

month later jerking of the head had greatly diminished, and at present has almost disappeared. His headache is relieved and he is able to follow the lines in his book without difficulty.

Case II. This case illustrates the benefit to be derived from partial tenotomy of the external recti in exophoria, both for near and distance: Mr. S., aged 30, had constant headache, referred to the occiput, confusion in reading, and difficulty in fixing his eyes. He always came home from the theatre with a headache. Examination showed a small amount of hyperopic astigmatism which was corrected under homatropine, but without much benefit. A partial tenotomy of both external recti was made, with most gratifying results.

Case III. This illustrates the relief of epilepsy by treatment of hyperphoria: W. M., aged 30, consulted me in March, 1905. He gave a history of suffering from severe headaches, from which he got some relief by sending his head as far backwards as possible. For a year or more he had had slight epileptic attacks, with loss of consciousness. They were not severe and were unattended by protrusion or biting of the tongue. They probably lasted but a minute or so, and in half an hour he had recovered, except for a feeling of listlessness and drowsiness. Examination showed a myopia of 4 degrees, with hyperphoria right of 6 degrees. After correction I partially divided the right superior rectus. A test showed still 2 degrees of hyperphoria. In spite of this, he steadily improved and the attacks ceased. I kept track of him for two years, during which time he continued well, but have not heard from him since.

What is the proper course to pursue, operation or prisms? Obviously, the first consideration should be the correction of the refraction. I believe many cases of slight heterophoria correct themselves when the irritation of incorrect or of no glasses is removed. In other cases where there is little or no refractive trouble, hyperphoria, even as little as 2 degrees will give rise to annoyance and must be corrected by prisms. This is especially true of hyperphoria. It may be necessary to do tenotomy in some of these cases. I think that where after wearing a prism singly or with a spherical glass with a prism of five degrees or thereabouts, for some time without relief of the symptoms, a partial tenotomy is indicated. I would recommend a partial tenotomy in all cases of hyperphoria or exophoria of 3 degrees or upwards, but I would be chary about operating on the internal rectus. I would prefer a small advancement of the opposing muscle. It is a serious matter to weaken anyone's accommodation, and the case should be studied with great care. Finally, let me deprecate promiscuous operating for heterophoria. Choose