however, showing no signs of sympathetic trouble. I eviscerated the injured eye and inserted an artificial vitreous according to principle already laid down. This was two and a half weeks ago. You see the result; he is now wearing an artificial eye. It would puzzle any one but an expert to tell which is which. The uninjured eye remains strong and well.

The second case illustrates a class of injury not at all uncommon, but too often badly managed. A week ago to-day this young man came to me a few minutes after having had the right eye cut by an exploding soda-water bottle. There was a penetrating wound about four millimetres in length at the inner sclero-corneal junction, but not through the cornea. Through the wound a knuckle of iris presented. I tried to replace it with spatula and fine probe, but it always popped out again. I then punctured the prolapse with a cataract knife, thus drawing off the aqueous humour; after this I succeeded easily in replacing the iris into the chamber, and instilled a drop of eserine solution four grains to the ounce. A compressive bandage over both eyes for three or four days constituted the after treatment. There is now scarcely a trace of the injury. The pupil is slightly oval and a little displaced towards the seat of injury, otherwise the eye seems perfect. The interesting point in this case is the effect of drawing off the aqueous humour. The prolapse could not be restrained until this had been done, and I believe the eserine was of use in helping to prevent a recurrence of the prolapse before the wound became firmly united.