seen these diseases arise in eyes cared for by a skilled and conscientious refractionist prior to and during the cataract and glaucoma age. But these results of eye-strain will not be found by those who deny the existence of the strain, often because they are too proud or too unskilled, or too inattentive to make the all-necessary diagnosis.

As to the efficacy of massage to lesson glaucomatous tension there can not be the slightest doubt in the mind of an observant person if he will make the trial. Of course the measure will not undo the effects of inflammatory and atrophic changes induced by high or long-continued excess of tension, and the permanency of reduced or normal tension gained by massage will depend upon the extent of damage done by the disease. As several of my cases suggest, when the damage is still mostly functional, permanent cure may be expected by massage and proper glasses immediately prescribed. When great organic damage has been done and the permanent amblyopia of atrophied tissues induced, spectacles are of no use. But even then routine massage may keep the eye quiet and prevent enucleation.

The technic of massage as I advise is simple, but requires delicacy of touch and intelligence on the part of those who carry it out. If the patient have these qualities she may be instructed in the art. If not, some friend or professional nurse must be taught. The soft parts of the ends of the fingers or thumbs are used, and through the closed lids. I begin with alternate palpation (called *taxis* by Dr. Richey, of Washington, D.C., who reports his results by the method in *Annals of Ophthalmology*, October, 1896) by two fingers exactly as in estimating tension, but much more slowly. All pressures and movements should begin and proceed to the extreme, very slowly and softly; the release or lessening of pressure may be a little more quick, but never sudden. The depth of the denting, or the force exerted will depend on the hardness of the globe. In high tensions greater pressures are safe. When the tension under massage approaches the normal, as it will do, the force exerted will be lessened to that which would produce clear discomfort if one's own or the normal eye were pressed. The patient's judgment of the matter must be consulted and will not be far wrong—an added reason for making the patient the operator when the intelligence and self-control will warrant.

Palpation should be through the upper lid with the eyeball in the positions of extreme adduction, normal forward-looking, extreme abduction, and extreme depression. In extreme elevation the lower lid is used. Each position must be ordered systematically while massage is being carried on; (the position of the other eye may be observed as a guide); in this way fully three-fourths of the globe is operated upon. The length of the sitting depends upon the time required to bring about normal tension, which is usually from three to five minutes. Sometimes normal tension will not follow so soon. I have yet to see any considerable bad results