Sometimes the surgeon will decide to leave a style in the duct permanently. These are made of silver, modelled after a pewter copy. The form varies with the practice of different surgeons; some bend the upper end into a hook, which lies on the edge of eyelid; others bury the upper end in the canaliculus. The latter form has the disadvantage of being lost not uncommonly. I have seen as many as four styles shown by the X-rays lying in some cavities other than the nasal duct.

The former is not very noticeable, and after it has been worn for some time can usually be left off during the day, being re-introduced at night.

It unfortunately sometimes happens that all these methods are unsuccessful. The stricture obstinately re-contracts after probing, and a style sets up so much irritation that it cannot be worn.

What then remains to do? By careful and repeated cleansing of the sac the patient may be kept comfortable, and the formation of abscesses, which is the chief danger, averted. I have known a patient learn to syringe out his own sac, and thus be more or less independent. The watering of course continues, and it becomes a question whether the sac should not be excised.

If this be done the patient is relieved of all necessity for attention, though the lachrymation is permanent. The operation requires general anæsthesia, the sac is dissected out, the duct scraped with a sharp spoon to remove all mucous membrane above the stricture, the canaliculi laid open, and their lining destroyed by the galvano-cautery. If done with proper precautions the wound heals by the first intention, and the patient may be discharged in a few days.

Many attempts have been made to deal with the stricture otherwise than by the slow dilatation probes. Stilling devised a knife which could be passed into the duct, dividing any cicatricial bands, and freeing the passage so as to allow the entrance of a large probe immediately. The method corresponds closely to forcible dilatation, and has the same disadvantages. Attempts have been made to reduce the surrounding tissue by electrolysis. I have no experience of this procedure. Dilatation by probes may be required to allow the electrode to enter.

It may be asked, Why should we trouble a patient with the worry of probing, &c., when, apart from a little lachrymation and discharge of muco-pus from the canaliculi, there is nothing amiss? The answer is that an eye full of pyogenic micro-organisms is always in danger. It is true that they cannot set up purulent ophthalmia, although they excite a troublesome catarrh, but they are ready to infect any wound, even the slightest, of the cornea, and this may under unfavourable circumstances lead to the loss of the eye.

Such patients, therefore, are living in perpetual danger.

As to the causes of the condition little certain can be said. Some few of the cases in infants are due to congenital obstruction, but in most the duct is found to be free. The sole cause often seen is the inoculation of the sac walls by the gonococcus in ophthalmia neonatorum. The mucous membrane becomes swollen and congested, and may block the duct without effectively preventing the onward course of a probe. In such cases the use of astringents and antiseptics to wash out the sac will suffice to bring about a cure.

In the adult, women are much more affected than men; and it is not at all clear why this should be so. Of course, in any condition where there is periostitis or ostitis of the facial bones the duct is likely to be affected, and therefore in hereditary syphilis we meet with very obstinate examples of this affection; apart from such, however, adult women not uncommonly become troubled by blocking of the nasal duct.

In the early stages no doubt this is often temporary, and due to the swelling of the mucous membrane. The congestion of the muco-periosteum may be indeed the primary cause, bringing about increased activity of the bone-forming cells, and a deposit of new bone round the walls.

(To be continued.)

Certification in Lunacy.

THE BORDER LINE.

An interesting address was given by Sir William R. Gowers last week before the members of the Medico-Psychological Association, in which he demonstrated that while the present lunacy laws afford protection to those whose insanity is beyond question, they act very prejudicially in those cases which are on the border line, and which, if taken in time, might be permanently cured. Under our present lunacy laws before such a patient can be received for treatment for payment, the nearest relative must sign a request that the patient shall be "detained and taken care of as a lunatic, idiot, or person of unsound mind." Then the patient is cross-examined by a medical practitioner, and, lastly, a document must be presented for signature by a Justice of the Peace. Naturally relatives often shrink from adopting this course till the case becomes hopeless from a curative point of view. In Scotland the law is reasonable and humane, and any patient on the verge of insanity, or definitely insane, can be taken uncertified for six months "with a view to recovery" on a medical recommendation. The lecturer suggested that the whole question, which is delicate and difficult, should be investigated by a Royal Commission.

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