

with great pain, or be very insidious in their onset. Pressure over the ciliary region will reveal tenderness, and a close examination of the iris will show a formation of new blood vessels. The inflammation may possibly subside here and a little vision be retained, but probably in ninety-nine cases out of one hundred an opaque membrane develops in the pupil and detachment of the retina takes place. Perhaps in a larger proportion than one per cent the inflammation disappears before complete blindness ensues, but unfortunately recurrence of the inflammation nearly always takes place and ultimately vision is entirely lost.

It is almost universally conceded by the best authorities that the affection in the first eye is an irido-cyclitis and that almost always traumatic in character. The cases in which the ciliary border has been wounded, and those in which a foreign body has been left in the eye are considered as especially dangerous. To be sure it is a well known fact that foreign bodies have been carried in the eye for the remainder of the life of the patient and no sympathetic trouble has developed. These bodies doubtless have become encapsuled and thus rendered non-irritable. Such bodies however from a very slight accident or jar may escape from their protective environments and produce violent inflammation, and thus in turn cause sympathetic inflammation in the fellow eye, hence the necessity of advising patients carrying foreign bodies in the eye to seek advice immediately any tenderness may develop. The time for development of sympathetic trouble after an injury is very, very rarely less than three weeks and may be thirty years or more. It has never been known to develop if the injured eye be removed within twenty-four hours after the accident. The common time for its appearance is from four to eight weeks.

TREATMENT.

First, in regard to prophylaxis, which is the most important. In some cases it is exceedingly difficult to decide as to the proper course to pursue. One wishing to keep in line with conservative principles will find difficulties which scarcely have a parallel in the whole range of surgery. Take a case of a foreign body presumed to be lodged in the coats, or within the eye. Perchance some days have elapsed since the accident; the external wound is healed, and the patient gives you an uncertain and unsatisfactory history. Of course, if the foreign body has entered through the cornea a scar will be visible, but if it has entered through the sclera the wound is often difficult to find; and yet in the latter case a careful examination would reveal the superficial tissue bound down to the deeper, and trying to move the ocular conjunctiva over the sclera one will find it attached at the point of entrance. Furthermore a point will be ascertained where great tenderness is manifested. Haemorrhage into the vitreous is in favor of the foreign body having pierced the coats; while if no haemorrhage has taken place the vitreous may be thoroughly explored with the ophthalmoscope and as a reward view the body and locate its exact position. When the lens has become opaque the thorough examination of the field of vision will become valuable. Iron and steel are the common particles projected into the eye, and the introduction of the electro-magnet has rendered great service in their removal. The electro-magnet consists of a core of soft iron around which is placed the coil of insulated copper wire, and this again is inclosed in an ebonite case. To one end of the instrument are attached the screws to receive the battery connections, at the other extremity the core of the magnet projects just beyond the ebonite jacket, and is tapped, and into it is screwed a needle which fits closely on the end of the instrument