

RANZCO Museum

The pain of the cure

George Bartisch published his text *Ophthalmouleia* in 1583. This was the first illustrated text of ophthalmology. He included a mask to cure strabismus (fig 1). While it did nothing to cure strabismus, it certainly hid the deviating eye. Chevalier John Taylor (fig 2.) of Norwich was in the same field and in the mid-18th century he cured strabismus by incising the conjunctiva of the deviating eye. After patching the fellow eye, the bloodied eye took up fixation. At that stage Taylor left town pretending that he had effected a cure.

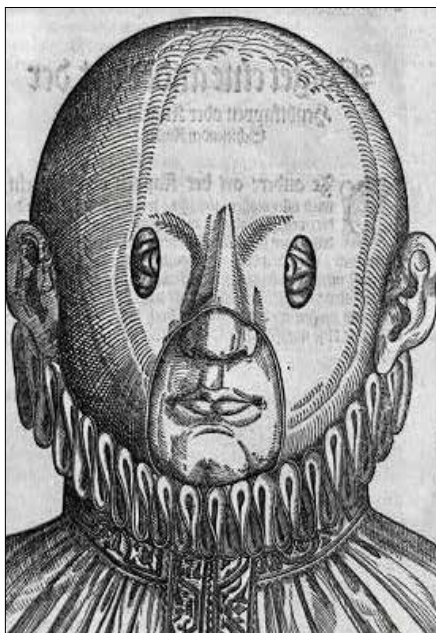


Fig 1. Strabismus mask for esotropia, Woodcut by Bartisch 1583



Fig 2. John Taylor 'the quack Ophthalmiator'

Up until the 1980s, occlusion for reluctant children was sometimes aided by forcibly splinting their arms to prevent them from removing the occluder.

Large incisions for cataract surgery relied on unsupported wound healing for a period of weeks before sutures were introduced in the 1950s. Prior to suturing, patients were nursed semi-recumbent, often with both eyes firmly padded (fig 3 & 4) for days and thereafter the operated eye for some weeks. The patient was fed a soft diet and remained unshaved with the bowels confined. At the end of this horrific period, it was not infrequent that iris prolapse and wound stretch resulted in high degrees of astigmatism. Claude Monet, the celebrated artist, underwent cataract surgery in 1923. His story and illustration of him being nursed with prolonged bed rest and dark glasses can be viewed on the RANZCO Museum website under 'Presentations'. Even with an excellent surgeon he achieved a four diopter astigmatic shift and hated the surgical result so much that he wrote a terrifying letter to his surgeon and declined to have the fellow eye treated despite the operation having been deemed a technical success.

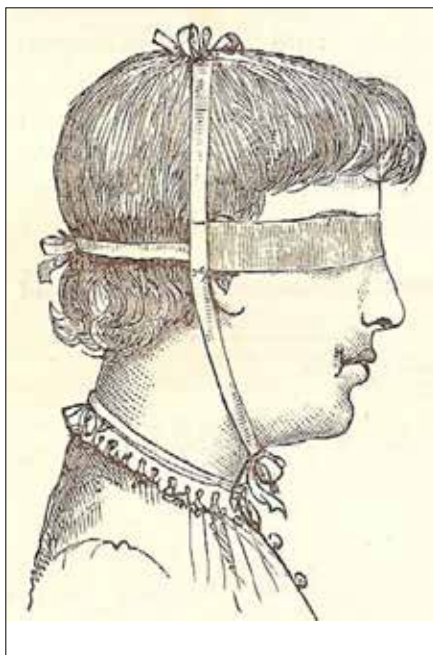


Fig 3. Graefe bandage for postoperative occlusion



Fig 4. Bonner Eye Guard

In the mid-50s, Sir Thomas Travers in Melbourne performed many of the early penetrating keratoplasties, usually on young males with keratoconus, with a small 6mm donor graft being punched on sterilised cork and held in place with egg membrane and a 6/0 silk mattress suture left in place for six weeks. During this time the patient would be confined to bed, often with both eyes padded, which led to a significant deal of resistance from the young patients. Well into the 70s there was debate about whether or not a patient with a hyphaema should be double padded to aid resorption. In an attempt to limit eye movement, patients were often fitted with pinhole spectacles (fig 5).



Fig 5. Pinhole spectacles

Similar brutal treatments for the treatment of trachoma included application of copper sulphate (fig 6) and silver nitrate from sticks applied to the tarsus as a method of chemical cautery. Prominent trachoma follicles were crushed using Knapp's roller.



Fig 6. Copper sulphate stick for tarsal application

It is worth reflecting on these barbaric practices to realise that nowadays 'less is more'.

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