

**ON THE COMBINED
METHOD OF CATARACT
EXTRACTION**

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On the combined method of cataract extraction by Henry R. Swanzy

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HENRY R. SWANZY

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COMBINED METHOD

OF

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CATARACT EXTRACTION.

BY

from HENRY R. SWANZY.

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On the combined method of cataract extraction.

By HENRY E. SWANZY.

IN this communication I desire to advocate the combined method for the extraction of cataract, and to report on 100 consecutive operations for uncomplicated senile cataract by that method.

For some years past ophthalmological journals, societies, and international meetings have teemed with papers in praise of the simple method of extraction, while anything in favour of the combined method has rarely been heard. So much so is this the case, that, I believe, if one's knowledge of ophthalmic work were derived from journals and the reports of societies alone, it might almost be concluded that the combined operation had fallen into desuetude, and yet I venture to think it really is the method most in use. Be this as it may, I am myself so content with the combined method that I have not yet been induced to abandon it, and I wish now to show why my allegiance has remained unshaken.

The series (see table at end of paper) of 100 consecutive extractions of uncomplicated senile cataracts, which I now report, is directly continuous with a series of 100 operations by the same method, which I reported to the surgical section of the Royal Academy of Medicine in Ireland on the 21st February, 1890.

During the period which the present series covers I operated on thirty other eyes for cataract. These were cases of complicated senile cataracts, traumatic cataracts, zonular cataracts, and one case operated on by another method (preliminary iridectomy). I have not included these cases in the series of 100, because to do so would

obviously detract from the value of the conclusions to be drawn from the statistics. The question we want to answer is, what is the best operation with which to restore good and permanent sight to the greatest number of people afflicted with cataract? How many cases must we operate on in which it is impossible that any operation could restore good vision! as, for example, cases complicated with central senile chorioiditis, some cases with detached retina, some with nebulous cornea, and so on. If we include these, and such like cases in the statistics of cataract operations, we vitiate those statistics, to the detriment of the operation which may be on its trial. We may, for instance, perform an operation on an eye with central senile chorioiditis which, in respect of operation and healing process, is absolutely faultless, and yet, by reason of the chorioidal disease, the resulting vision enables the case to be classed as a partial success only. Again, in traumatic cataracts, the traumatism often extends to other parts of the eye than the lens, and this is liable to militate against the success of any operation for the extraction of the cataract, by reducing the vision obtained, or by promoting inflammatory reaction during the healing process. This series, in short, includes extractions done by this one method alone on uncomplicated senile cataracts, or on those with slight complications (*e. g.* very slight corneal nebulae or slight opacities in the vitreous humour), which would not of themselves materially interfere with vision.

But, while it would not be right to include in this series the classes of cases referred to, I shall append them to this paper in a separate table, so that there may be no misapprehension in respect of them.

Now as regards the vision obtained in this series of 100 cases, it was as follows :

In 11 $\frac{6}{8}$.	In 37 $\frac{6}{18}$.	In 2 $\frac{6}{30}$.	In 1 $\frac{3}{30}$.
In 12 $\frac{6}{9}$.	In 6 $\frac{6}{24}$.	In 1 $\frac{4}{30}$.	In 3 P. L.
In 21 $\frac{6}{12}$.	In 6 $\frac{9}{36}$.		

Reckoning, as Prof. Knapp and others do, V. of $\frac{6}{30}$

and more as good results, V. of $\frac{1}{80}$ to $\frac{6}{80}$ as partial results, and P. L. as failure, there have been in this series 95 good results, two partial results, and three failures.

As regards the three failures, the first (No. 15) was due to iritis following on an operation rendered difficult from the indocility of the patient; hæmorrhage in the anterior chamber occurred, and finally the cataract had to be delivered with the vectis, but without loss of vitreous: iritis supervened, and caused a closed pupil. The second failure (No. 88) was in an eye in which the delivery was difficult owing to the large size of the lens: it would have been better to have enlarged the incision: severe plastic iritis ensued. The third failure (No. 94) was in an eye in which a normal operation was performed, but iritis came on: two months later V. was $\frac{6}{36}$, a good result, but the pupil was small and somewhat occluded with capsule. I then performed a capsulotomy, but, owing to the smallness of the pupil, the result was negative. About three weeks later I did an iridotomy which included the capsule: no inflammatory reaction followed immediately on this operation, but about fourteen days later irido-cyclitis came on, and vision was reduced to P. L. I regret I was not content with the $\frac{6}{36}$ first obtained, or that I did not postpone the secondary operations to a much later period.

In respect of the two partial results, the first (No. 10) is noted as being discharged with "much capsule, to return," but the patient has not been seen since. Probably a capsulotomy here would elevate the case amongst the good results. The second partial result (No. 89) was an eye in which there were slight cortical remains left. Five weeks later a capsulotomy was performed, and this was followed by much irritation, with high tension for ten days. A week after this had subsided, a second capsulotomy was made, the opening produced by the first being unsatisfactory, and this again was followed by high tension, with cloudy aqueous, pericorneal injection, and pain. The patient was discharged a fortnight later, the eye being

quiet. Here, too, I believe I hurried with the secondary operations too much.

As regards the good results, the vision noted is that taken when the patient was last seen. This was very often within a month after the extraction had been performed, and, in that circumstance, it is, I think, satisfactory to find that eighty-one cases obtained a visual acuity of $\frac{6}{18}$ or more, the remaining fourteen cases obtaining from $\frac{6}{60}$ to $\frac{6}{34}$.

The cataracts were all either ripe or nearly ripe. I do not operate on half-ripe cataracts; yet by maturity I do not mean, in every case, complete opacity.

The accidents which occurred during the operation were few. Loss of vitreous humour occurred only twice (Nos. 21 and 45), and that in small quantity. Once (No. 41) the vitreous humour presented in the wound, but returned without loss. In two instances (Nos. 35 and 46) the sphincter iridis was not included in the iridectomy. In one of these cases (No. 35) it was afterwards seized with the forceps and excised; in the other it was left standing. The event is one of no importance.

Hæmorrhage into the anterior chamber to such an extent as to interfere materially with the operation or healing process took place three times (Nos. 15, 52, and 76). In one of these cases it is noted as occurring after the iridectomy; its source in the other two cases is not noted. But there was slight hæmorrhage into the anterior chamber in a good many other cases, of which no note was made, as it was insignificant in amount. Yet, it must be admitted, that even a slight bleeding into the anterior chamber renders the division of the capsule a more difficult step than it otherwise is. It seems to be very generally accepted that the source of the bleeding in this operation is always the iris, and this is put forward as a disadvantage of the combined method. But that is not my experience. I find that in a very few cases bleeding from the iris does take place, but that by far its most common source is the corneal limbus.

Once, in its passage across the anterior chamber, the

point of the knife became engaged in the iris, but was immediately disengaged without further trouble.

The section was made slightly too short in four cases (Nos. 59, 76, 88, and 96). In two of these (Nos. 59 and 96) it was extended with the aid of scissors; in the two other cases this was not done. Of the two cases in which the wound was extended, the healing process in one (No. 59) proceeded normally, while in the other (No. 96) there was slight inflammatory reaction of the uveal tract, although not any recognisable iritis. Of the two cases in which the wound was not enlarged, the healing process in one (No. 76) was normal, but in the other (No. 88) severe plastic iritis came on, resulting in a closed pupil—and this was one of the failures.

Some cortex was left behind twenty-seven times, but, except in three cases (Nos. 12, 24, and 34), it was quite insignificant in amount, and carried with it no unpleasant consequences for the eye. In one (No. 12) of these three cases high tension came on about four weeks later, necessitating a linear incision in the upper part of the cornea, through which much cortex was evacuated. The case then went on smoothly, and obtained $\frac{6}{8}$ of vision. In the second case (No. 24) a dissection of the cortical remains was practised twelve days after the extraction, and the patient was ultimately discharged with $\frac{6}{4}$ of vision. In the third case (No. 34) the cortical remains in swelling pushed the iris forwards, and occasioned much irritation, which required leeching about the twelfth day. All the cortex was absorbed by the twenty-first day, and the vision obtained was $\frac{6}{8}$.

A curious complication, if I may so term it, of the operation was experienced in two (Nos. 13 and 91) of the series, namely, reflex vomiting. The patients were women, one fifty, the other sixty-three years of age. They were both very docile, and were not apparently excited or anxious about their operations. In one of the cases (No. 13) the vomiting continued for some hours after the patient got to bed, and caused an irregularity in the heal-

ing process which I shall refer to presently. In the other case (No. 91) no harm resulted. This concludes the list of accidents, irregularities, and complications of the operation which occurred in this 100 cases.

And now, in respect of the healing process. There was not a single case of suppuration. My aseptic measures or antiseptic precautions, whichever they may best be called, are as follows:—The patient's face is washed with hot water and soap just before the operation. After he is on the couch, and the eye has been cocaineized, I evert the lids, and wash and wipe out the conjunctival sac with a bit of lint previously boiled in sublimate lotion, 1 in 10,000, and now wet with the same lotion. Special attention is paid in the wiping and washing to the upper and lower conjunctival fornix, and to the inner canthus. Then the outside of the lids, and particularly their margins and the eyelashes, are wiped and washed with the sublimate lotion. This lotion, too, is employed all through the operation, with boiled morsels of lint for wiping away coagula and débris. The instruments are boiled for several minutes before use, and then laid in a bath of solution of hydronaphthol, 1 in 1200, out of which I take them for use. The blade alone of the knife is plunged in boiling water for a minute or two, as the handle is of ivory. The dressing consists of a bit of lint next the eye, and over this a layer of absorbent cotton wool. Both lint and wool have been boiled in the sublimate lotion, and are wet with it when laid on the eye. Over them is placed a piece of oiled-silk protective, large enough to extend half an inch beyond the dressing all round. This serves to keep the dressings moist, and, as I think, to retain their antiseptic qualities. The dressings are kept in their place by means of a roller bandage which goes three times across the eye. The bandage is, of course, clean; but it has not been subjected to any sterilising process. All eye-drops are made with sublimate solution, 1 in 10,000, but are not further sterilised. I am aware that many surgeons adopt much more elaborate precautions than