junction of the canaliculus with the lachrymal sac; (3) Or toward the nasal end of the sac, especially just below the sac.

Symptoms.—Many patients complain of nothing more than the continual annoyance caused by the overflow of tears, but the majority of patients complain of burning, smarting and inability to use the eye continuously owing to the blurring of the vision by the excess of tears on the cornea. There are tendernesses and swelling over the sac with œdema extending to the eye-lids. The carnucle is swollen to twice its normal size, and there is more or less epiphoria. In dacryocystitis the pus will be readily evacuated in the inner canthus by pressure on the sac with the finger.

Course and Complications.—The disease will remain stationary or grow worse. Its tendency is not to get well of itself. Recovery will be slow, requiring months or years. The large number of cases may be completely cured, but it would be unreasonable to expect a complete cure in all cases. Proper treatment will benefit all cases, but not a few cases will have some trouble remaining despite the best efforts of the surgeon. In cases that are neglected for a long time, the subjacent bone may become carious, and a passage may be made into the superior nasal fossa or into the cells of the ethmoid. The discharge may have an offensive odor. The pus being often infectious, due to the presence of micro-organisms, may cause suppuration in corneal wounds. For this reason no operations, such as iridectomy or cataract extraction should be undertaken until the lachrymal trouble is cured. If the lachrymal disease continues unchecked or cured, blephoritis, chronic conjunctionitis, erysipelas, or erythema of the skin of the eye-lids is liable to follow.

Treatment.—Stricture will invariably result speedily from dacryocystitis; generally before the patient comes to the surgeon he has been suffering from stricture for some time. Now, in order to cure the disease it is necessary to bring about absorption of the stricture. How can a probe passed and left in situ for ten minutes, once daily, or once every few days, be expected to produce absorption of hypertrophied tissue or fibrous bands? A simple attack of cold will cause a relapse of the trouble.

After slitting up the canaliculus, probes of various kinds and sizes are usually passed with a view to dilate the stricture, but this is a very slow process, and unless persisted in regularly for a long time it fails to produce absorption of the stricture. I have seen patients undergo the probing and washing out process of treatment daily for months and years and still there was no cure. Besides the probing and the syringing being annoying and painful, many of my patients begged