January 1938 Issue
Vol. 5 No. 1

CORECTOPIA, IRIDONCUS, AND PSEUDOPTOSIS

Fr. T. A. W. Elmgren
Columbia, S. C.

Each patient brings to the Optometrists problems foreign to previous patients that have entrusted their Ocular discomfort to us for examination, research work, and correction.

An Optometrist's opportunity to render service to his fellow man comes to him through mysterious channels by pathways and highways, from far and near. They all come for one reason only: namely, service. How capable we are to render such service depends upon education, inherited talents, environment, experience, etc., and in keeping correct records of all cases. All cases are unusual to the patients, and should be so to the Optometrists, be he located in the small towns and depend on local clientele, or located in the metropolitan areas where patients come from the width and breadth of the land.

The case I now have the honor to present to you was the first of its kind that I have had the pleasure to serve out of tens of thousands. It was indeed an unusual case; a case of such nature that it is doubtful if many of us will have the pleasure to see or correct this particular sort of ocular irregularity of a congenital nature. However, it is possible that many of us will have similar cases caused by accidents in our Industrial centers or in sports.

The patient is a young man nineteen years of age, Seminary student, born in Africa, son of missionaries, father Australian, mother Swedish, a brilliant chap, handicapped by low visual acuity, and 'Congenital Corectopia, Iridoncus', and habitual Pseudoptosis.

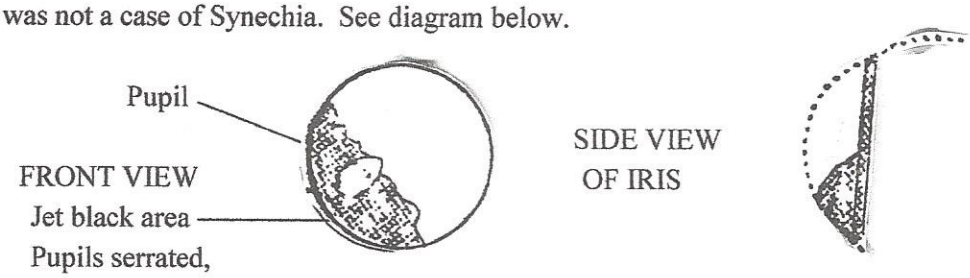
On Nov. 21st, 1936, I examined this young man, found him timid and self-conscious, with mental alertness above average, anxious to have something done for him.

History: He informed me that he knew he could not see well on the left eye, but could see fairly well with the right eye by turning the head slightly. Health good, tonsils out, slight malaria a few times, has been conscious all his life that he did not see like his boyhood playmates. His eyes were examined in east Africa 10 years ago and spectacles prescribed which he used for a year without any degree of satisfaction. A few years ago he was in a hospital in a California City where a nurse called the attending physician's attention to the fact that the pupil of right eye was located down and out, oval in shape, and the lower 1/3 of the iris was jet black. The young man informed them that he was born that way. Several prominent practitioners in the city asked for permission to operate to see if the pupil could be moved up into the proper position and to remove the black "growth" on the iris. Permission was not granted, so nothing was attempted along the line of surgery nor was anything done to correct any of his ocular irregularities.

My examination revealed:

Type: Syntonic, leaning toward Pyknic
Visual Acuity: N.E. O.D. 0.60, O. S. 0.30
Photophobia
Pale bluish gray iris with a slight brownish cast.

Pupil in the right eye oval or Cigg shaped, located downward and outward at a 45 degree angle, lower edge 1 M from the Cornea scleral margin, the lower 1/3 area of the iris jet black, said from viewed from the side, showed the anterior surface elevated, protruding or expanded on the anterior surface. Apparently it was not a case of Synechia. See diagram below.



Pupils serrated,
Right superior Palpebra dropping, making a narrow Palpebral fissure.
Ophthalmoscopy: Pale fundus.
Ophthalmometer: 45 AT 30 BY 46 ½ at 135
441/2 120 by 46 ½ at 35

Campimeter: Constricted fields
Habitual phoria at distance 1 exo, at near 4 exo
Static Retinoscopy: O.D. plus 0.75 combine with minus 1.50 axis 135
O.S. plus 1.00 combined with minus 1.00 axis 100
Dynamic Retinoscopy: O.D. plus 2.00 combined with minus 1.50 axis 135
O.S. plus 2.00 combined with minus 1.00 axis 100
Subjective findings: O.D. plus 1.50 combined with minus 1.00 axis 135
O.S. plus 1.75 combined with minus 1.00 axis 105
Visual Acuity: O.D. 0.80, O.S. 0.80, O.U. 0.90
Induced phoria at distance 2 eso, at near 6 exo. Temporal equals subjective findings.

The first objective in this case was to see what we could do to remove Corectopia, Iridoncus, Pseudoptosis, and to eliminate timidness or self-consciousness; thereby bringing this young man's dormant leadership into activity. We will not refer to refractions and ductions during the period we had him under our observation, except to state that the final Rx for lenses was O.D. plus 2.00 combined with minus 1.00 axis 135, O.S. 2.25 combined with minus 1.00 axis 100.

Here was a case on my hands, or should I say in the lap of Optometry, with unlimited opportunity to serve, to give to the profession and humanity something really worthwhile. Let us proceed with the case.

The question I had to decide was what to do first. The examination showed that the pupillary reflexes were poor; that is, the muscular systems of the iris did not function normally. There were several other angles that to consider besides correcting the Ocular anomalies. An important one was that the student body and faculty of the Seminary were watching the results. Being somewhat on the spot I was compelled to show results in the least amount of time possible.

I decided to concentrate on the photophobia, mental depression, Pseudoptosis, etc., so I prescribed NL μπ, red on the left, 5/10 to start and gradually increasing to 5/20.

Within 2 weeks a favorable change in the Photophobia and Pseudoptosis was established. I had a faint idea that the Iridoncus was less black; it apparently had begun to take on a chocolate or dark brown cast. Probably the most encouraging accomplishment was the young man's attitude and appreciation of what Syntonics was doing for him.

On December 4th NL αω was prescribed alternating with NL μπ. This Rx to be used 20 times. He missed a week during the Christmas holidays; so it was January 5th we re-examined him.

At that time there was a positive evidence that the pupil had moved up towards the center and was less oval. The Iridoncus had become brown and oblique illumination showed less than on previous examinations. The Pseudoptosis had disappeared; the iris reflexes responded favorably, especially in the left eye; the right eye did not function quite so freely, especially so in the lower area.

The Syntonic Rx was now altered to L αω, alternating red, eliminating NL μπ. On account of heavy Seminary work he could only receive Syntonics three times a week. This was given for one month.

On March 10th he returned for a progress examination. The iris now showed very little brown in the original black area, in fact, the iris had a uniform blue-gray appearance, the only way to detect any difference was by illumination. The pupil showed the slightest amount of oval shape, functioning perfectly, edges clear out with no serration.

As his studies were slightly lighter during March we again gave him Syntonics to bring the case to a happy conclusion. Syntonic Rx–NL μπ, red on left 5/15. Alternating with NL απ, red on right 5/15.

Progress examination in the middle of May showed all findings negative, uniform bluish-gray coloring of the iris, pupils of equal size and perfect reflexes. No trace of Corectopia nor Iridoncus.

In conclusion, may I say that this case was remarkable from many angles. Probably the most important to the patient's future services in life was the fact that in a few months time he changed from a timid student, who hated to take part in college activities to an aggressive leader. I had planned to bring him to this assembly so he could tell you in his own words what it has meant to him, but he accepted a position in New England as a Camp Counselor this summer and, therefore, could not be here.

Gentleman, Syntonics was put to a severe test and won out. I sit humbly at its feet.