curvature of the diseased tarsal plate, to correct the malposition of the lashes. The other leaves the diseased tarsus untouched, but separates the lashes from it and fills in the resulting gap by skin or preferably mucous membrane. The former is more suited to severe cases, the later to slight deformities.

In England, trachoma for the most part is more or less efficiently treated during the active stage, and therefore the slighter deformities are those with which we have most usually to deal. The curvature of the cartilage is rarely extreme, and the lashes hardly brush the cornea for the most part, only a few of the more posterior being really inturned.

It will be remembered that in describing the anatomy of the lids the existence of a "grey line" on the margin was mentioned lying behind the lashes, and in front of the tarsal plate. This was said then to indicate the position of cellular tissue interposed between the cartilage and the hair follicles.

From this line an incision is made dividing the lid into two parallel plates. In the anterior should lie all the hairs; in the posterior is the malformed cartilage. By separating the two, the lashes can readily be placed in their normal position. The gap left must be filled in, so that there may be no reproduction of the deformity, and this is best done by a piece of mucous membrane taken from the lip of the patient and fixed in the wound as little damaged as possible; personally, I prefer to fix it by sutures which do not penetrate it at all, but only press it down into the wound, in the way recommended by Mutermilch. The ends of the sutures are not tied, but secured to the forehead or cheek by means of collodion; a dry pad of gamgee tissue is placed over the wound and left undisturbed for three days, after which the sutures may be removed and all dressings left off. If the deformity is greater than can be corrected by this method, the procedure I adopt is the following: The lid being held in Snellin's clamp, which stops all hæmorrhage and therefore renders the manipulations easier, an incision is made just above the hair follicles through the skins and tissues down to the cartilage, and this is, by slight dissection, exposed in its whole transverse extent just about at the position of the greatest curvature. A groove is cut through the thickened and diseased tissue from side to side, so that the lower part is only connected with the upper by the conjunctiva; it is easy to pass sutures so that the lower part is rotated through a right angle round its own transverse axis, and is held in the new position until cicatrisation fixes it there.

In these operations, and others on the lids, a Snellin's clamp is often very useful. Sometimes a flat spatula is more convenient; both should be at hand. The Snellin's clamp is made for right and left lids; the handle with the screw lies on the cheek, and therefore indicates for which side the instrument is devised. The flat solid plate is, of course, placed on the inner side of the lid. A Bere's knife may be required; an ordinary scalpel, dissecting and fixation forceps, a small pair of scissors, needles and a needle-holder complete the equipment.

In cleansing the skin of the lids before operation the nurse must remember the close apposition of the cornea. She must take care that any strong antiseptic used does not spread beyond the region of the operation.

Very little after-attention is required; the wounds heal rapidly, and all dressings may usually be left off with safety within a week. The stitches may be taken out about the fourth day.

In the lower lid entropion is often spasmodic, and due to the irregular contraction of the orbicularis muscle.

(To be continued.)

School Sanitation.

We are not aware that the hotly-discussed Education Bill touches on sanitation. Presumably it does not deal with anything so practical. More's the pity. In Germany, Dr. D. Forsyth, Chairman of the Berlin Board of Health, points out in an excellent article pertaining to school sanitation how much the capacity to learn depends upon ventilation. He makes the proper school ventilation largely responsible for: (1) Restlessness and inattention of pupils; (2) weariness and irritability of teachers; (3) headaches and colds; (4) the spread of disease.

The following suggestions are made:—

(*a*) School buildings should not be more than two storeys high.

(*b*) All schoolrooms should contain air-space equal to 250 cubic feet per pupil.

(*c*) All schoolrooms should contain floor-space equal to 20 square feet for each pupil.

(*d*) The square foot of window surface should be at least one-fifth of the square foot of floor surface.

(*e*) No pupil should be seated farther away from the window than one and a-half times the distance from the top of the window to the floor.

(*f*) No schoolroom should be heated by direct radiation.

(*g*) Air from the outside should always be used to furnish fresh air for the rooms.

(*h*) Quantities of fresh air moderately heated should be furnished, and in no case should fresh air be heated by high temperature, because it is thereby vitiated.

(*i*) Pupils should be furnished at least 30 cubic feet of air per minute.

We commend these suggestions to the notice of those responsible for the efficient education of all classes. Healthy bodies mean healthy minds.

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