attended by severe brow headache and symptoms of cellulitis of the orbit.

One case of chronic chorioiditis and complete amaurosis, the

compulsion eye being affected with chorioiditis.

Contrary to the usual belief, the pupil being affected with retinal congestion. In every case, except one,

the excision afforded an unequivocal advantage to the patient.

ADMISSION OF THE EYELID TO THE GLOBE. In two cases in

which a bulbar excision had been attempted, the lid adhered to the globe, Mr. Solomon dissected back the connec-

ting band, and passed three fine sutures through its free

extremity, which prevented it from coming into contact

priorly than where the conjunctival fold exists in the healthy

eye; just behind this point, a narrow slit was made through

the substance of the lid, through which the apex of the flap

was drawn out and secured in position by means of the sutures

which had been previously passed through the wound. In

this maneuvre the flap was doubled upon itself, and made to

supply the place of the conjunctival fold that the burned

dermatograph had occupied, and, at the same time to oppose its unabraded

mucous surface to the cut conjunctiva of the globe. In one

case, as the connecting band was short, Mr. Solomon slit up

the outer commissure for a short distance, without which this

plan of operating could not have been carried out. In each

case chloroform was administered; and with a view to keep

the parts at rest, the globe was secured in an inverted position by

means of a ligature passed through a slip of conjunctiva

nearer the outer rim of the cornea and the integument on the

bridge of the nose.

Original Communications.

A FEW REMARKS ABOUT SQUINT, ESPECIALLY

EXTERNAL SQUINT.

By Haynes Walton, Esq., Surgeon to St. Mary's Hospital, and

the Central London Ophthalmic Hospital.

There are not a few medical men, who doubt that strabismus

may be removed by an operation; that is not to be wondered

at. It would not be difficult to find a goodly number who

question the virtues of orthopaedic practice, and several other

long recognised and valuable additions to practical surgery.

Within a few weeks I operated, in private, on a case of internal

squint, in the presence of a modern surgeon, to my entire

satisfaction, and with the best results. My medical brother,

as I supposed, was pleased; but his real sentiments were con-

veyed to me on our way to town, by this question, asked with

great solemnity: “Without any reserve, do you really think

that the operation will benefit the child?” It would certainly

be easier to deal with an oblique eye, or, perhaps, most physi-

cal deformities, than with this gentleman’s prejudices. But

many, who are even well acquainted with the beautiful results

now obtained in this variety of the affection, think that ex-

ternal squint is never remediable. It is to combat this in

particular, to publish a few facts, and endeavour to counteract

to some extent, an impression which is more or less abroad, of

my discomfitting surgical treatment, that I write.

The great question about squint is, what is the true

position of the eye, is rare, and it is undeniable, that with this absolute

numerical disparity, there is a relatively less number that are

admissible for an operation, that is, in which success can

reasonably be expected. As in convergent squint, one eye

may be affected, or both be involved; but, unlike it, the de-

tection of the single or the double implication can be so

readily, and unerringly made out, that there is not the same

necessity for certain indispensable tests.

I avoid going into the pathology of strabismus, as it is quite

beyond the scope of this short, and, as it is intended, practical

communication.

The class of cases in which the greatest relief can be

afforded, is that in which one eye only is turned out, and the

vision is but slightly affected; and the less this function is

interfered with the more certainly will operative treatment be

beneficial. But the great criticism for our guidance in the

selection of cases, that is on which our prognosis should be

founded, is the manner in which the eye can be righted, when

the eye has been set so far out.

I am strongly of opinion, that a single operation in the form

brought to the centre of the orbit, and maintained there; and,

above all, if it can be so kept for a few seconds after the other

has been opened, I strongly recommend an operation. I give

equally strong assurances of success, when without sound

eye being closed, the deformed one can be brought parallel

with its fellow, and so kept for a short period.

During this week, I have had the satisfaction of examin-

ing a young woman, on whom I operated several months ago,

through the recommendation of Mr. J. W. Window, whose

case was of this latter favourable kind. A well marked

squat had existed eight or nine years, and the eye was presby-

opic or long-sighted. I operated in expectation of some

benefit. Anomalous extinctions followed, but perfect

parallelism was not restored. Now this partial effect is the usual

occurrence in external squint; I looked for it, and with patient

expectation awaited the result. After another month, when I disarmed her,

the natural position had nearly been attained; and now, after the lapse of four months, I find as

great perfection as can possibly be accomplished. I defy any one to tell, from the appearances, that the eye had ever

squinted, or that a surgical operation had been done. There

is almost complete restoration of sight.

Under less encouraging circumstances I often recommend

surgical treatment, well knowing that even when the highest

result cannot be accomplished, improvement will ensue.

There are, however, cases, such for instance in which the

eversion is so extreme, and the power of inversion so limited,

and with which I have never failed to find a very defective

retraction, that I should decline to interfere. Three weeks ago I

operated successfully, in private, in the presence of Dr. Sieve-

king and Mr. Farrant, on a young lady of eighteen, who had

squinted two years. She could not see a hand, with the eye

affected, nor could she recognise acquaintances; but

she could bring the eye to the centre of the orbit, and

maintain it there so long as she directed the sound one to any
distinct object.

Concerning double external squint, the results of operations

have been less satisfactory, because the circumstances under

which I have operated, and which are those that are, I believe,

usually met with in the double affection, are less promising.

Yet when the eyes are involved in an equal degree, and either

can be singly used, and made straight, the double operation

may be confidently undertaken. Like the solitary deformities,

there are less favourable states which will yield less perfect

ends.

The last double operation I did at the Ophthalmic Hospital,

but a fortnight ago, was no less pleasing to myself, and those

of my colleagues that assisted me, than to the patient, a

woman twenty-five years old, who said she squinted since

quite a girl. She used one eye at a time, and employed either

apparently indiscriminately. She saw only distinctly enough

to do coarse needlework, and blurred over small type, but

could read large characters. In fourteen days after the opera-

tion she could read and work better, and the eyes were as

nearly as possible in unison with their movements. Sometime

I detected a very slight excess of red eye, in my vision, but so slight, that it was not likely to be remarked by a casual

observer.

I operate in this manner. Having retracted the eyelids

with the double spring wire retractor, I make, just over the

two of the external rectus, a vertical slit in the con-

junctiva and the subconjunctival tissue, which latter may be

so thin as scarcely to be recognised, or so dense as to demand

attention and carefulness in cutting through it. After

creating the little hook below the muscle, which I secure

and sever close to the sclerotic. I complete the process by

bringing the edges of the conjunctival wound together by

one or two sutures; if a single one does not affect the desired

adjustment, I apply a second. This does not cause the slight-

est irritation, and possesses all the advantages that are to

be got from the accurate closing of incised wounds, as

compared with tearing the edges of the eye, so often done

in the old operations. I do not practice the so called

conjunctival division of the muscle, as suggested by Monsieur

Guerin, for internal squint, by which he hoped to overcome

the dropping of the caruncle, and other defects arising from ex-

cessive dissections at the corner of the eye at this

time. As my opinions on this point have been made so public

by the reporters of the several medical journals, as well as by

some of my pupils, I consider it useless to advance them here.

I disclaim altogether the practice of this operation, which I

would merely say, for the benefit of those who are as yet beginners

in ophthalmic surgery, and may feel disposed, from what they

have heard of Guerin’s operation in internal squint, to try it

in a case, if I am sure that they do it, that they will not

be disappointed, that the theory does not apply to operation on

the external rectus, and that the different anatomical disposition of the

parts about the outside of the eye, renders the division of

the muscle by the French system so uncertain. There

is almost complete restoration of sight.

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