in after life it must be sought for carefully, and will elude all but the most searching examination.

Should the whole thickness of the cornea be perforated, there is more to fear. In the first place, the infectious material is allowed free access to the globe, and may there give rise to general suppuration, panophthalmitis; this, of course, meaning total loss of the eye, with a period of tedious recovery, during which the contents are discharged piecemeal, and the eyeball shrinks to a wrinkled stump. Further, even where diffuse infection is avoided, the deeper parts of the eye are likely to suffer.

As soon as perforation takes place, the contents of the anterior chamber escape, and the iris and lens press forward. If the perforation be marginal, the iris plugs the gap immediately, forming a prolapse of the iris. As the ulcer heals the new scar tissue is matted with the iritic tissue, and the whole forms the new cornea. This has not, at least on its first formation, resisting power equal to the remainder of the corneal tissue. It is therefore very frequently unable to bear the ordinary intraocular tension and yields, forming a bulging area of some size, which necessarily interferes with the general curvature of the cornea, and thus with vision. If the staphyloma, or bulging, be limited, the support of a bandage is sufficient to overcome the yielding tendency, and the scar is given time to consolidate. The resulting cornea may not be abnormally curved. The iris will be permanently embodied in the cornea, a condition named anterior synechia. Thus the functions of the iris are also interfered with. Nor are these the only changes; the lens, as we have seen above, presses forward, and comes into contact with the back of the cornea. In consequence of this contact changes are set up in the anterior cells of the lens, which lead to their irregular proliferation.

The lack of regularity causes opacity, and there is found at the middle of the anterior surface of the lens, a small pyramidal whitish spot—an anterior polar cataract.

This is of small importance, and hardly interferes with vision at all. The amount of light entering the pupil is slightly diminished, but no rays pass through the opacity, and thus the image on the retina is not disturbed—just as one can stick a piece of plaster on the centre of a lens without interfering with the clear formation of the image; the brightness is necessarily reduced, but only slightly.

Opacities of the cornea much more seriously interfere with the visual acuity. They are rarely as dense, and never as sharply defined as anterior polar cataract, and much irregularly diffused light is able to filter through them, which, falling on the retinal image, blurs and distorts it. For this reason it has been proposed to tattoo the semiopaque arece, and thus prevent, by rendering them opaque, the retinal blurring. In some instances this has been done with good effect, but the operation is not without risk; it has been followed on more than one occasion by sympathetic ophthalmia, and has been given up by the large majority of ophthalmic surgeons.

One other important complication of central corneal lesion must be mentioned shortly. If the image on the retina be not sharp, the child has no incentive to accurate fixation of the eyes, and thus never learns exactly to coordinate its ocular muscles. The result is that the eyes are in constant jerky movement around one or other axis, the condition called nystagmus.

The first six months of life are the most important for learning ocular fixation, and if vision is defective throughout them, from any cause, nystagmus is extremely likely to result. It is important therefore, if there is any clear cornea, to utilise it as the position of a new pupil by iridectomy quite early. By this means in a certain number of cases, nystagmus will be avoided. and this, if it has once set in, is rarely recovered from.

(To be continued.)

Appointments.

Matron.

Miss Margaret Gouldson has been appointed Matron of Lady Warwick's Home for Cripples, Emscote, Warwick. She was trained at the General Infirmary, Chester, and has held the position of Superintendent Nurse at the Union Infirmary, Alcester, and Charge Nurse at the Western Hospital, Fulham.

Miss Ada E. Pratt has been appointed Matron of St. George's Home for Children, Chelsea. She was trained at the Victoria Hospital, Chelsea, and at the County Hospital, York. Her subsequent appointments have been Sister at the County Hospital, York, and temporary Matron at the Budleigh Salterton Hospital.

Miss H. E. Cook has been appointed Matron of the Isolation Hospital, Cheshunt. She was trained at the City Hospital, Birmingham, and has held the position of Assistant Nurse at the Brook Hospital, Shooter's Hill, Charge Nurse at the Isolation Hospital, Willesden, Charge Nurse at the Evan Fraser Hospital, Sutton, Hull, and for two years worked in a Medical and Surgical Home at Putney.

Night Superintendent.

Miss C. Stott has been appointed Night Superintendent at the Royal Infirmary, Sheffield. She was trained for three years at the Infirmary, Birkenhead, where she was afterwards Sister. She has recently held the position of Sister at St. Giles' Infirmary, Camberwell.

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