properly administered. Quinine, however, should only be used as a prophylactic in very exceptional circumstances. The best preventive of malaria was to keep the mosquito away from the body. He believed that the intelligent and persistent use of the mosquito-net and mosquito-protected houses would reduce the risk of being attacked by malaria almost to zero. All malarial patients should be protected from mosquito bites, or rather the mosquito should be protected from infection by malarial patients. The houses in malarious districts should be well raised above the ground, for the mosquito did not like high flights. Ventilation and lighting should be carefully attended to and houses for Europeans should be built away from the native communities, as in malarious districts practically all the native children were subjects of malarial infection. Europeans, moreover, should be most careful as to the admission of young natives into their houses. The only efficient and radical means for the suppression of malarial infection over large areas was the complete destruction of mosquitoes, and the only way in which that could be effected was by the abolition of their breeding places, namely, collections of stagnant or semi-stagnant water. The experiments now being carried out in West Africa by the Liverpool School of Tropical Medicine under the supervision of Major Ross, if successful, would undoubtedly revolutionise the sanitation of native towns. He strongly urged the necessity of educating the masses of the people in malarious countries as to measures that ought to be taken to combat the disease, and concluded by suggesting that some central association should be formed in this country on the lines of the well-known Italian society, which should have for its object the propagation of correct ideas with regard to malaria, and encouraging the inception of prophylactic and other measures for the suppression of malaria in the outlying portions of the Empire.

Dr. Manson, replying to the discussion that ensued, traversed the idea that malaria was caused by the decomposition of vegetable matter, or was exhaled from the earth. There was no question whatever that malaria was a living entity, a parasite, and he could not conceive how decomposing vegetable matter, or cracks in the ground could produce such a living organism. The conclusion he had come to was that the malarial parasite could only get into man through the mosquito.

Nursing of Diseases of the Eye.

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THE CHIEF SYMPTOMS OF OCULAR DISEASE.

(Continued from p. 265.)

Inflammatory pain, when due to conjunctivitis, has much the same local characters as that already described. There is a smarting, burning sensation, rarely severe except in the cases where the cornea is involved, often compared to the presence of dust or sand under the lids. It is often combined with inability to bear exposure to light, a symptom called photophobia; the dread may be so great as to cause a spasmodic closure of the lids, blepharospasm.

When the normal eye is suddenly exposed to a strong light, a sensation of unease is experienced, hardly amounting to pain. But when the cornea is ulcerated this sensation is very often greatly heightened, and prevents the patient opening the eyes at all. A common reflex, the result of the exposure of an inflamed cornea to light, is a sneeze. It is difficult to follow in what way the fibrils of the fifth nerve, which supply the cornea, can be affected by light falling on the retina. There is no apparent anatomical connection between the optic nerve and the trigeminal.

There must be in all probability a central disturbance.

In some comparatively uncommon instances a flash of electric light, which is absolutely momentary in its action, causes prolonged discomfort. This does not come on immediately on the incidence of the stimulus, but follows after an interval of some hours. There is great lacrymation and injection of the conjunctiva, combined in many cases with spasm of the orbicularis palpebrarum (the sphincter of the lids), so that the eyes cannot be opened. This disease, which is the same as snow-blindness, lasts for many hours, even though the stimulus be instantaneous. The mechanism can hardly be one of direct irritation since the interval is too long: mechanical and chemical irritants produce an immediate conjunctivitis.

In common with the simpler forms of photophobia it is relieved by the use of cocaine, cold bathing and rest in a darkened room.

Atropine, which is often of the greatest value in the aero- and photophobia of children, has not seemed to me to be of much value.

The part of the light which seems the most active in the production of snow-blindness is the violet and ultra violet region of the spectrum. To prevent recurrence, dark glasses should be used.

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