itely better for a few amongst the legion with iritis to have such a 'bilious attack,' and come out of it with a 'widely dilated pupil,' than to suffer the irreparable mischief that often ensues from closed pupil or adherent iris, owing to the non-use or inefficient application of a mydriatic. Too frequently in iritis a gr. $\frac{1}{4}$ or gr. $\frac{1}{2}$ ad. ℥j. solution is ordered once or twice a day, with little or no effect; instead of a 4 gr. sol., after the maxim, "get the pupil fully dilated and keep it so," even if the drops require to be used every hour for the first day or two.

There are some precautions that should be observed in prescribing atropine. *"Poison"* should be conspicuous on the label—fortunately druggists are now compelled to observe this point. Precise directions should be given how to apply the solution, and at what intervals. In adults, one drop at a time generally suffices, and the solution should be dropped into the conjunctival sac near the outer canthus. In cases of copious lachrymation, as in the strumous ophthalmia of children, two or three drops are necessary, because the strength is almost instantly reduced by the tears. The most thorough and merciful method of making the application (without anæsthetic) in infants and young children who resist, is to compress the head between one's knees as in a vice, the nurse having the patient on her lap and holding the hands. The eyelids can then be separated, or the upper lid drawn back with a small duck-bill speculum, or with the index finger, the end of which is placed against the free border so as to avoid everting the lid. The tears should then be wiped away or soaked up before putting in the drops. Again, it is much better to order the applications "every 2, 4, or 6 hours," *e.g.*, than to put the indefinite "three or four times a day." The *sulphate* of atropia should be used as it is very soluble, neutral, and unirritating, while the alkaloid is quite insoluble in water, and requires the addition of acid, spirits, &c., for solution.

To avoid danger and alarm, those concerned should be told the initial symptoms of poisoning by atropine, and how to act if they develop; and also its power of dilating the pupil, and, in strong solutions, of paralysing the accommodation, even through the medium of a soiled finger or handkerchief. The unpleasant dryness of the throat caused by repeated instillations of strong solutions, 2 or 4 gr. ad. ℥j., can be easily relieved by an occasional sip of an aqueous solution of glycerine, or of gum arabic with sugar, &c. The progress of cases under atropine treatment should be carefully watched, and patients requested to report at short intervals. Atropine is a very costly as well as poisonous drug, and economy, efficiency, and safety are gained by using some form of drop-tube, and prescribing but a small quantity of the solution at once, as decomposition readily occurs, and irritation is produced. In lieu of drop-tubes specially made, one can easily attach an artificial rubber teat to the end of a short piece of narrow glass tubing, first sealing the few tiny holes by lightly touching their edges with the point of a heated probe or wire. A quill, barrel-pen, brush, &c., are also made to do duty. To secure dilatation for ordinary ophthalmoscopic examinations it is unnecessary and improper to use a strong solution, which will keep the pupil dilated, and accommodation paralysed for days; gr. $\frac{1}{8}$ or $\frac{1}{4}$ ad. ℥j. suffices (2 or 4 drops of 4 gr. sol. ad. ℥j. aq.), and the pupil contracts in a few hours.

To the Editor of the Canadian Journal of Medical Science.

CASE OF RECURRENT APOPLEXY.

BY WILLIAM OLDRIGHT, M.A., M.D.

SIR,—Believing that the following will be of interest on account of the obscurity of the case at the outset, its melancholy clearing up at the end, and the post-mortem confirmation, I send it for publication.

I was called to see Mr. Pearly on Sunday morning. I found my friend, Dr. Bridgman, who had been summoned at the same time, already there. The symptoms, as described by the friendswere epilepti form, but the pulse was very slow, and *rather* full. During the day the patient's condition improved, and I had good hope that he would recover.

On the following morning he was not quite so well, temperature high, face somewhat flushed, pulse about 125, and a good deal of headache, especially in front part of head; would readily answer questions and converse, but appeared dull. On visiting him again, about 6 p.m., I was told that I had been sent for about