and salivation caused by the jaborandi is to be attributed the diminution in the size of the body. The skin is no longer firm, tense, and waxy as it was, but soft and pliable. It, however, retains the feeling of hypertrophy when pinched up. The weakness is more pronounced, as we have seen, and the interval between the hungry spells is shortened. Our case is somewhat anomalous as regards the ravenous appetite, which we have not found described by any author we have consulted. There can be no difference of opinion as to the termination of the case.

SOME REMARKS ON PENETRATING WOUNDS OF THE EYEBALL.

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Accidental penetrating wounds of the eyeball are liable to prove disastrous in three principal ways:

(1) From the immediate destructive character of the injury.

(2) From the consecutive inflammatory reaction.

(3) From extension of the latter to the other eye.

With the first of these factors the ophthalmic surgeon has nothing to do, but with the second and third his responsibility may be grave in the extreme. Notwithstanding the well-known rules of procedure in the management of injuries to the eye, none but the expert can justly appreciate the difficulties and dangers that now and then require to be faced. For my own part, many years' experience have impressed me more and more with one important fact; that is, the paramount importance of immediate attention to this class of injuries. I have no statistics to offer, but I am quite sure the lack of prompt and suitable treatment is the chief element in the disastrous results so often seen to follow comparatively unimportant injuries.

I do not propose to take up the whole subject of traumatic lesions of the eye, but will confine my remarks to penetrating wounds in what is known as the ciliary region—that is, a zone of the eyeball bounded in front by the cornea and behind by the posterior extremities of the ciliary processes. The breadth of this