New York Society for ... October 5, 1942

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SOCIETY PROCEEDINGS

EDITED BY DR. DONALD J. LYLE

NEW YORK SOCIETY FOR CLINICAL OPHTHALMOLOGY

October 5, 1942

DR. ISADORE GIVNER, *presiding*

STANDARDIZATION OF THE SCHIÖTZ TONOMETER

DR. ADOLPH POSNER presented an exhibit and demonstration on this subject during the instructional hour.

DISASSOCIATION OF THYROTOXICOSIS AND OPHTHALMOPATHY IN GRAVES'S DISEASE

DR. SAUL HERTZ stated that there are cases in which no correlation between the degree of ophthalmopathy and the degree of thyrotoxicosis in Graves's disease exists. Low degrees of thyrotoxicosis may exist with serious ophthalmopathy, and vice versa. Cases of serious eye disturbances require special handling both from the diagnostic and therapeutic point of view and must be considered apart from the ordinary cases of Graves's disease. The eye disturbances often improve with iodine therapy, but the best results have been obtained with iodine and thyroid. Occasionally it has been necessary to add X-ray treatment to the thyroid. Thyroidectomy is definitely contraindicated in this type of case.

A recent survey by Dr. J. H. Means has indicated that, in a group of representative clinics, thyroidectomy preceded the orbital decompressions in over 90 percent of cases requiring orbital decompression. On the other hand, no orbital decompressions have been performed at the Massachusetts General Hospital Clinic for three years since the institution of the present policy of averting thyroidectomy in cases suspected of being in the special group of ophthalmopathic Graves's disease.

Pictures were shown to illustrate the difference between cases of the ordinary type of Graves's disease and those of the progressive or malignant exophthalmic type.

Discussion. Dr. Maurice Bruger stated that Dr. Givner and he had studied the effect of vitamins B_6 and E in eight patients with postthyroidectomy exoph-

thalmos. These vitamins were chosen because of their recognized value in some forms of muscular dystrophy. It was thought that there might be some influence on the myopathic changes in the extraocular muscles, the prime factor in the causation of exophthalmos. In addition, three patients were given ergotamine tartrate and one prostigmine bromide. Vitamins B_{12} and E were without effect on the degree of exophthalmos or on the extent of the lid retraction. Ergotamine tartrate, however, improved the Dalrymple sign appreciably without altering the exophthalmos. Prostigmine bromide was without measurable effect.

Dr. Daniel Kravitz asked Dr. Hertz how he accounted for the exophthalmos when the ocular muscles were not enlarged.

Dr. H. M. Katzin asked Dr. Hertz to enlarge on the subject of treatment of malignant exophthalmos with X-ray therapy to the thyroid gland.

Dr. Hertz, in closing, said that from the medical point of view, it seems not unbelievable that one could have edema of the orbital tissues and that the muscles need not necessarily be involved. He cautioned that one has to be very strict in placing the patient in the category of malignant exophthalmos. His experience with X-ray treatment has been limited. It has been effective in a few cases in which iodine and thyroid therapy did not fully control the condition.

Surgical Procedures for Exophthalmos in Hyperthyroidism

Dr. Edmund B. Spaeth stated that the surgical treatment of exophthalmos from thyrotoxicosis depends upon the degree of exophthalmos present, the rapidity of its progress, and the period at which it appears as a surgical situation, such as the stationary exophthalmos of thyrotoxicosis (regardless of whether or not a thyroidectomy has been done), and that type of exophthalmos which follows after a thyroidectomy.

Other complications, such as oculomotor disturbances, retraction of the upper lid, conjunctival edema, and an endangered cornea from lagophthalmos are all additional factors, frequently of serious import. It is these complications, as they appear, that control the seriousness of the condition being treated; also they decide, to a very large extent, the type of surgery that is necessary in any given case.

Malignant or progressive exophthalmos can be treated successfully only by some type of orbital decompression. The subzygomatic route for this, it seems, is as satisfactory a procedure as is the transfrontal approach for the removal of the roof of the orbit. Anatomically there should be no choice between the two when considering this type of exophthalmos.

Discussion. Dr. John H. Dunnington stated that operations done for cosmetic reasons are often disappointing to the patient. They expect too much in spite of our efforts to depict the true picture to them. He has, therefore, been inclined to operate only when the lagophthalmos or other symptoms demand action. Recession of the levator as described by Goldstein will remove the disfigurement caused by retraction of the upper lid, and in his opinion its use should be restricted to cases manifesting a marked exposure of the sclera above the upper corneoscleral margin. Lateral tarsorrhaphy narrows the palpebral fissure satisfactorily, and he believes the best technique is that described by Wheeler. In this operation a tongue of tarsus denuded of its epithelium is inserted into the opposite lid. This operation gives an acute angle to the external canthus and is far superior to the rounded one that follows after the use of the Fuchs technique.