patients with varying success; it involves a deep dissection in the neck to expose the superior cervical ganglion lying behind the internal carotid, and its value is still so problematical that it has not found great favour in England.

It is, in any case, an operation better entrusted to a general than to an ophthalmic surgeon.

In judging the effect of treatment it must be remembered that some cases of glaucoma are extraordinarily slow. I have recently seen a man in whom the disease was diagnosed in 1886. He has been without treatment since that time; the field in one eye is still but little contracted, and vision is $\frac{6}{12}$. The other has lost all useful vision; both show deep cups, but the iris is active in each.

All cases of glaucoma in which some obvious exciting cause is present are termed secondary. Any interference with excretion may produce increased tension, whether by altering the character of the intra-ocular fluids and so making their exit at the filtration angle more difficult, or by preventing their access to that angle mechanically. The latter is more commonly severe. The most common of all causes of secondary glaucoma is iritis. If the iris, as a result of inflammation, be adherent by its whole surface or by the whole circumference of the pupil to the lens, the aqueous humour, unable to pass into the anterior chamber, collects behind the iris and presses this forward, giving rise to the condition known as Iris bombé, which we have already described in the course of the lecture on iritis. The tension rises, and an acute attack of glaucoma may come on. There is no need, in these cases, to do a large iridectomy. It suffices to re-establish communication between the posterior and anterior chambers by even a small opening. For the performance of the operation, the instruments required are speculum, fixation forceps, knife (probably a keratome), iris forceps and scissors, and repositor. The method and position of the wound will vary with the condition of the pupil. If it is clear and not blocked by lymph, the surgeon will make a small incision in the upper part of the corneal limb, and, drawing out a fragment of iris, will cut it off at a single closure of the scissors.

If the pupil be filled with lymph, the operation will have two objects: primarily to restore communication between the two chambers, and then, secondarily, to lay bare a part of the lens which is not covered with lymph, so as to improve the visual power by making an artificial pupil. Other things being equal, the surgeon will probably choose to make his incision in the inner and lower quadrant. The iridectomy must be small and close to the pupillary margin, so as to leave the edge of the lens and the circumlental space covered by the base of the iris. If these be laid bare, the irregular and unequal refraction will greatly impair useful vision, and might even cause diplopia.

Sometimes, either as a result of laceration of the anterior capsule, or dislocation *en masse*, the lens matter passes into the anterior chamber and blocks the filtration angle. In the first case, the contents of the anterior chamber may require to be evacuated by the surgeon; in the latter the lens may sometimes be induced to regain its ordinary position, and the pupil may be closed behind it with eserine. The accident, however, not uncommonly recurs.

There are few special points in the after-treatment of these cases of secondary glaucoma. It is clear, however, that as the base of the iris is not the immediate cause of the reduction of excretion, atropine is not necessarily contra-indicated, and, indeed, will be ordered in many instances by the surgeon.

*(To be continued.)*

## Appointments.

MATRONS.

Miss Edgar has been unanimously appointed Matron of the Fleming Hospital, Aberlour, out of thirty-seven applicants for the post. She was trained at the Royal Infirmary, Stirling, and subsequently, by the desire of the directors, went for a year to the Royal Infirmary, Edinburgh, where she worked as an extra nurse, and obtained an insight into the organisation of a large institution. She then returned to the Royal Infirmary, Stirling, where, as Staff Nurse and Assistant Matron, she has worked for the last ten years.

Miss Kathleen Disney has been appointed Matron and Superintendent of District Nursing, in connection with the Cottage Hospital, Brixham. She was trained at the London Hospital, where she remained for six years, during which time she acted for three years as Night Superintendent. She subsequently held the positions of Matron of the Boston Hospital and of the Royal Infirmary, Preston. She holds the certificate of the London Obstetrical Society.

SISTERS.

Miss C. Terry has been appointed Sister at the Allt-yr-yn Hospital, Newport. She was trained for three years at the Royal Southern Hospital, Liverpool, and held the position of Charge Nurse at the Northern Hospital, Winchmore Hill, for five years. She also, for a time, held the position of Charge Nurse at the Royal National Hospital, Ventnor, and for the last three years has been connected with the private nursing staff of the Royal United Hospital, Bath.

Miss L. Geddes Buck has been appointed Sister at the Colchester Hospital. She was trained at the Royal Portsmouth Hospital, and has held the position of Sister at the Lewisham Infirmary.

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