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CORNEAL SCAR

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Picture with me if you will, a person 51 years of age, handicapped with a cone shaped cornea completely covered with an opaque scar extending beyond the corneoscleral margin with the eye showing inflammation at all times and turning outward. A man whose friends and associates continually inquire of him, "What is the matter with the eye". And "why did he not see some specialist about doing something for him". Now you have a picture of the case I wish to present at this time.

HISTORY: Left eye became inflamed in 1908, accompanying the inflammation he had severe headaches, mostly on the left frontal and temporal side. The physician consulted diagnosed it as "Iritis". He remained under this physician's care for 18 months. During this period the cornea began to assume a grayish shade, the sclera inflamed at all times.

Becoming despondent he consulted a physician in another city, who advised him he had a "cataract". He remained under the second physician's care for some time, then consulted the third physician who diagnosed it as "subluxation of the crystalline lens".

The fourth physician diagnosed it as some sort of a "hemorrhage" or "ulcer". Over a period of 28 years he received first one treatment and then another without relief. In the meantime the cornea had become cone shaped, covered over with a chalky white opacity which extended over the corneosclera. The vision was gone; the headache and inflammation remained. Periodically the inflammation and headaches would subside slightly – to return again. At times he was unable to work regularly, and many days only for a few hours. An inferior complex developed which retarded him in his work and social life.

During the late winter and early spring of 1936 he had the most severe attack during the 28 years of his difficulty and before Syntonics came into the picture. He was advised by his physician to have the eye removed to prevent the right eye from becoming affected and to stop the terrific pains in the head. Naturally, he did not want the eye removed; but then again a person may decide to do anything to get rid of a painful eye and headache.

On May 19th, 1936, he asked me what I would suggest. After listening to the history as outlined above, I suggested that before he decided to have an operation I would be delighted to see what Syntonics would do for him. He accepted my suggestion like a drowning man grasping at a straw. I don't know how skeptical he was, but he surely was anxious to keep his eye and became comfortable. It is not necessary for me to state that I welcomed the opportunity to assume the undertaking. I had nothing to lose, neither did he. It was possible for both of us to gain; he in comfort, I in experience; so we began with Syntonics.

FINDINGS: O.S., Keratoscleritis, Blepharoconjunctivitis, conical cornea, totally opaque, extending over the corneosclera, -- we will refer to this condition as "corneal scar" in the paper – no view of the iris,

strong and rapid pulse, temperature above normal, underweight, eye deviate outward 60 degrees or more. TYPE: Asthenic.

The following Syntonic Rx was used: Local μυ (mu upsilon), red on left, 5/10 gradually increasing the time to 5/20.

At the end of 10 days the head was free from pain, inflammation had begun to subside. By June 15th he made the statement that the eye and head felt more comfortable than any time he could recall during the past 28 years.

Bu July 20th, 1936 the corneal car had started to clear up in the superior region of the corneosclera, a faint small area of the Iris had become visible under illumination; and the eye did not deviate quite as much as before starting Syntonics.

By August 10th the corneal scar had retarded from the corneosclera except at the extreme infra. The upper 2/5 of the iris could be seen by side illumination and the pupil showed up as a small pin point. He was added to the Syntonic Rx for 10 days to learn what effect it would have. Well, it nauscated him so we again used L μυ for 10 days, then NL μυ for 30 days.

By October 1st he had become less nervous and the corneal scar had changed to a watery appearance, the only part of the scar that had a severe conical shape and the chalky white appearance was in an area below the center. The upper part of the iris had become quite visible, easy to see and the pupil had increased in size. There was an appearance of water floating or dropping in front of the iris at this time. It remained for a long period remaining very noticeable at times while at others it was not so noticeable.

We then used NL μπ for 10 days, after which we used NL μυ D for two weeks followed by NL μυ D, flashed, monocular until December 4th. We covered up the right eye so as to endeavor to make the left eye turn inward and locate the illumination. It worked very nicely but fatigued him slightly.

On December 4th we tried NL α (alpha), binocular, as an experiment for five days and found that it had a tendency to irritate him so changed to L μυD, monocular, right eye excluded, holding his head straight and he soon learned to turn the eye and locate the illumination. This Rx alternated with N/L- μυ, binocular, was used until the middle of June.

For the past month we have used L- μυD, monocular, the right eye excluded.

Syntonics has accomplished something worthwhile, even if he never secures better vision than being able to differentiate between darkness and light. The opaqueness has not cleared 100 percent, nor enough for us to examine the eyeground, but hope someday to be able to do so. He has not lost any time from his work on account of the eye. He has not had headaches except on one occasion when he returned from a motor trip. The eye is not inflamed and people have stopped asking him “What’s the matter with your eye?”

It has been a very interesting case. We have had the pleasure of watching the changes take place; of seeing the eye turn from an opaque chalky white to almost a natural appearance; of seeing the iris gradually appear and show its brown tint; of watching the little pin-point pupil increase in size until now at times it is of equal size of the pupil in the right eye. We rejoice with him over the changes and improvements for we have seen the eye gradually turn from its deviating position to the few times that he has been able to hold it straight.

I will never forget the first time he could detect a light held at a short distance from him. He first learned distinguishing red, then green, followed by amber, but it took a long time to distinguish blue, in fact, blue is still hard for him to locate.

The hours spent on this case have broadened our opportunity for service leading us into pathways undreamed of before. Suffice it to state that I now have two other patients for similar treatment, and the one who has tuberculosis in the left eye, and the other a chronic case of blepharitis and a marginal ulcer, both of which cases have a high error or refraction.