together by sutures. A large piece of skin was then cut away from the arm, made as thin as possible, trimmed, fitted, and adjusted upon the upper lid, and all the parts covered with gold-beater's skin, compress and bandage.

Not to go into too many details, the transplanted skin did not unite save at one point, and had to be removed after a few days; and grafting, by means of small grafts, was afterwards done. The patient was discharged on the 22nd July, 1879, cicatrization being complete.

The lids had parted slightly, short bands having formed by traction at the points of union, the division of which was deferred.

Remarks.—It need hardly be urged that this method of blepharoplasty conveys a lesson of practical moment in general surgery. In some cases, at least, the planting of a large piece of skin on a raw (lymph-exuding) surface will be found preferable to the old plan of putting small grafts on a pus-secreting one. Much painstaking care is required in its execution, and the tendency of the flap to contract is certainly a disadvantage; but it is sometimes available when other methods are not, and its results seem to compare favourably with those of transplantation of large flaps with pedicle.

Dr. H. D. Noyes, of New York (N. Y. *Medical Record*, March 27th, 1880), after reporting some successful and unsuccessful cases of his own, and citing others, says,—"A number of cases have proved failures. In some of these instances failure is sufficiently accounted for * * *; at the same time, if out of fifteen cases ten have proved successes, it is something remarkable."

In my own cases there were two successes and one failure, the latter being almost a foregone conclusion.

A few points should be observed, which, if not essential, are most important. 1. In contrast with other flaps, the transplanted skin should be thoroughly freed from subcutaneous connective tissue and fat, which is most easily done by means of sharp scissors. 2. It must be adjusted and the edges coapted with the greatest nicety, all oozing of blood having ceased from the raw surface, which should be quite clean; and it should be kept well covered and undisturbed. 3. Allowance must be made for extraordinary contraction of the skin after its removal, say 35 to 50 per cent., and for further shrinkage after union. 4. The general integument and the subject should be healthy. 5. The special indication in blepharoplasty is the destruction of the skin of the lid or lids, with preservation of their free edges, so that they can be temporarily united; the tissues around the orbit being so altered or diseased as to preclude or jeopardize the proper nourishment of a flap through its pedicle. And it is to be preferred, *cæteris paribus*, when there is a likelihood of increasing the deformity by utilizing the skin of the face after the usual methods.

CASE 3.—*Epithelioma of Eyelids and Inner Canthus. Blepharoplasty by Sliding Flaps.*

Mr. M—— consulted me July 27th, '77, in regard to disease of the lower lid of the left eye, which had begun in 1862 as a large pimple on the edge of the lid near the lachrymal punctum, with ensuing excoriation, slight discharge, and scabbing. For the first twelve years the disease was confined to the inner fourth of the lower lid. It then began to creep outwards. There has been no pain from the outset. The whole ciliary border of the lid is now involved, the inner fourth presenting an ulcerated fissure, with hard, slightly-raised edges, and there is partial ectropion. The immediate removal of the diseased tissues was advised, but the case was not seen again until July, '79, when the outer canthus and also the lachrymal sac and the inner end of the upper lid had been invaded. An operation was again advised, a guarded prognosis being given.

July 21st, '79, the patient being anæsthetized by Dr. Zimmerman, and Dr. Covernton, the family physician, kindly assisting, the whole of the lower lid from the ocular conjunctiva to below the edge of the orbit, the outer end of upper lid as well as its inner fourth, and the lachrymal sac with some of the orbital tissue behind it were cut away. An incision was then made down the side of the nose, and a large horizontal flap dissected back with its base on and below the malar bone. This was slid up against the globe, and its upper