administer atropine—both as a means to combat iritis, which is often found complicating some corneal ulcer, and as a sedative of the local nervous and vascular system. It has been already pointed out that by this means the photophobia so often accompanying ulceration will usually be brought to subside.

When the eye is sufficiently relieved to allow a careful examination, the size and character of the sore must be noted.

Ulcers are classed to some extent by their shape. A not uncommon form is that known as dendritic; here the ulcer is almost linear, with narrow offshoots branching in various directions, each branch having a rounded end, the whole somewhat resembling the growth of a small plant. Another form, sometimes called "creeping," or "serpiginous," gradually extends over a large area of the membrane, eating away by a narrow convex edge and healing behind, dragging a leash of vessels after it. Both these varieties are often associated with iritis. A last and more serious form is known as "rodent" or "Mooren's" ulcer. The first name is unfortunate, as suggesting a like nature to rodent ulcer of the skin, which this disease certainly does not possess. It is a very chronic superficial affection, lasting months or years, not often painful, but eventually involving, unless checked, the whole surface of the cornea and therefore interfering very greatly with vision.

When the nurse has carefully observed both the shape and size of the ulcer, it remains to note the state of its floor and spreading edge, which affords valuable indications for treatment. The active part can always be marked out by placing a small quantity of fluorescine dissolved in alkaline solution in the cul-de-sac. This stain has the power of colouring the cornea green where the epithelium is removed. It is difficult to avoid an excess of fluorescine, which rapidly stains the skin of the face yellow by overflow. A drop, from a dropper, stains the whole lid of the patient as well as the ulcer. This is not a little unsightly and inconvenient to the patient. If the dropper be emptied back into the bottle after filling, sufficient is almost always left to form a small bubble on the end when the air is gently expressed. This little bubble may be burst against the ulcer, and thus an excess of the dye avoided. No evil results from even extensive staining, and it is merely the temporary disfigurement which is avoided by this. The dye can be washed off the skin with water. The corneal stain remains for some ten minutes. Where the ulcer is spreading, the floor, when unstained, is grey in colour, and covered with small rough irregularities. Often there may be an ill-defined ring of haze surrounding the margin and showing where pus cells are invading the healthy tissue. The active edge is often sharply cut and everted, especially in Mooren's ulcer. Pus from the ulcer sometimes tracks between the layers of the cornea and forms an abscess. When the ulcer is very deep, and has eaten through to the posterior elastic membrane (Descemet's membrane) the floor often appears clear, smooth, and transparent; and bulges in a small convexity from intra-ocular pressure.

The iris, becoming involved in the inflammation, pours out a purulent exudation which sinks to the lowest part of the anterior chamber and forms a "hypopyon." A careful watch must be kept for the first appearance; as the anterior chamber lies partly behind the sclerotic the pus can be seen when the patient looks downwards before sufficient is collected to be visible directly from the front.

The pus may be in part formed from the cornea also; it does not, however, come from the ulcerated anterior but from the posterior surface.

The treatment in all instances has for its chief objects to arrest and prevent the growth of micro-organisms, and to neutralise the evil sequelæ from iritis. The latter object is best to be attained by the free use of atropine; the former may be secured by local antiseptics. In some cases quinine is of great service, and is perhaps the least irritating of any antiseptic; but where the ulcer is obviously spreading, the galvano-cautery is by far the most rapid and certain bactericide. The active edge and the infiltrated zone should be destroyed freely. If there be a large hypopyon, the surgeon may elect to perforate the cornea and draw out the mass with forceps. Usually this will not be necessary.

(To be continued.)

Appointments.

Matrons.

Miss Ada Dixon has been appointed Matron of the Home for Incurables, Carlisle. She was trained at the Guest Hospital, Dudley, and has acted as Night Superintendent and also had charge of the women's and children's wards for two and a-half years.

Miss Margaret Gray has been appointed Matron of the Isolation Hospital, Oxford. She received her training at the Royal Infirmary, Perth, and has also held the positions of Night Superintendent and Sister at the Oxford Isolation Hospital.

Sister.

Miss Amy Erwood has been appointed Sister of the theatre and children's ward at the General Hospital, Tunbridge Wells. She was trained at King's College Hospital, London. For three years Miss Erwood was a member of the Nurses' Co-operation, New Cavendish Street, and has since held the position of Sister at the County Hospital, Lincoln, for three years, having had charge of both a male medical ward and the children's ward.

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