

**LECTURES ON  
DISEASES  
OF THE EYE**

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Lectures on Diseases of the Eye by Charles Bell Taylor

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**CHARLES BELL TAYLOR**

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ON  
DISEASES OF THE EYE.

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## Clinical Lectures on Diseases of the Eye.

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### LECTURE I.

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#### CATARACT.

GENTLEMEN,—The female patient you have just seen is sixty-five years of age, blind from cataract in both eyes, and exceedingly deaf. The male patient is a labouring man, toil-worn, weather-beaten, and seventy-five years of age. He has been blind some months from cataract in the left eye, and the right is dim, although he can still see to go about with it. I saw these patients for the first time this evening, and propose to operate at once, using artificial light; before doing so, however, permit me to comment upon several questions which have arisen in connection with these and other similar cases.

What is Cataract? Cataract is an opacity of the lens. How is it that so many aged persons suffer from cataract? Well, I suppose we must look upon cataract in aged persons as one of the natural phenomena of life—the culminating point in that process of hardening, shrinking, and degeneration which the lens undergoes in common with other tissues as we grow older, and which seems natural to us all. When, for example, an average individual attains the age of forty and upwards, he requires glasses. Why is this? Simply because the lens has become too hard to fulfil its usual function



in the process of accommodation for near objects. As time passes on, this—shall I call it natural sclerosis?—increases, until in certain cases the normal relationship of the lens fibres is so changed that it becomes opaque; the patient cannot see, and the surgeon cannot illuminate the fundus of the eyeball: that is cataract. The lens has become opaque, and, so far from assisting vision, constitutes an actual obstruction to the passage of the rays of light. Would it be possible to restore the transparency of the lens? What a momentous question! As well ask, would it be possible to restore youth? And yet there is no doubt that by judicious treatment the progress of senile cataract may be retarded. I have seen benefit from electricity, and quite marvellous results, in certain cases caused by accident, or complicated with gout, diabetes, and albuminuria. In both these patients, however, the lens is quite opaque—the cataract is fully formed. There is no possibility of any clearing up. The obstruction must be removed, and this can only be done by operation. What operation shall we perform? Will any surgical procedure short of actual removal of the lens from the organism—that is extraction, as it is called—suffice? I fear not. If we attempted in either of these cases to disintegrate, macerate, and dissolve the lens *in situ* by repeated needle operations, we should in all probability only excite iritis, to which aged persons are especially liable. Very likely the inflammation would prove uncontrollable, and we should be driven to extract at last under far more unfavourable conditions than exist at present. Would it be wise, in obedience to the ancient precept, “*Squamam in oculis emovendam potius quam extrahendam,*” to attempt to depress the lens, dislodge it from the axis of vision, and thus permit the reproduction of images upon the

retina? I do not think so. The lens is apt to rise again, or act with all the pernicious influence of a foreign body in the vitreous chamber; so that, although I am not at all disposed to deny that such an operation may be occasionally successful, the risk is too great, and I should not dream of attempting it in either of these cases.\*

It is clear, therefore, gentlemen, that our only resource is extraction. What is the best method of performing extraction? In order that you may appreciate this question it will be necessary to glance at the history of the operation, which may be said to have commenced in 1762; for although, as the quotation from Pliny just cited proves, there can be no doubt that a method of extraction was known to the ancients, it was not until that date, when Daviel presented his classic memoir to the French Academy, "Sur une nouvelle Méthode de guérir la Cataract par l'Extraction," that the actual removal of the lens from the eyeball assumed its proper place as a recognized operation in contemporary surgery. Daviel operated while seated himself and facing his patient, who also occupied a chair on a lower level. He used a lance-shaped knife, and incised the lower half of the circumference of the cornea, delivering the lens through the natural pupil. When successful, the flap operation, as it is called, left nothing to be desired, but fifteen eyes in a hundred were irrevocably lost, and twenty more so damaged that it is a matter for special wonder that no serious attempt at improvement was made until 1860, when Herr von Graefe, the celebrated professor of Berlin,

\* In illustration of the occasional success attending depression, I may remark that some years ago I extracted cataracts from both eyes for an eminent practitioner of medicine, who had so successfully operated by couching, as he termed it, upon his own brother (a clergyman) that his patient was able to resume his duties as rector of a large parish.

announced, as the result of the daily examination of eyes recently operated on, that the part of the eyeball which took the initiative in the destructive inflammatory process was the portion of iris contused during the exit of the lens, and that this stretching and bruising was consequently the *teterrima causa* of subsequent disaster and loss of sight. Acting on this hint, Mooren, of Dusseldorf, excised the piece of iris corresponding to the flap some weeks before extracting; and Schufte, at that time Von Graefe's assistant, seeing the small proportion of eyes lost after iridectomy—about one in five hundred—simply performed that operation in the ordinary way, and then scooped out the lens with a spoon. Shortly afterwards Graefe published his famous memoir on linear extraction, placing the wound in the plane of the lens entirely outside the cornea. Jacobson, of Königsberg, and Pagenstecher, of Wiesbaden, followed with similar sclerotic incisions both upwards and downwards, the latter removing the lens with its capsule entire by means of a large spoon. I visited Graefe's, Pagenstecher's, and Mooren's clinics at this time in order to study their various methods of operating, and, after careful investigation of the whole subject, arrived at the conclusion that Schufte's incision in the corneal margin was the best, and that it needed but to be slightly enlarged in order to enable us to extract the lens without the objectionable scoop or the use of any traction instrument whatever. After operating in this way with most brilliant success upon a number of cases with an incision combined with an iridectomy, and comprising only one-third of the upper segment of the cornea, I published an account of the procedure in the *Ophthalmic Review* and *Edinburgh Medical Journal*, and it has since been universally adopted as the operation *par excellence* for cataract