stance when allowed direct access to it. The needle is entered through the cornea, not, as formerly, through the sclerotic; hence the term keratonyxis. Instead of resorting to repeated needling during the three or six months required to effect absorption of the lens, *linear* extraction is sometimes adopted as an expeditious and comparatively safe substitute, the lens substance, rendered flocculent and diffluent by maceration for a few days in the aqueous after a free needling, being gently extruded through a short corneal incision. Suction by means of careful aspiration through a tube or by the use of a syringe is sometimes practised, instead of evacuation by pressure and use of the curette. But it is better to make haste slowly in many of these cases, simple needling being the safest procedure. As already explained, lesion of the capsule or disturbance of nutrition by violence is followed by more or less diffuse opacity of the lens, and, therefore, *traumatic* cataract is a not uncommon condition. In such cases it is important to secure the maximum dilatation of the pupil at the earliest moment and keep it up by the use of a strong mydriatic, as sol. atropiæ sulph. gr 4–8 ad ℥ aq. Cold or ice water dressings may be required, and they often do good service, during the first few days. In traumatic cataract an operation may be unnecessary, absorption of the lens quietly taking place, but in older subjects extraction may be required, and in younger linear extraction may be done. The latter or a paracentesis is imperative if the eye becomes hard (glaucomatous) or very irritable owing to rapid swelling of the lens, etc. Not unfrequently the posterior capsule becomes gauze-like or partly opaque after extraction, and more decidedly so after. iritis,—so-called secondary cataract. Supplementary needling is then required, or a resort to iridotomy,—the division of pupillary membranes and iris by means of a delicate pair of scissors entered through an incision in the cornea. Very strong convex lenses have to be worn after extraction, and with these the final visual result is pretty satisfactory in about 85 per cent. of the cases; ability to read ordinary print being recovered in about 75 per cent.; and sight enough to go about alone in 90 per cent.

GLAUCOMA.

The chief characteristic of this interesting morbid condition is increased tension or plumpness of the eyeball, which, when in any marked degree, can be readily recognized by palpation. It is to be feared many eyes are allowed to become hopelessly spoiled for lack of this simple procedure, which is too little practised. Primary glaucoma may be of inflammatory or non-inflammatory form, and the glaucomatous state is also secondary to other diseases, as keratitis, staphyloma, dislocated lens, tumour, hæmorrhagic retinitis, &c. Idiopathically, it generally occurs in subjects over forty-five years, and mostly in females. Dyspepsia seems to predispose to it, and an inflammatory attack is sometimes lighted up by great fatigue, anxiety, or shock. Occasionally, it occurs in young subjects by virtue of heredity, and, now and then, the instillation of atropine acts as an exciting cause in older persons.*

Simple, chronic, or *non-inflammatory* glaucoma is insidious in its progress, and the globe may have become tense, the visual field contracted to a very small area, only central vision and that defective being retained, and the optic disc atrophied and sunken from pressure, the eye meanwhile looking healthy and the subject only aroused to the active condition by the second eye following suit,—a calamity that generally occurs: vision fails more and more, sometimes with, often without, intercurrent inflammation, the pupil is fixed and generally dilated, the lens possibly cataractous, the globe becomes distinctly hard, and, finally, the sight extinct. (G. absolutum.)

In the *acute, inflammatory* form the symptoms are indicative of actual mischief—intense pain, œdema of lids, turgescence and hardness of the globe, steamy cornea, dilated fixed pupil, and blindness. Often there is sympathetic vomiting, and sometimes the diagnosis of a "bilious attack" has been made. Spontaneous partial recovery may occur, but relapses ensue and the eye is lost, and ulti-

* For a number of years it has been the writer's practice not to use atropine for ophthalmoscopic cases. At any rate, strong solutions are unnecessary and needlessly unpleasant, a very weak solution, gr. ⅛, ¼ ad. ℥j. aq. generally sufficing.