of adhesion, one above and two below, giving the pupil the shape represented in Fig. 1. The solution of atropia. sulph.

Fig. 1. 

Fig. 2. 

Fig. 3. 

was again applied, and repeated during the afternoon and evening, and on Monday, upon examination, it was found that the adhesion above had yielded to the midriatic. Fig. 2. The atropine solution was continued, and on Tuesday there was but one point of adhesion remaining (Fig. 3). On Wednesday, the pupil was widely dilated, and the iris free from adhesions. The pupil was kept fully dilated for about a week longer, when all irritation having disappeared, the treatment was discontinued.

Constitutional treatment is not resorted to until after the atropine solution has been vigorously applied for twenty-four or forty-eight hours, and then in those cases only where the pupil is not dilating.

The adhesions of the iris will yield more promptly to the atropia after local depletion, and local depletion should be resorted to in all cases of iritis accompanied with considerable pain. From one to three ounces are taken from the temple, either by cupping or leeches, in the evening, and the patient is almost certain to be relieved from all nocturnal pain.

In 1866, Mr. Teale, of the Leeds Infirmary, published (*Ophthalmic Hospital Reports*, Vol. v.)