five grains to the ounce of water. But I much prefer, after pus begins to form, to use nitrate of silver, five grains to the ounce, brushing the lids rapidly with a camel's hair brush wet with this solution, afterwards quickly brushing away the superfluous fluid with the same brush rapidly dipped in plain water and drawn in the same way across the partially everted lids. This should be repeated every other day, or every fourth or fifth day, according to the severity or necessities of the case.

This leads me to the treatment of *gonorrhœal ophthalmia* and the *purulent ophthalmia* of *infants*, diseases which any one may be compelled to treat, and diseases, too, which require the utmost boldness and decision for successful management. No time can be lost. In the case of infants, see that the eye is cleansed *every hour* in bad cases with warm water and a piece of soft cloth; evert the lids by pressing up the upper with the first finger of the left hand, and depressing the lower with the second finger. Then rapidly wipe away with the moistened rag all secretion, and rapidly brush over after this cleansing a two-grain solution of nitrate of silver in the manner above stated. This is to be used in urgent cases every three hours, until the case begins to yield; in mild cases, once daily. Then the milder lotions can be used, viz: Acidi boracici, gr. ij-iij to ounce of camphor-water. If this treatment be carried out faithfully and properly, no case of this kind need ever be lost.

In the gonorrhœal cases, the silver solution, five grains to the ounce, should be used *once* daily, and the eye kept the remainder of the time covered with ice-water compresses. This is imperative in these cases and must not be neglected. In both diseases the bowels should be kept freely open, and the ordinary sedatives (in case of constitutional disturbance) appropriate to the condition should be given. These are the sheet anchors, nitrate of silver and ice compresses, and I might here say of the former that the proper time to apply is always *after the discharge of pus begins, never before, in any conjunctival inflammation.* The use of more than five grains to the ounce is never required, just as powerful an impression being available with this strength as with the more concentrated solutions, the whole question hinging on the duration and thoroughness with which the agent is applied. The frequency of these applications may be regulated by the copiousness of the discharge, which always lessens under their use, and only requires subsequent applications when it begins to flow freely again. More than once in twenty-four hours is seldom ever required.

Where only one eye is affected, the sound eye should be closed with linen compresses covered with and cemented to the orbit with collodion—space being left in the outer and lower angle for ventilation.

Iritis, with excessive conjunctival injections, is often mistaken for conjunctivitis, and the condition of the iris overlooked in the effort to subdue the conjunctival hyperæmia, until extensive adhesions form and the integrity of the eye is permanently destroyed. *Iritis must be recognized at once, and throttled in its beginning,* if we hope to stave off the inevitable adhesions and the train of evils that constantly menace the neglected organ. If the following rules be considered in all doubtful cases, mistakes of this kind are impossible. Always examine the action of the pupils. Let the patient confront a bright light, and interpose the hand between the eye and the light; if the pupil responds naturally, as compared with the other or any healthy eye, if there be no pain, no dimness of vision, no great ciliary injection, then exclude iritis. If this test proves unsatisfactory, then drop into the eye a drop or two of a four-grain solution of atropia, which will settle beyond question any further doubt. If the pupil dilate within twenty minutes and show a perfectly circular contour, then you may safely assure your patient that the iris is unaffected.

Remember, then, that the signs of iritis are four: First, discoloration of the iris, often slight at first; second, ciliary injection; third, dimness of vision and sluggish pupil; fourth, pain; all, or most of which, are absent in conjunctivitis. Another capital point is to notice the maximum of congestion; if in the fold of the conjunctiva, think of conjunctivitis: if surrounding the cornea (ciliary injection), rather look for iritis or inflammation or ulceration of the cornea or ciliary body (cyclitis)—all of which call loudly for atropia, the remedy *par excellence* for diseases in this locality. In a broad, general sense, atropine is indicated in all conditions involving congestion of the blood-vessels forming the ciliary zone, and any injection here should always suggest a thorough scrutiny of the iris and cornea.

Another safe rule in ocular therapeutics is, when a question of doubt between the use of astringents and atropine arises, to give the latter. Eliminating the rare cases where atropine causes a prolapse of the iris through a perforating ulcer of the margin of the cornea, and an occasional irritation of the conjunctiva, and, perhaps, in some cases of glaucoma, I know of no condition of the eye in which atropine can do harm, and there is certainly no other agent so universally useful.

The treatment of iritis is pre-eminently by atropia. *Secure full dilatation of the pupil at once,* if possible by instillation of the four-grain solution every few hours; once secured, maintain dilatation by the two-grain or one-grain solution used thrice daily, and supplement by hot fomentations to the closed lids, calomel purges and aconite where the fever runs high.

Before leaving this subject, I would suggest that, in all cases of sharp fever, accompanied by violent pains in the head and eyes, the iris be examined with reference to iritis, and the signs of