TREATMENT OF ACUTE IRITIS IN ADULTS.

At the Eye and Ear Infirmary, Toronto, out of a total of 2122 cases of disease of the eye, 39 are recorded as iritis. Although occurring with far less frequency than catarrhal or phlyctenular diseases of the conjunctiva, or superficial phlyctenular disease of the cornea, acute inflammatory disease of the iris runs a much more rapid course, and, when neglected, is 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 early recognized, 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 inflammation of the interior of the eye, extending forwards.

The plan of treatment that is found most satisfactory, and almost uniformly successful, though not new, does not seem to be carefully carried out in many cases.

Von Græfe teaches that the 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.

Though in some it may be advisable to adopt general treatment, for instance, when the patient suffers from syphilis; in perhaps half the cases, if the treatment is commenced early, the disease can be brought to a successful termination by the local treatment alone. The following is a good illustrative case:—One Sabbath morning, a patient applied to me, stating that the eye had been painful that morning and the sight was "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. Two hours after, the pupil was slightly dilated, but irregular. There were three points of adhesion, one above and two below, giving the appearance represented in Fig. 1. The solution of atrop. sul. was again applied, and repeated