acute glaucoma (to be mentioned further on) be looked for.

Many cases of *inflammation of the lids* are brought about and maintained by errors of refraction, which can be readily corrected by properly fitted glasses, and physicians should be on the watch for this condition. All cases of obstinate conjunctivitis, inflammation of the lids, and even irritation and gritty sensations in the eyes, after reading especially, or at near work, should direct attention to this condition, and the patient should be sent to the oculist to have his vision tested.

The possibility of stricture in the nasal duct should always be borne in mind, and in obscure cases of excessive lachrymation and chronic inflammation of the inner angles of the conjunctiva, the finger should be pressed over the course of the lachrymal sac to ascertain the patency of this canal. If there be any obstruction, this manipulation will cause an abundant discharge of pus or tears which cannot be expressed in ordinary conditions of health.

Every practitioner should be familiar with the symptoms of *acute glaucoma*, for upon his recognition of this distinctive malady depends his ability to rescue vision from certain destruction. The text-books tell us of many cases of this affection which were allowed to run on to utter destruction of the eye, under the convenient diagnosis of bilious attacks, neuralgia of the eye, and other familiar but fatal names. As before stated, whenever called to a case of violent headache, ocular pains and fever, no harm will be done by keeping this affection in view, and a single eye saved well repays one from many interrogations, which, perhaps, are often unnecessary.

The *signs of acute glaucoma* are, first, pain, more or less violent; second, dimness of vision; third dilation of the pupil; fourth, shallowing of the anterior chamber; fifth, steamy cornea and increased hardness of the eye on palpation. This is generally accompanied by great congestion and often swelling of the lids, and often by fever and vomiting. The tension of the globe of the eye is quite characteristic, and can be readily appreciated by comparing with the fellow eye, being often of strong hardness, and forms the most constant and reliable symptom of this dangerous malady. It should always be looked for, and when accompanied by the foregoing symptoms, is conclusive. The patient should at once be treated freely with purges, leeches to the temples; and if the surgeon declines to risk iridectomy, which should be done preferably in all cases, let him instill at once a four-grain solution of eserine into the eye, to be repeated according to the degree of pain and tension; then cover the eye with hot compresses, and secure the aid of some surgeon who can perform the operation of iridectomy or sclerotomy—operations which, under such circumstances, might be undertaken by any one possessing steadiness of hand. The details of the operation can be found in any work on ophthalmic surgery. Instead of using the iridectomy knife, Van Graefe's cataract knife may be used for the corneal incision, which should be smaller and a little posterior to the ordinary incision, for cataract. The iris should be removed to the full extent of the incision, if possible, for upon this greatly depends the completeness and benefit of the operation.

Chronic glaucoma is often confounded with senile cataract on account of the greenish pupillary reflex. Make it a rule to examine the *tension* in all cases of doubt, and get the history of the case. There is nearly always a history of pain in glaucoma, none in cataract, and there is also more or less conjunctival hyperæmia in the former; none in the latter. When, therefore, you have increase of tension with impaired vision and pain in the eye, the probabilities are strongly for glaucoma. These cases should be sent to the oculist, and where this is not practicable, eserine should be tried, a few drops into the eye several times daily (two grains to ounce of water).

I next desire to call attention to the very important subject of *impaction of foreign bodies*, one upon which every physician should be thoroughly informed, inasmuch as they are constantly called upon to treat these cases, and upon their skill often depends the results to the vision and usefulness of the organ. Foreign bodies imbedded in the cornea are best removed by the spud; and time will be saved to the inexpert operator if he will use the speculum and fixation forceps in firmly adherent particles, thereby giving him complete control over the movements of the eye. Children should be chloroformed, and in some instances sensitive females may also require anæsthesia. When the body is firmly imbedded, it may become necessary to dig it out with a sharp instrument, but this should be generally avoided. When the body penetrates the cornea and reaches partly into the anterior chamber, more care must be taken, and often two needles required—one penetrating the cornea and steadying or pressing the particle outwards; the second employed in digging around and loosening the body from without. Bodies lodging in the anterior chamber must be removed at once by an incision into the cornea, and a removal, if necessary, of a part of the iris; where this body prolapses into the wound or when it receives the fragment into its tissue, this must be done at once, or the eye will be surely destroyed by iritis, cyclitis, or, perhaps inflammation of the entire organ; when the body lodges in the bloodless, nerveless tissue of the lens, no immediate operation is necessary, and palliative measures should be instituted. Instances are on record of foreign substances remaining in this locality for long periods, without inducing greater damage than that of opacity in the neighborhood of the body. This tolerance cannot be said of any other portion of the eye, however, and whenever the particle lodges elsewhere it must be either removed or the eye will perish. Especially is this true of the vitreous body Whenever the intrud-