UVEITIS 75 YEARS AGO

David Kaufman

Curator RANZCO Museum

1940

Chronic bacterial infection was rife with TB and Syphilis causing granulomatous uveitis.

Recurring Streptococcal throat , Prostatitis, Cystitis were frequent chronic infections with associated reactive uveitis

1940

- No specific treatment for TB or Syphilis at that time
- It would be 15+ years before Steroids become available
- 20 years immunosuppression
- 60 years targeted immune therapies

DIAGNOSIS

The Gullstrand Slit lamp was widely used in 1940

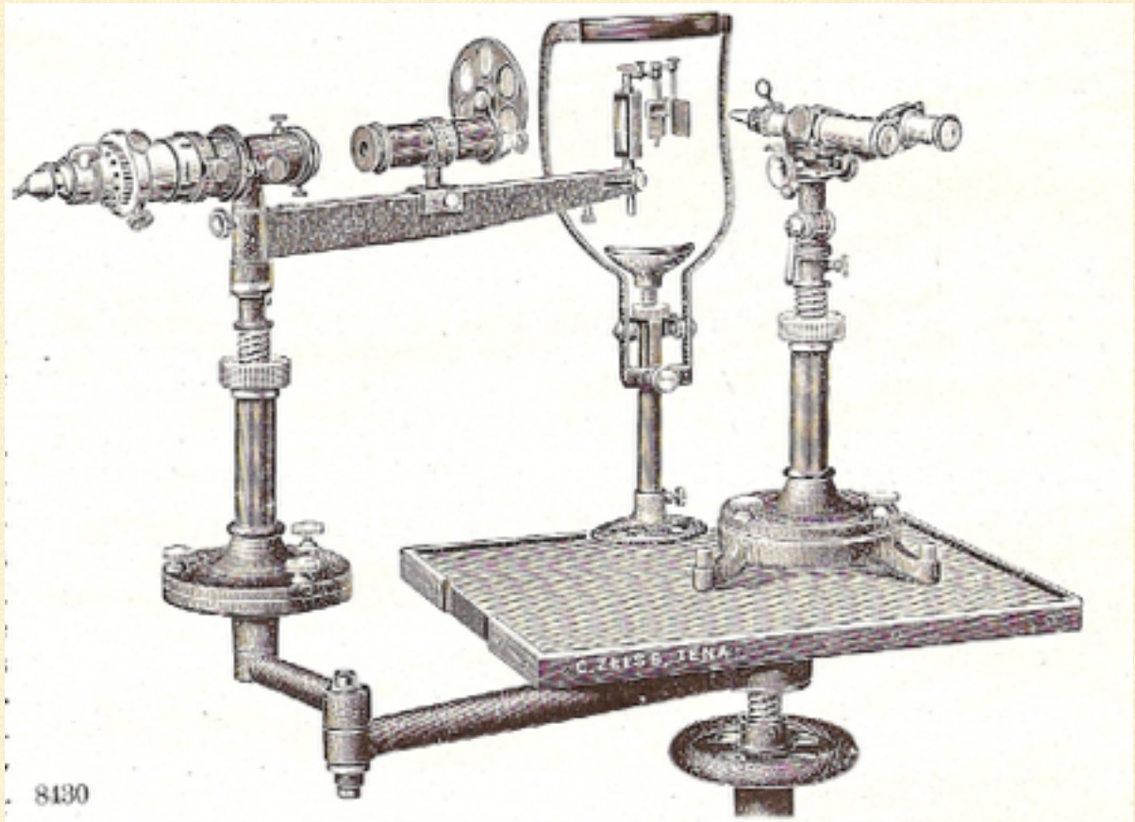


Fig. 2. Complete set of apparatus for eye hospitals: **Slit Nitra lamp** with Koeppe diaphragm tube, polariser, revolving coloured glass wheel and non-spherical aplanatic Vogt slit lamp lens with adjustable Koeppe silvered mirror, and Koppe eye microscope with single objective, analyser and binocular attachment for ultra-microscopic and micro-polariscopic observations. Above this: A Vogt **slit arc lamp** (interchangeable with the Nitra lamp) with cooling cell, Koeppe diaphragm tube with polariser, and double revolving wheel with smoked glasses and coloured glasses, with non-spherical aplanatic Vogt slit lamp lens and adjustable Koeppe silvered mirror (about $^1/_{10}$ act. size).

EXAMINATION

Introcular pressures were measured by Schioetz tonometry

EXAMINATION

Ophthalmologists often relied on loupes

AETIOLOGICAL TREATMENT

- General treatment was aimed at finding a focus of infection and its removal

- "Eliminative treatment is best instituted by a smart saline purge"

AETIOLOGICAL TREATMENT

- Teeth and tonsils removed
- All presumed foci of infection were drained or removed

LOCAL THERAPY

- Local applications of heat aiming to raise temperature of anterior chamber to 42C

- Foments , poultices , Maddox electric pads on the lids

- Leeches applied to brow to reduce inflammation

IRRIGATION

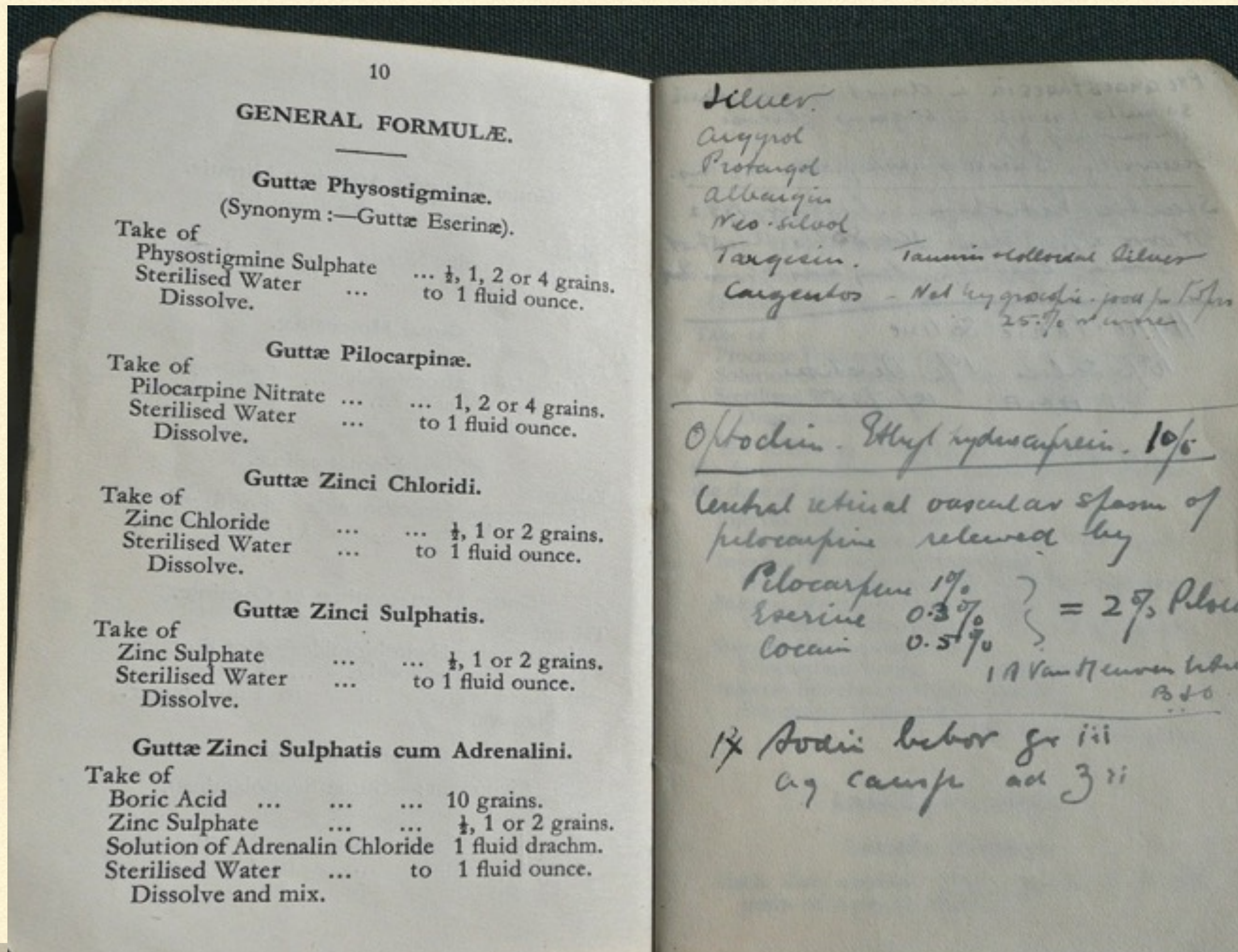
Undines and eye baths were used to provide some comfort

POCKET CASE DISPENSARIES

OPHTHALMOLOGISTS FREQUENTLY MIXED AND DISPENSED DRUGS FROM MINIATURE PHARMACIES

Drugs in tablet form with mixing beaker, glass rod and camel hair brush

MOORFIELD'S PHARMACOPEIA



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GENERAL FORMULÆ.

Guttæ Physostigminæ.
(Synonym :—Guttæ Eserinæ).

Take of
Physostigmine Sulphate ... ½, 1, 2 or 4 grains.
Sterilised Water ... to 1 fluid ounce.
Dissolve.

Guttæ Pilocarpinæ.

Take of
Pilocarpine Nitrate ... ... 1, 2 or 4 grains.
Sterilised Water ... to 1 fluid ounce.
Dissolve.

Guttæ Zinci Chloridi.

Take of
Zinc Chloride ... ... ½, 1 or 2 grains.
Sterilised Water ... to 1 fluid ounce.
Dissolve.

Guttæ Zinci Sulphatis.

Take of
Zinc Sulphate ... ... ½, 1 or 2 grains.
Sterilised Water ... to 1 fluid ounce.
Dissolve.

Guttæ Zinci Sulphatis cum Adrenalini.

Take of
Boric Acid ... ... 10 grains.
Zinc Sulphate ... ... ½, 1 or 2 grains.
Solution of Adrenalin Chloride 1 fluid drachm.
Sterilised Water ... to 1 fluid ounce.
Dissolve and mix.

HEAT AND FEVER THERAPY

ADAPTED FROM FEVER THERAPY FOR NEUROSYPHILIS, THESE EXTREME MEASURES HAD MANY PROPONENTS

- "A valuable method of elimination is through the skin, the induction of profuse sweating augmented by subcutaneous injection of pilocarpine " Duke Elder
- Induced hyperthermia in heat cabinets
- Malarial crises

PROTEIN SHOCK THERAPY

20 ml milk injected intramuscularily

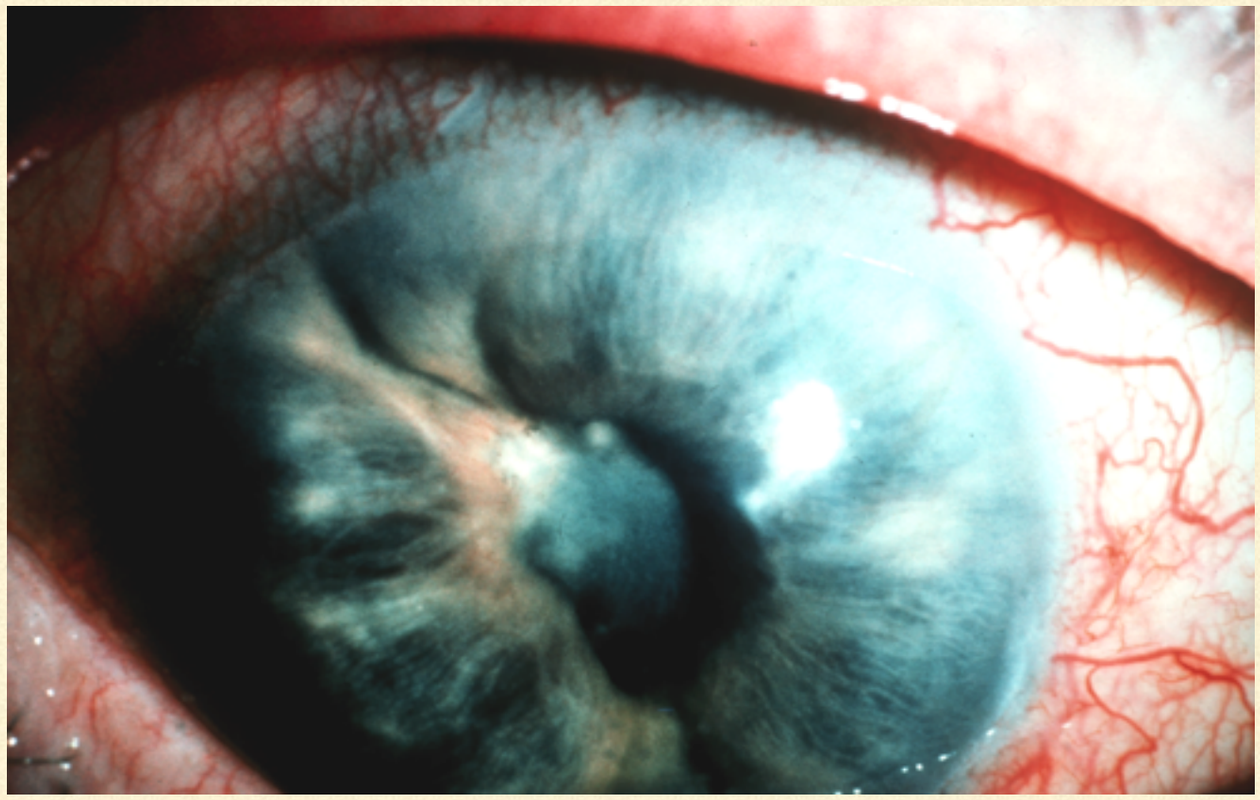
PROTEIN SHOCK THERAPY

This controversial and painful treatment induced

- Fever, erythema leukocytosis
- Its mode of action was postulated to stimulate endogenous steroid production

PUPIL BLOCK

Pupil block was treated by Atropine and Iridotomy



Graefe quadripuncture of iris created 4 iridotomies

FISTULIZING SURGERY

Corneo scleral trephines

The pressure is renewed and the rotation continued until the loss of resistance against the sclera indicates penetration. The drill is raised; if the trephine has penetrated into the anterior chamber, the iris will be immediately pushed through the opening into the wound, and the scleral button raised upward on its hinge (Fig. 89).

Pressure must at this time continue on the eyeball and against the cornea with the toothpick sponge, in order to prevent the iris from slipping back into the anterior chamber. If the iris once slipped back into the anterior chamber, it could not again be caught, and

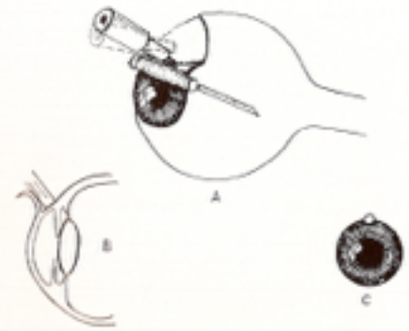


Fig. 88.—Elliott Sclerocorneal Trephine: *a* and *b*: Using the toothpick applicator rolled under the flap as a fixation to pull the eye down, the Stevenson trephine is placed perpendicular to the sclera, held tightly against its surface, tilted well toward the cornea and slid over the scleral surface until the resistance of the flap attachment is felt, when it is raised almost perpendicular again and the rotating begun to remove the button. *c*: Shows the position of the opening, half-way in sclera and cornea with peripheral iridectomy.

one would have to be satisfied with a sclerocorneal opening without

and a portion excised near the base with the iris scissors; concluding by tilting the blades of the scissors slightly upward and away from the cornea will enable one to perform a peripheral iridectomy without touching the sphincter of the iris (Fig. 90). The Green brothers recommend excision of the iris for peripheral iridectomy without first grasping it with the forceps, but in doing this there is danger of slipping the iris back into the anterior chamber.

As soon as the piece of iris has been excised, the sclerocorneal button is grasped with the iris forceps and cut close to its hinge

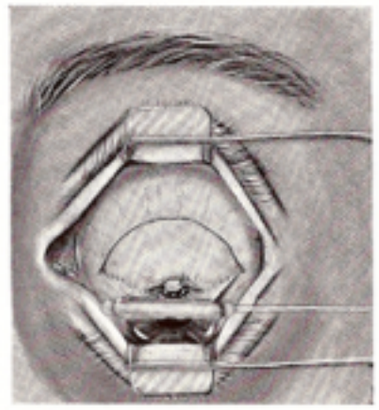


Fig. 89.—Elliott Sclerocorneal Trephine: As soon as the trephine has perforated the cornea, the aqueous gushes out pushing the upper portion of the iris with it. The button is usually held in place by a small hinge of sclera, owing to the trephine's having been tilted slightly toward the cornea.

Fistulizing surgery was used as a last resort for uveitic glaucoma