Von Graefe. Paracentesis corneæ, the so-called tenotomy of the ciliary muscle, &c., have been found to exert only a temporarily beneficial result, whereas excision of a segment of the iris produces a radical effect. And the sooner it is done after the disease proper has appeared, the more perfect is the cure. If the operation is put off until marked organic changes have ensued, only partial success attends it. Hence it should be done before the premonitory stage passes over finally into the disease proper, or if acute inflammatory glaucoma has set in, the operation should be done without delay. In many cases, if done within a fortnight, the result is most excellent; and even when in late stages, if the field of vision be good, a useful amount of vision is restored. In the variety termed *glaucoma fulminans*, which is the most acute and destructive in its effects, the operation should be done as soon as possible. In the chronic-inflammatory form, the operation will, in the less advanced stages, generally stay the progress of the disease, and preserve the existing vision. In the simple or chronic variety, the operation proves useful, but, unless done early, it generally fails to improve vision. The disease is, however, arrested, and in more that 90 per cent permanent protection from blindness is obtained. If the first operation produce an imperfect result, another segment of iris may be removed, and the effect is better when this is done from the side opposite to the first excision. In the last stages of glaucoma, if an iridectomy does not suffice to relieve pain, &c., it is sometimes advisable to enucleate the eye. At whatever stage the iridectomy be done, the incision in the cornea should be peripheral; a large piece of iris (about one-fifth) should be excised, the coloboma extending to the ciliary processes; and great care should always be exercised that the iris does not remain included in the wound, and so become involved in the cicatrix (anterior synechia), for its inclusion indirectly promotes the secretory irritability of the eye, and, therefore, a relapse. The typical compound coloboma is key-hole shaped, the edges of the artificial pupil being of equal length. When an iridectomy cannot be obtained, the inflammatory attacks —which are sometimes only distinguishable from simple iritis, or choroiditis by the increased tension or nerve cupping—should be treated by tapping the anterior chamber, atropine topically, morphia hypodermically, and deplotion from the temples.

Paracentesis corneæ is often very useful, and iridectomy indispensable in secondary glaucoma, as *e. g.* in pannus, large corneal cicatrices from deep and extensive ulceration, progressive staphyloma, traumatic cataract, choroidal diseases, &c.