

# My Notes & Procedures

By

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## Ophthalmic Nursing Series (X)

### Perforating Eye Injuries

Injuries to the conjunctiva and cornea have already been considered under Series VII. We now consider the more serious injuries in which the globe of the eye has been penetrated.

#### Wounds of the Eye Ball.

Every effort is made by the surgeon to save the eye and only very occasionally will the eye be removed at once. However, if the eye does not respond favourably to treatment it may have to be removed a week or so later. (See Sympathetic Ophthalmitis.)

A general anaesthetic is usually required for repair of injuries. If any iris is protruding from the eye, the surgeon usually cuts it off so that infected iris is not returned within the eye to carry infection with it.

A corneal wound is often covered with a conjunctival flap and sutured *in situ*, under which it is hoped that the corneal wound will heal. When the sutures are removed the conjunctival flap slides back into place.

Atropine and penicillin drops are usually ordered.

#### Intra-Ocular Foreign Bodies.

Any foreign body lodging in the eye must be removed at an early date. It may have injured the structures of the eye in its passage and may be infected and so cause generalised infection of the eye. Even if non-infected, a metallic foreign body tends to "dissolve" in the fluids of the eye and the metallic salts thus formed may cause eventual blindness. Fortunately, most intra-ocular foreign bodies are magnetable and this makes their

removal possible. The patient is X-rayed, and, the X-ray Department "localises" the foreign body. If it is not lodged in the eye, having possibly traversed the eye and gone out into the orbit behind, it is often left alone. If it is in the eye, preparations are made to remove it with the help of the giant magnet. A local anaesthetic is usually employed and the foreign body is removed by one or two methods depending on whether it is thought to be in the anterior or posterior part of the eye.

#### Interior Method.

The giant magnet, which is on a stand is lowered over the patient's eye and switched on, and the magnetable foreign body is very carefully drawn into the anterior chamber and may be seen flickering about in there. The giant magnet is then removed and a small keratome incision is made at the edge of the cornea and the hand magnet is used to lift the foreign body out of the wound.

(Note. Watches must be left outside the theatre when the magnets are in use.)

#### Posterior Method.

Under a local anaesthetic, the conjunctiva is incised and the sclera exposed in the supposed vicinity of the foreign body. A small hole is cut in the sclera and the tip of the hand magnet applied to the wound and the foreign body drawn out. Sutures close the wound.

Penicillin drops are usually ordered in both instances.

**Sympathetic Ophthalmitis.**

A perforating injury to the eye sometimes gives rise to a severe type of uveitis which may in two or three weeks affect the uninjured eye also. Blindness may ensue in BOTH eyes. This danger is always present in an eye injury and may also occur after an eye operation. Hence it is sometimes necessary to enucleate an eye following an injury that has been repaired, or an eye that has had an intra-ocular operation, if the surgeon becomes apprehensive of the possibility of sympathetic ophthalmitis ensuing. When once this infection is established it is usually too late to remove the injured eye. The careful observation of the eye during nursing treatment and

the prompt reporting of progress and any changes, cannot be too strongly emphasised. Recently ACTH has been employed with considerable success in the treatment of this condition.

**Enucleation of Eye.**

A general anaesthetic is usually given. The conjunctiva is incised around the limbus and the eye muscles picked up with a squint hook and cut. The optic nerve is then cut and the eye removed. Some surgeons use hot (116 F) normal saline irrigations to control bleeding.

The eye socket needs careful attention and an artificial eye should not be used until the socket is completely healed and healthy.

## T. N. A. I. Council Nominations

The following nominations have been made by the Council for the various vacancies that will fall due in November. The names listed are subject to final approval by the Council when it meets in Nagpur. The Conference will elect office bearers on November 12 at 2 p.m. in Nagpur.

LAKSHMI DEVI,  
*General Secretary.*

**President (1 vacancy)**

Miss E. Buchanan, Asstt. Dean, College of Nursing, New Delhi.  
Mrs. Najib Khan, 6 Lake Road, Jamshedpur, Bihar.  
Mrs. D. G. Howard, Superintendent of Nursing Services, Hyderabad.

**Vice-President (East) (1 vacancy)**

Miss A. Cherian, Nursing Superintendent, Lady Dufferin Victoria Hospital, Calcutta.  
Mrs. Najib Khan, 6 Lake Road, Jamshedpur.  
Sister Cyril, Sister Tutor, Holy Family Hospital, Patna.

**Vice-President (South) (1 vacancy)**

Mrs. A. Thangaraj, formerly Sister Tutor, Lady Hope School of Nursing, Madras.  
Miss A. Jacob, Nursing Superintendent, C.M.C. Hospital, Vellore, M.S.  
Miss T. K. Neudoerffer, Kugler Hospital, Guntur, M.S.

**Hon. Treasurer (1 vacancy)**

Mrs. E. Van der Gracht, Nursing Superintendent, Willingdon Nursing Home, New Delhi.  
Miss B. G. Dawson, Nursing Superintendent, Lady Hardinge Hospital, New Delhi.  
Miss T. K. Adranvala, Chief Nursing Superintendent, Office of the D.G.H.S., New Delhi.