A.B. Norton
Ophthalmic Diseases and their Homoeopathic Therapeutics

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Ophthalmic Diseases and their Homoeopathic Therapeutics
von A.B. Norton
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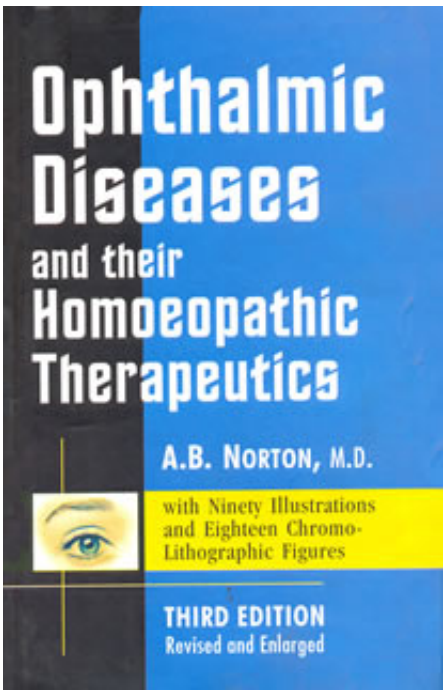

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CHAPTER XXI.

Diseases of the Vitreous Body.

Anatomy.—The vitreous humor is the transparent, jelly-like structure occupying the space between the lens and the retina. The vitreous has somewhat of a depression on its anterior surface called the *lenticular fossa* in which rests the crystalline lens, and to the posterior capsule of which the vitreous is attached, while behind, it is adherent to the optic nerve. The presence of a *hyaloid membrane* inclosing the vitreous is claimed by some authorities; but, according to others, the so-called hyaloid is identical with the internal limiting membrane of the retina, which, according to Lieberkuehn, from the developmental standpoint, belongs to the vitreous. The structure of the vitreous has not with certainty been determined. It is claimed that it can be split into concentric layers and various forms of cells have been found in it. These cells are toward the centre roundish in shape and more stellate or fusiform toward the peripheral layers of the vitreous. Chemically the vitreous is 98 per cent, water, with salts, extractive matter and a trace of albumin. Its consistency becomes less as age advances and in adult life is slightly more tenacious than the white of an egg. Its index of refraction is identical with that of the aqueous humor. A canal of about 2 mm. in diameter runs through the vitreous from the optic nerve to the centre of the posterior capsule of the lens, and during fœtal life it contains the hyaloid artery. The vitreous contains neither blood-vessels nor nerves, and, yet, on account of its cells, it must be considered an organized structure.

Hyalitis Suppurativa.—Purulent inflammation of the vitreous may occur when a foreign body has penetrated into it, or it may be the result of an extension of some other inflammation of the eye and generally from an inflammation of the retina, choroid

or ciliary body. It is now generally accepted that a primary hyalitis may occur and manifest itself either as an opacity or it may go on to suppuration. Pus may be found in the vitreous in some infectious blood diseases, and is due to exhaustion and debility. After cataract extraction or the removal of a staphyloma suppuration has sometimes been noticed as beginning in the prolapsed vitreous.

SYMPTOMS.—There may be bulging of the pupillary border of the iris and retraction of its periphery. Posterior synechige are usually present and the tension is diminished Together with the inflammation of the iris and ciliary body there is more or less pericorneal injection, Ophthalmoscopic examination will show a light yellowish reflex from the fundus, and, when the pus is circumscribed, the appearance resembles very closely a glioma of the retina and is sometimes called *pseudo-glioma.* It is distinguished from the true glioma by the history, the appearance of the iris and the symptoms of iritis and by the diminished tension. The vitreous is hazy while in glioma it is clear.

COURSE.—Suppuration of the vitreous usually results in destruction of the eye. It generally becomes complicated with choroiditis and often extends to a general inflammation of the eye or panophthalmitis. If the active process continues the eyeball ruptures and atrophy follows. Less severe inflammatory conditions of the vitreous, resulting in opacities and more or less destruction of vision may occur and, when it does, it is usually an extension from inflammation of other structures.

TREATMENT.—Hyalitis rarely occurs idiopathically, being usually associated with severe inflammations of the fundus, especially inflammation of the whole or part of the uveal tract. The treatment must then be directed to the primary disease. Particularly study the remedies recommended for choroiditis. Traumatic inflammation of the vitreous humor is more frequently observed, especially from a foreign body, which usually necessitates the removal of the eye.

When occurring in cases of great debility from low fevers and if seen in its earlier stages a stimulating, nourishing treatment may save the eye; but, as a rule, when pus has once formed in the vitreous the eye cannot be saved and enucleation is demanded.

Opacitates Vitrei *(Myodesopsia, Musae Volitantes, Synchysis .Synchysis Scintillans).*— Opacities in the vitreous may vary greatly in form and size from a mere diffuse dust-like haziness to large membranous patches or strings. Their color may also vary from a gray to a decided black and they may be either fixed or floating in the vitreous. The diffuse opacities are often so transparent that they will simply appear to hide the retina as through a thin veil, or fine dust, and this form of opacity generally occurs in syphilitic retinitis or choroiditis. In other cases there will be such intense opacities of the vitreous as to obscure all reflex from the fundus, and the diagnosis is made by exclusion by oblique illumination, the presence of any opacity of the cornea, anterior chamber or lens. If this condition results from a haemorrhage, there may sometimes be seen on the posterior surface of the lens a red appearance from particles of blood which have become attached to the lens capsule. Membranous opacities may often be seen adherent by one or more points to the retina, choroid or disc.

SYMPTOMS. — The subjective symptoms depend upon the amount and density of the opacities. Thick, circumscribed opacities cause less impairment of vision than do thin and transparent but diffuse ones. Vision, therefore, may be not at all affected or wholly lost, but, in cases of floating opacities, varies according as the opacity is in the line of vision or not. Patients describe the appearance as gray or black spots of different sizes and shapes and often are able to draw pictures of their appearance.

Opacities of the vitreous are best determined by an examination with the direct method at the distance of about thirty centimetres and, as the patient moves the eye upward and downward, dark spots or streaks are brought into view in the red reflex of the fundus. The movement of the eye may have to be continued for some time before the opacity comes into view. The rapidity of the movement of the opacity increases in proportion to the fluidity of the vitreous and the movement continues after movement of the eye ceases. Vitreous opacities move in an opposite direction to the movement of the eye, while opacities of the lens or cornea move with the movement of the eye and cease as soon as the eye comes to rest. Opacity of the cornea or lens can be recognized by an oblique illumination.

COURSE.—Diffuse opacities may entirely clear up, or they may become aggregated into thick, circumscribed shreds, while the remainder of the mass becomes more transparent. The thick, circumscribed opacities may be somewhat absorbed but more slowly and obstinately.

CAUSES.[1]—Opacities are especially found in myopes, with posterior staphyloma and choroidal changes. They are frequently due to some inflammation of the ciliary body, choroid or retina, or from an injury of the eye which has caused a haemorrhage into the vitreous. They have also in many instances been due to various general conditions, such as exhaustion after severe constitutional diseases, in anaemia, menstrual disturbances, syphilis, constipation, etc., and have frequently been seen where no cause can be given for their origin.

In *muscae volitantes* or *myodesopsia* there is no true opacity of the vitreous, and the black spots complained of by patients as floating before the eye when looking at a bright surface are due to shadows upon the retina produced by some normal elements in the vitreous or from small particles of secretions or tears moving over the cornea. In these cases there is no interference with vision and the ophthalmoscope shows no opacity. They will frequently cause great annoyance, especially in nervous individuals, and are generally attributed by the laity to biliousness or indigestion.

Synchysis is a fluidity of the vitreous and can only be diagnosticated by the rapid movement of opacities in the vitreous during motions of the eye. The tension of the eye is often diminished, but low tension does not necessarily indicate fluidity of vitreous, although soft eyeballs usually contain fluid vitreous. Synchysis is more often found in elderly people with staphyloma or choroidal disease. Synchysis, when present in cataract cases, may complicate the extraction by loss of vitreous.

Synchysis Scintillans is where the fluid vitreous contains numerous scales of cholesterin and tyrosin. When seen it presents, with the ophthalmoscope, a beautiful appearance, as of a shower of brilliant crystals. This condition seems to be associated usually with choroiditis, although it may be seen in eyes presenting no evidence of other disease. The vision, as a rule, is but slightly affected.

TREATMENT.—Dense membranous opacities may be torn with a fine needle, though operative measures are not usually required. If the opacity has been recent, especially if haemorrhagic, a compress bandage should be applied and the patient kept in bed.

If there has been haemorrhage into the vitreous humor, their absorption may be hastened by Arnica, Bell., Crotal., Ham. virg., *Lack,,* Ledum or Phos. If the opacities are the result of inflammation of the choroid or retina, benefit has been derived from the following: Arg. nit., Aurum, Bell., Gels., Jab., *Kali iod.,* Kali mur., Kalmia, Lach., Merc., *Nat mur.,* Phos., Prunus, Sen., Sil. and Sulph.

Haemorrhage into the Vitreous.—Usually occurs from the vessels of the choroid, retina or ciliary body, and generally results from an injury, such as a blow or wound of the eye or concussion of the skull. The haemorrhage may be partial or entirely fill the vitreous, being so dense as to wholly obscure the red reflex of the fundus, and then may often be seen as a dark red. mass by the oblique illumination. There is partial or total blindness, which may have come on gradually or suddenly. Spontaneous haemorrhage into the vitreous and retina have been seen to occur. The haemorrhage will often be wholly or partially absorbed in the course of a few weeks, but more frequently floating opacities remain behind.

Foreign Bodies in the Vitreous.—Usually in injury the foreign body will become lodged in the coats of the eye, although it may penetrate into the vitreous. It most generally passes iu through the cornea, wounding the iris and lens, or lens alone, and more often becomes lodged either in the iris or lens. In some cases the foreign body will penetrate by the way of the sclera, in which it may be lodged. It may drop into the vitreous, or, passing through the vitreous, become lodged in the coats of the eye at the opposite side, or, penetrating these, may become embedded in the tissues of the orbit. A foreign body within the vitreous usually becomes within a few hours surrounded by a cloudy opacity which may become organized, forming a cyst wall around it, but as a rule, instead of becoming encysted, it will result in inflammation, which may lead to abscess, or, remaining localized,

result in detachment of the retina; or, by an extension of the inflammation, cause panophthalmitis

In some cases the foreign body will remain visible in the vitreous for some time without becoming fixed or encysted, and may lead, when in this condition, to either glaucoma,or sympathetic ophthalmia. The entrance of the foreign body is usually accompanied by haemorrhage from the choroidal vessels. The most frequent foreign bodies are chips of iron, steel, glass and shot—the latter are always more favorable than are other foreign substances. In diagnosing foreign bodies in the vitreous, the history of the injury will be the first clue. We may then find a corneal wound or scar, with evidences of injury of the iris or lens, by the ophthalmoscope. If there is not too great haziness of the lens or vitreous, we may often see the foreign body itself, if a piece of iron or steel, of a bluish or greenish white color with a glistening border.

TREATMENT.—Removal of the foreign body by means of the electro-magnet has been successfully done in many cases. The magnet is, of course, only applicable to particles of iron or steel, yet, as these substances form the large majority of cases, its use has been the means of saving many eyes that, previous to its employment, would have been lost. If seen shortly after the injury, before the wound is closed, the opening, if in the sclera, is somewhat enlarged, so that the substance will not be brushed off when the magnet is withdrawn. The needle of the magnet is then introduced through the wound to as near the foreign body as possible. When the substance can be located by the ophthalmoscope the needle can be passed directly to it. If, however, it cannot be seen, the appearance of the wound will often indicate the direction to be followed and a certain amount of exploratory excursions are permissible. If the penetration has been through the cornea and lens, the lens should first be removed and the needle inserted through the corneal opening. Haab * uses a very powerful magnet applied to the surface of the eyeball, and many successful results have been reported from this method. After the wound has closed, if the substance can be discerned with the ophthalmoscope, an opening may be made in the sclera by means

*Bericht d. Ophthal. Gesellschaft zu Heidelberg, 1892.

of a meridional cut through the equatorial part of the sclera and the magnet used. If, however, the substance cannot be discerned, it is better to delay opening the sclera until the eye gives evidence of well developed inflammatory symptoms, as in rare instances it becomes encapsulated and may be allowed to remain, if the patient is made to thoroughly understand the importance of an immediate enucleation of the eye upon the first evidence of sympathetic irritation. Failing in the attempt to remove the foreign body, if the injury has been sufficient to destroy vision, enucleation or evisceration may be employed at once.

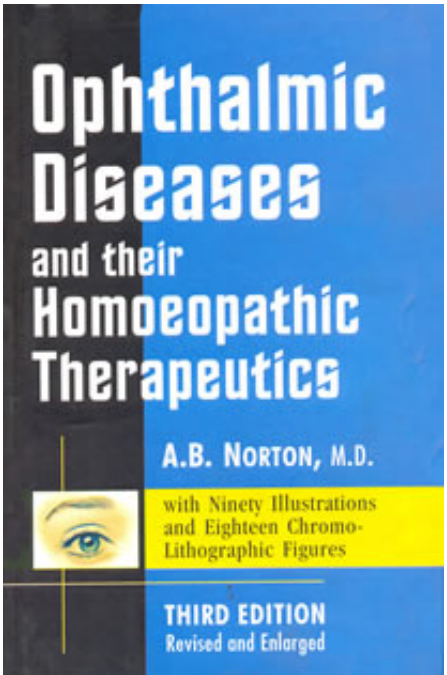
The inflammation arising from injuries must be subdued by ice compresses, the instillation of Atropine, and proper internal medication. The remedies will usually be *Aeon,,* Am., Calend., Ham., Led. or. Rhus.

Cysticercus in the Vitreous.—The presence of a parasite in the eye is of extremely rare occurrence in this country, but is quite frequently met with in North Germany. Its origin is between the choroid and retina. It causes detachment of the retina, and finally perforates it, enters the vitreous and sooner or later causes an irido-cyclitis, with inflammatory changes which end in destruction of the eye. It has a dumb-bell shape, is iridescent, and has a peristaltic motion. The treatment is to remove the cysticercus.

Persistent Hyaloid Artery.—The hyaloid artery is an extension from the central artery of the retina which in the embryo runs from the papilla to the lens and furnishes the nourishment of the lens. Obliteration of this artery is usually complete before the termination of foetal life, but sometimes it fails and some vestige of the artery remains. With the ophthalmoscope a somewhat tortuous cord may be seen, which may extend from the disc forward to the lens or merely as a rudimentary strand attached either to the disc or lens, and in some instances it has been seen to contain blood. This condition is often found associated with persistent pupillary membrane or other foetal abnormalities. The vision is often but slightly affected.

Detachment of the Vitreous.—The vitreous may become

detached from the retina by traumatism, or haemorrhages, as a result of exudation in choroiditis and from intra-ocular growths. It is always of serious import from its tendency, by dragging upon the retina, to cause a detachment of that membrane. It is considered by some authorities to be a forerunner of nearly all detachments of the retina. Galezowski diagnosed detachment by a semicircular gray rim at the border of the optic disc, but there appears to be no constant signs by which it can be diagnosed with certainty.



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