PSEUDO-PSEUDOMEMBRANOUS CONJUNCTIVITIS—CASE 1 AN UNUSUAL EYE INJURY—CASE 2

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Pseudo—pseudomembranous conjunctivitis—Case 1

DURING a minor epidemic of Type 8 adenovirus keratoconjunctivitis in Singapore, a twelve-year old schoolgirl presented with typical physical signs of the condition—red eye, oedema of the plica, tearing, large conjunctival follicles, pre-auricular adenitis with tenderness and complaint of burning and foreign-body sensation. Later, a minimal punctate keratitis from corneal stromal infiltration developed.

At the first attendance I reassured her mother but mentioned, *inter alia*, that, occasionally, a white membrane appeared on the inner surface of the lids (pseudo-membranous conjunctivitis). I suggested, in view of the ease with which direct transmission of the disease could occur, that the girl should remain off school for a week or two, prescribed symptomatic treatment and arranged to see her again.

At subsequent visits the inflammation was seen to be resolving satisfactorily and eventually I indicated that she would soon be able to return to school.

Shortly afterwards, she attended again and I was interested to observe unusual swellings in the lower lids (Fig. 1) caused by a bulky white material rolled up in the lower conjunctival fornices. Her mother told me that she had been removing this material at regular intervals by everting the lids and that it collected again very quickly, sometimes in as short a period as one hour. The material was not in the least adherent to the conjunctivae and was confined to the inferior fornices. Closer examination showed it to consist of rolled-up and damped pieces of absorbent toilet paper (Fig. 2).

This ingenious attempt to prolong her holiday from school by simulating a pseudomembranous conjunctivitis did not, unhappily, meet with the success it deserved!

Fig. 1. Unusual swelling in the lower lid.

Fig. 2. Absorbent toilet paper under lower lid.

An unusual eye injury—Case 2

Guardsmen Rapley was carrying a carving fork, prongs uppermost, when he tripped and fell. The hand holding the fork struck the top of a refrigerator and his face fell on to the upturned utensil. One of the tines penetrated his left eye. The unfortunate soldier pulled out the fork and reported to his Medical Officer, who sent him to me.

Examination showed a circular scleral perforation, about 2 mm in diameter, on the 10 o'clock radius, 8 mm from the corneal margin. A bead of vitreous was protruding from the wound. The optical media were clear and there was no sign of blood in the vitreous. The fundal appearances were normal and the retina flat. There was a small contusion just below the middle of the left eyebrow but no sign of a skin perforation.

Visual acuity was Right 6/6, Left 6/9 and apart from a dull ache in the eye and blurring of vision, Left, he was symptom-free.

On questioning, he said that the carving fork had just been washed in hot water with detergent and had been left to dry on a draining board before he picked it up.

Arrangements were made for immediate surgery and he was in theatre within an hour.

The conjunctival wound was extended with scissors and the prolapsed bead of vitreous held up in forceps and abscised. The scleral wound was then firmly closed with two interrupted silk sutures. A semi-circle of diathermy applications was made around the site of the wound so as to seal down the retina and minimise the risk of detachment, and the conjunctiva was closed with fine catgut.

A sub-conjunctival injection of Cephaloridine 250 mg was given, as prophylaxis against infection, and strict bed rest was ordered for a week post-operatively, during which time topical and systemic antibiotics were exhibited. Progress was uneventful and he has now returned to duty, apparently unharmed. When last seen the optical media were clear and there were no signs of keratic precipitates, aqueous flare, ciliary flush, nor any other indication of intra-ocular inflammation.

Discussion

Penetrating wounds of the eye are always serious and the consequences often grave. Apart from physical disorganisation, perhaps the most worrying aspect is the probability of infection. Intraocular infection is extremely likely, notwithstanding energetic treatment, to lead to severe visual loss.

Guardsmen R. was astonishingly lucky. Firstly, he succeeded in finding the one area of the sclera which may be penetrated without major risk of damage to important structure. This is the "pars plana" of the ciliary body, the smooth, flat, 4 mm wide strip separating the main part of the ciliary body, anteriorly, from the retina, behind. The pars plana is relatively avascular and functionally unimportant.

Secondly, Guardsman R. had the good sense to select an instrument of penetration which had recently been washed in hot water and detergent.

By an ironical mischance, this case was followed, two days later by that of the two year old son of an R.A.M.C. junior N.C.O., who poked the point of a sharp kitchen knife through the cornea, iris and lens of his Right eye. This, unhappily, is the comple-

mentary situation—the type of trauma likely to cause maximal functional loss. The integrity of the cornea is, of course, fundamental to good vision and loss of transparency means severe visual disturbances. In this context, the site of the corneal wound is all-important—a central injury being of gravest significance. Prolapse of iris usually occurs immediately after penetrating corneal wound and as the prolapsed tissue will be contaminated it must be excised, leaving a permanently deformed and enlarged pupil. Penetrating trauma to the lens always leads to total opacification and blindness, the only cure of which is the removal of the lens (cataract extraction). Unfortunately an eye without a lens requires a strong spectacle correction for clear vision, and because the new lens is necessarily much further from the retina than the lens it replaces, the retinal image is some 30 per cent larger than normal. By the use of a contact lens, this enlargement can be reduced to about 10 per cent, but, even so, single binocular vision is seldom achieved. Such an eye is, of course, incapable of accommodation and additional spectacle power is needed for clear near vision.

Appointments to The Queen

Major-General R. G. MacFarlane, M.B.E., M.D., F.R.C.P.(Ed.), late R.A.M.C., has been appointed Honorary Physician to The Queen with effect from 6 May 1973, in succession to Brigadier T. P. H. McKelvey, M.B., F.R.C.P., who has retired.

Major-General E. L. O. Hood, M.B., Ch.B., late R.A.M.C., has been appointed Honorary Physician to The Queen with effect from 13 May 1973, in succession to Major-General R. I. Mitchell, O.B.E., M.B., who has retired.

Major-General T. W. Carrick, O.B.E., F.F.C.M., D.P.H., D.I.H., late R.A.M.C., has been appointed Honorary Surgeon to The Queen with effect from 29 May 1973, in succession to Lieutenant-General Sir Norman Talbot, K.B.E., T.D., M.D., F.R.C.O.G., who has retired.

Brigadier A. B. Dick, T.D., M.B., Ch.B., M.F.C.M., D.T.M.&H., M.B.I.M., late R.A.M.C., has been appointed Honorary Physician to The Queen with effect from 22 May 1973, in succession to Brigadier J. F. D. Murphy, M.D., F.R.C.Psych., D.P.M who has retired.

Brigadier J. E. Miller, M.C., M.R.C.S., L.R.C.P., M.R.C.G.P., late R.A.M.C. has been appointed Honorary Surgeon to The Queen with effect from 4 May 1973, in succession to Major-General N. C. Rogers, M.B., F.R.C.S., who has retired.