mometer has been used, while at Moorfields and Edinburgh I never saw it once appealed to, as they say it only registers the corneal astigmatism. The lental astigmatism, however, is generally so small as to hardly affect the result.

Operation Department.—The operating room is the brightest I have ever seen, the end being simply a large window. Stationary and portable electric lights are also used. The floor is marble and the operating table is a glass-topped one. Work in this department commences at 10.30 a.m. and lasts until 1 or 2 p.m., and on an average there are seven or eight operations every day. All instruments, including Von Graefe's knife and the keratome, are boiled for four minutes before use.

Enucleations.—The well-known Vienna method is in vogue. A speculum is seldom used. Desmarre's elevators are preferred, and these, of course, necessitate an assistant. In enucleation of the right eye, the internal rectus and conjunctiva overlying are firmly taken hold of by a pair of strong, hooked forceps. This grasp is retained throughout the whole operation. The conjunctiva and internal rectus are divided just behind the forceps. Retaining hold of the stump of the internal rectus, the conjunctiva is severed around the whole extent of the limbus, and well undermined. A pair of blunt-pointed, straight scissors is then used, without the aid of a strabismus hook, to divide the superior and inferior recti and oblique muscles. The optic nerve is then cut, the eye is now drawn well forward and to the left, after which the external rectus is divided and the operation is complete. The conjunctiva with Tenon's capsule is sometimes drawn together by a running suture.

Mule's operation is sometimes done and a gilded ball is used for the artificial vitreous.

Evisceration is done for staphyloma but is never substituted for enucleation in sympathetic ophthalmitis.

Extractions.—These are never done in the wards. Pressure is avoided by the lids being separated by the fingers of an assistant; and when on rare occasions the speculum is used, it is removed as soon as the corneal incision is completed. When our Hofrath was operating, iridectomy accompanied extraction only in those cases where the pupillary reaction was very sluggish. With the object of preventing infection and of hastening healing he always made an extensive conjunctival flap, and after the extraction the conjunctival wound was often sutured by means of the finest silk. Capsule forceps are used instead of the cystotome, and I have seen the cataract lifted out bodily by means of these. The iris forceps replace Tyrrell's hook. The patient is very slowly and gently assisted from the table and allowed to walk to his bed, where he lies for three or four days and has the eye dressed every morning.