There is always some risk of vomiting after an operation for which general anæsthesia is necessary. This is to be prevented by any possible means, for it may have injurious results on the eye. As regards after-treatment, there is little special to say about the dressing of the wounded eye.

During the first two or three days the patient should submit to having both eyes bandaged. It is most important that the healing of the operation wound should be speedy and uneventful. If iritis or cyclitis occur we are prohibited from using atropine, and thus our greatest auxiliary is cut off. Should signs of ciliary congestion appear, heat and leeches are of great value.

From the nature of the case and its urgency, it is not possible to take any lengthy measures for the production of asepsis; it is very rare, however, that the corneal wound becomes inoculated. An equally rare accident is intra-ocular hæmorrhage; from the sudden relief of tension the coats of the vessels may give way, and the poured-out blood will break up all the contents of the globe.

An important point in the after-treatment of the case refers to the other eye. The tendency is for the disease to be bilateral; the shock of the operation has not infrequently brought on a crisis in the fellow eye. The nurse must remember always to instil eserine freely into it to preserve contraction of the pupil, and prevent, if possible, an acute attack. The neglect of this simple precaution may cause the loss of the remaining eye.

It may happen that from unavoidable circumstances an immediate operation cannot be undertaken; we must then endeavour to reduce the intra-ocular tension by other means. We have seen that eserine contracts the pupil, and so stretches the iris, diminishing the thickness of the mass at the base, and opening up the iritic angle. This drug, therefore, and other myotics are, to some extent, antagonistic to primary glaucoma, and should be used freely in drops of gr. ij. or gr. iij. to the ounce. A drop may be put into the eye every ten minutes for an hour, and continued four or six times daily. Leeches to the temple relieve pain, and to a slight extent, perhaps, alter the vascular system and tension. The greatest agent is in alteration of the general tension by free purgation.

To relieve pain and to procure sleep, which always exercises a good effect on the glaucomatous attack, morphia may be given; the action of the drug on the pupil is also directly favourable.

Dionine, applied locally, may also be used as an analgesic.

Much good may be done temporarily in suitable cases by massage. The manipulations of several observers in succession, while estimating tension, are often sufficient materially to lower the resistance, so that the observations form a descending scale. Similar movements may be used to reduce the contents of the globe and the intra-ocular pressure, when from any circumstances operation is inadvisable or impossible. If the eye is tender, the gentlest touch and the most minute vibratory movements must be applied. After a short time, two or three minutes at most, a definite reduction of the tension can be recognised, and now the strength may be slightly increased. Care must be taken never to hurt the patient; the pressure must never excite pain. If the patient complains, the touch must be lighter and the movements smaller until no discomfort is felt, when they can be again increased.

The good results are only temporary, the pressure rises again, but the massage may be re-applied two or three times a day, or oftener. The fingers can give in the way thus mentioned most valuable results. In several patients, where for one reason or another immediate operation was not advised, I have known the intra-ocular tension kept in limits and the progress of the disease stayed for long periods.

The patient may readily be taught to apply this for himself, but must be warned not to repeat the manipulation too frequently.

A mechanical vibrator has been used for this purpose with excellent results, but it has few, if any, real advantages over skilled digital movement; the cost is considerable.

If the disease be not checked by treatment, vision may be totally destroyed as a result of the first attack; more commonly the tension gradually is lowered, and the eye partially recovers, but the visual acuity is always diminished and the visual field contracted, especially on the nasal side. Sooner or later a second acute attack takes place, and is followed by others. Each leaves the eye somewhat less perfect than before, and eventually complete blindness follows.

Such was the inevitable end until Von Graefe introduced the operation of iridectomy.

(To be continued.)

The Dundee Private Hospital for Women.

Some pleasant things were said by Mrs. Carlaw Martin, who presided last week at the annual meeting of subscribers to the Dundee Private Hospital for Women. No apology, she said, need now be made for the existence of the hospital; it was only necessary to pay a tribute to its usefulness. In this connection she specially mentioned that the best thanks of all concerned were due to Dr. Emily Thomson, Dr. Alice Moorhead, and the Matron, Miss Menmuir, for the success which had attended their labours. The financial report was presented by the Hon. Secretary, Miss Walker, the medical report by Dr. Alice Moorhead, and Dr. Jessie Macgregor (of Edinburgh) moved their adoption. Dr. Grant and Dr. Mackie Whyte spoke appreciatively of the work done by medical women.

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