The *serpentary ulcer* of Sæmisch, so called from its pursuing a serpentine course across the cornea, is another dangerous form of ulcer. It commences as a greyish-white infiltration, which in a short time passes over into ulceration, extending rapidly in depth and circumference, forming a large slough. It is not infrequently associated with pus in the anterior chamber, hence is called a "hypopyon ulcer." In some cases there is practically no pain; in others, again, there is great pain and ciliary neuralgia. Like the other severer ulcers, it always occurs in the old and feeble, and is frequently started by some trifling injury or foreign body in the eye.

The *treatment* is local and constitutional. Locally, one would use, in case of much inflammatory reaction, atropine or warm belladonna fomentations, with or without opium. In sloughy ulcers, eserine is to be preferred to atropine. The strength should not exceed 1/8 to 1/4 grain to the ounce. The mistake is sometimes made of blaming eserine for producing iritis. The real error is in using eserine too strong. In the weaker solutions it is productive of great good. I have found that the use of steam directly to the affected part is of the greatest benefit. An ordinary steam atomizer will do for the purpose, though special forms of steam-producers are made. It may be plain or medicated. I have also suggested the use of hot water, 80° to 120° F., in the form of a spray, direct on the cornea, the eye being held open by an assistant. It is surprising how hot water can be borne in this way. In the serpentary ulcer, or in any other ulcer which threatens to perforate, paracentesis should be done early. After perforation, natural or artificial, the eye should be dressed by the free applications of iodoform. It is comparatively valueless except in sloughing ulcers. Nitrate of silver has been recommended. It usually creates too much reaction when applied directly to the cornea. In suitable cases, indolent ulcers, it is better applied to the conjunctiva. There will be sufficient excess to affect the ulcer. The remedy *par excellence* in crescentic, rodent, ring and sloughy ulcers generally is the actual cautery. It may be used as galvano-cautery, thermo-cautery, or in the form of a steel wire or probe heated to dull red heat. Until the discovery of the value of this means of cure, these ulcers were looked upon as hopeless. Under its genial warmth ulcers cicatrize and eyes are saved.

There remains but to mention pyrozone or acrolozone in the treatment of ulcers of the cornea. I find that the direct application of either of these agents, by means of a pledget of cotton on a probe, materially assists cure, or is sufficient to bring it about in cases which are not too far advanced.

Internally, tonic measures should be adopted: iron, quinine, cod liver oil, hypophosphites, strychnia; and in old and enfeebled persons stimulants will be found of service.

A CASE OF CHOLECYSTDUODENOSTOMY WITH THE AID OF THE MURPHY BUTTON.

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Mrs. S——, aged 39 years, the mother of four children, had suffered for fifteen months from cholelithiasis, with marked reflex disturbances of digestion, but no jaundice. There was tenderness over the gall-bladder, but no enlargement.

The diagnosis was calculus in the cystic duct.

Treatment with olive oil, salicylate of soda or arsenic gave no relief.

In March, an aggravation of her symptoms confined her to bed, and from the hopelessness of her case surgical interference was deemed advisable.

March 29. Assisted by Dr. Sweetnam, Dr. Elliott administering ether, I made an incision in the upper part of the right linea semi-lunaris. The omentum and duodenum presented at the wound, the gall-bladder was naturally distended and could be readily brought in opposition with the duodenum. On examination, a gall-stone thrice the size of a pea was felt in the cystic duct. Murphy's intestinal compression forceps were found unsatisfactory, as they repeatedly slipped off and allowed the contents to pass. A large flat sponge was placed in front of the kidney. A running thread was placed in the duodenum and another in the gall-bladder. Half of button was inserted into the bowel, and the remaining part into the gall-bladder. Owing to the thickness of the latter, stitching was difficult, and the usual incision—two-thirds the diameter of the button—required to be extended.