it is usually safe to uncover the eye which has not been operated on; but the other should be kept bandaged for ten days or a fortnight. During this time the injection should disappear. After this a shade or dark goggles should be worn.

During the course of healing and convalescence the dressing should be changed twice daily, washed with boric acid solution and a few drops allowed to enter the conjunctival sac; it is a routine practice of mine to use atropine once daily.

After three weeks all protection may often be discarded. The vision may now be tested. Often it will be found that some small remains of the lens or thickened and wrinkled capsule persist in sufficient amount to interfere with vision. Not infrequently a second operation has to be undertaken to remove this, but it is well to separate the two procedures by several months.

The removal of the lens leaves the eye very hypermetropic. If the patient were emmetropic before the operation, a lens of about + 11·0D will be required for distance, and one of about 14·0D for reading.

Defects in the healing may interfere with the good result. The wound may be inoculated at the time of operation or soon after; the first sign is usually to be found in slight redness and œdema of the lids, and an extensive amount of discharge that may be muco-purulent. There is more pain than normal. These signs may be observed within forty-eight hours of the operation. The surgeon should be at once summoned. If the lids are opened, the wound may be seen as a greyish infiltrated line. Strenuous measures are now urgently needed to save the eye. The wound must be opened up and cauterised with the galvanic cautery from end to end. Iodoform and atropin ointment may be placed in the eye. It is better not to pad the eye closely after this, to allow the escape of discharge, and gentle irrigating with sterile water may be employed, the reservoir of the douche being raised only a few inches above the outflow. Under favourable circumstances a useful eye may be saved. More commonly the whole suppurates freely, and is lost. Much depends on early recognition of the infection.

Severe pain occurring immediately or within a few hours after operation is a very important sign. It not uncommonly means intra-ocular hæmorrhage. The intra-ocular tension balances to some extent the strain of the pressure in the arteries of the eye by supporting them on the outside. When owing to an incision this is materially reduced, the vessel walls, too often the seat of disease, may give way. This accident may prove fatal to the eye; the blood escaping forces out the vitreous, and at the first dressing the globe will sometimes be found full of blood, with clots hanging out of the gaping wound. If such a mishap occur, cold should be immediately applied as an attempt to stop the escape of blood, and the bandage readjusted so as to apply even gentle pressure.

A much more common and less serious sequel is iritis: this is rarely severe unless there is infection at the time of operation, or the margin of the coloboma is caught in the corneal wound. It will delay convalescence for some days, but usually subsides under atropine.

In a few cases, however, the inflammation is more persistent and attacks the ciliary body, giving rise to cyclitis. If this does not subside under treatment, it not uncommonly leads to sympathetic ophthalmia—affecting the other eye. The prognosis in this case is very grave. The subject of sympathetic inflammation will be dealt with later.

(To be continued.)

Appointments.

Matrons.

Miss A. A. Browne has been appointed Matron of the Grove Hospital, Tooting. She was trained at the London Hospital, and has held the position of Night Sister at St. Pancras Infirmary for two years, and of Superintendent Nurse at the Union Hospital, Newcastle-on-Tyne, for a year and eight months.

Miss Agnes Ramsay has been appointed Matron of the Stephen Cottage Hospital, Dufftown. She was trained at the Western Infirmary, Glasgow, and after obtaining training in fever and maternity work, acted as Sister in the County of Lanark Fever Hospital, and subsequently as Superintendent Nurse in the Dover Infirmary. Her last appointment was that of Matron of the Hatton Nursing Home, Ceylon, which she resigned last April.

Miss Agnes Maud Oslar has been appointed Matron of the Wrexham Infirmary, Denbighshire. She received her training at the Royal Albert Edward Infirmary, Wigan, and has been working in connection with that institution for the past seven years. During her training Miss Oslar won the second prize awarded for distinguished merit. She has held, in succession, the posts of Sister in a men's surgical ward, Night Superintendent, and for the last fourteen months that of Assistant Matron. Miss Oslar also holds the diploma of the London Obstetrical Society, and for a short time acted as Night Superintendent in Miss McCaul's Nursing Home, Welbeck Street, London, W.

Assistant Matron.

Miss E. E. Fletcher has been appointed Assistant Matron at the Royal Albert Edward Infirmary, Wigan. Miss Fletcher has been connected with the Wigan Infirmary for over six years. She was the first prize probationer of her year, and since then has been in succession Sister of Women's Wards, Sister of Men's Surgical Wards, and Theatre Sister.

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