

regularly, thereby causing an unevenness of surface over which the lids are constantly rubbing. Under these circumstances a state of irritation is produced in the corneal tissue which is apt to extend to the ciliary region, causing a tedious recovery. Even a slight abrasion of the cornea from any injury may give rise to diseased action out of all proportion to the amount of tissue destruction; showing that the very concussion of the eyeball is an important element in such injuries. What aggravates these cases of corneal disease still further, and adds to their importance, is the frequency with which the lens is involved in corneal injuries. Such cases often constitute some of the most serious difficulties met with in eye diseases, and give rise to much anxiety.

*Case 1.—Foreign body in Iris.* Alfred H—, a stone cutter by occupation, consulted me in May, 1880. While engaged at his work a piece of steel penetrated the cornea and lodged in the Iris of his left eye. Its bright metallic lustre was readily seen to the left of the pupil, near its border, and in the horizontal diameter. I advised its removal at once, to which he readily consented. I gave him Ether and then introduced an Iridectomy knife at the outer corneal border just as in the ordinary operation for Iridectomy. I was very careful to let the aqueous humour drain away slowly, so as not to disturb the position of the Iris, but allow it to remain spread out. I then with the Iridectomy forceps grasped the portion of Iris, near the pupil, which contained the piece of steel, drew it out and with scissors cut it off, leaving the pupil not much interfered with, except a little elongated outwards.

His sight was nearly or quite as good afterwards as before the injury. He has now removed to the United States, but his brother told me about two years ago that his eye has never troubled him since, and that his sight is good.

*Case 2.—Foreign body in Iris.* Philip W—, Machinist. Consulted me Nov., 1884. Found a piece of steel in the right eye, embedded in the Iris at its upper and inner part, rather nearer to the ciliary border than to the pupil. The accident had occurred only half an hour before. I advised its immediate removal, and made an appointment with him to have the operation performed in two hours time that I might meanwhile get some cocaine which I had ordered and had just arrived at the custom's office. I considered the case a very suitable one for testing the properties of that drug which had just been introduced on this side of the Atlantic, and I had been enabled to procure a small quantity of the drug through a medical friend in New York. After he went home, his wife, who expected to be confined in a few days, persuaded him, as he was not then suffering much pain, to defer the operation. I did not see him again for two weeks. His eye was then very much inflamed and the metal was also concealed by plastic exudation which covered it and also partially blocked the pupil. Extensive synechiae existed at the pupillary border. He had severe pain so that he could not sleep at

night. In short he had Iritis. What was at first a very desirable case for an operation, was now the very opposite, and I frankly told him so, and expressed surprise at his behaviour. Atropine failed to exert any influence upon the size of the pupil and the sight was very much impaired. There was no other alternative but to remove the piece of steel notwithstanding the unfavourable conditions. It was even difficult to locate its present site and I was partly dependent upon my memory. I used the cocaine not because I considered it was a proper case for it; but as an aid to the chloroform which was administered by Dr. Lindsay, who also assisted me at the operation. The cloudiness of the cornea at the site of the original wound, to the border of which the Iris was now attached, complicated matters very much. My object was while introducing the knife at the corneal border, to guide its point so as to free the attached Iris. Having succeeded in this I then, after some trouble, managed to grasp the piece of steel and finally accomplished its removal. I was surprised at the firmness of the newly organized material which held it down. This was the main obstacle to its removal, as the steel when first seen was lying partly on the surface of the Iris. It was a thin, flat piece, about one eighth of an inch square. If it had been very small its removal would have been more difficult. The subsequent healing was much more satisfactory than I had expected. In about two weeks the inflammation had almost subsided; though some ciliary injection remained for some time longer. The sight was very much impaired, as already stated, owing to the organized material in the pupillary space. I saw him about a year ago and found the eye strong, not abnormally sensitive in any way, tension normal, and with but little evidence of the original trouble, except a small corneal opacity. After the performance of an ordinary Iridectomy for an artificial pupil he has a prospect for very fair sight.

*Case 3.—Injury of cornea from gunpowder.* John McP—, miner. Consulted me in April, 1878. Left eye totally destroyed. Right cornea so injured that very little clear corneal tissue was left, except at the extreme upper border. The injury had occurred six weeks before. Inflammation of the cornea existed and intense photophobia. He remained under treatment for three weeks. The inflammation disappeared as well as the dread of light. The sight which at first was reduced to perception of light, improved. I then advised him to go home, so that the eye would become stronger and bear the operation for Iridectomy without the danger of lighting up fresh inflammation. During the latter part of June he returned and I operated without any difficulty; but as the clear portion of cornea was so much covered by the upper lid, he did not receive as much benefit from the operation as I had hoped. Having tried the effect of raising his upper lid and found how much improvement followed, especially when a prism with its base downwards was used, I determined upon making section of the superior Rectus tendon to allow the