free medical attention and a free and expensive professional education? Will they mount their coal cart and solemnly promise to give of their very best to the sick and suffering? Will they give, freely and generously, more than the stipulated 48 hours per week service if need arises, without agitating for every single minute back? Will they forgo the tiresome business of counting every single halfpenny to see if one is missing, and instead do an extra little service for their patients? Will they attend to their professional studies with all the assiduous attention which they are willing to devote to their pay books and salary grades, and those pamphlets which deal with their "rights" and wages under this or that Act? Will they promise to be kind, considerate and gentle and most attentive to their patients' needs? £5 per week may not be too high a price to pay for all this, yet it will cost the nation dear. Is it really more blessed to get than to give?

G. M. H.

## NEWS FROM ACROSS THE ATLANTIC.

From the *American Journal of Nursing* we learn that at the Biennial Nursing Convention of the American Nurses' Association, the National League of Nursing Education, and the National Organisation of Public Health Nursing, in Chicago from May 31st to June 4th, approximately 8,000 members of the organisations were present, and current problems of nursing were discussed, and decisions made. We learn also that the sun shone for the five days!

At the Convention, Miss Katharine J. Densford, who presided over the meetings of the International Congress of Nurses in Atlantic City last year, retired, and Miss Pearl McIver, United States Public Health Service, Washington, D.C., was elected President of the American Nurses' Association.

From the *Canadian Nurse* we learn of another Convention of Nurses held, this time, in Canada, at Sackville which commenced on June 28th and terminated on July 1st, when Miss Ethel Mildred Cryderman was installed as President of the Canadian Nurses' Association. Miss Cryderman was a student in the School of Nursing of the Toronto General Hospital and graduated in 1916. She served with the Army Medical Corps during the First World War and was mentioned in despatches in 1918.

She served three years as Staff Nurse with the Toronto Department of Public Health; took a Course in Midwifery at the Radcliffe Infirmary, Oxford, and Mothercraft in London, and on returning to Canada became District Supervisor with the Toronto Department.

She later joined the Victorian Order of Nurses for Canada as a national supervisor, and in 1934, she was appointed to her present position as Director of the Toronto Branch of the Victorian Order of Nurses.

It is said that Miss Cryderman is always dignified, poised and unruffled, and will lead the "parliament" of the Canadian Nurses' Association actively and with assurance.

We wish these two ladies a successful term of office.

## DETACHMENT OF RETINA.

A. PRIMARY. B. SECONDARY.

A. PRIMARY DETACHMENT OF RETINA.

A condition in which a hole or tear occurs in the retina which becomes detached from the choroid and floats forward. Localised accumulation of fluid under the retina causes the appearance of a ballooning of the retina. The hole or tear can only be seen with an ophthalmoscope; it can be of varying shapes and sizes and may be single or multiple. The more common types are:—

1. Anterior dialysis or disinsertion (Trauma).
2. U-shaped tears. (Myopia).
3. Round holes.

If left untreated the detachment progresses until the whole retina becomes completely detached. When this occurs, usually after several months or years, no vision is left. The end result is usually a blind eye with secondary iridocyolitis, secondary cataract and a low tension with posterior synechiæ. The eye may become painful, requiring enucleation.

*Symptoms.*

1. Black spots, which may float about.
2. Flashes of light.
3. A dark shadow extending across the field of vision as the area of detachment increases.
4. Loss of vision. May not be noticed until the macula area becomes detached or covered by the detachment. When this happens there is sudden loss of central vision, which may be reduced to hand movements.

*Signs.*

Usually only present on ophthalmoscopic examination.

*Treatment.*

Two main objects of surgical treatment:—

1. Closure of the hole or tear. This is done by the conjunctiva being stripped back, and the choroid is burnt at the possible site of tear, followed by punctures to release the sub-retinal fluid.

*Pre-operative treatment.*

Doctor orders eyes to be dilated with homatropine and cocaine or sub-conjunctival injection of mydricaine to aid examination in finding the site of tear.

In rare cases the patient is double padded for approximately 14 days before the operation, and maintains a certain position which the surgeon orders.

If the surgeon decides, the nurse prepares the patient's eye.

The eyelashes are cut, the eye is irrigated. Aperient given; urine tested; any chest condition noted and reported.

Until the operation the eye is usually treated with atropine and penicillin.

*Post-operative treatment.*

The position is decided by the surgeon post-operatively. (Flat—one or two pillows—Fowler's position—head to the left or right, etc.) Conjunctival sutures removed on the fifth day.

Patient is treated on bed absolute for 14–16 days. Pillows increased according to progress.

Pinholes given 14th to 16th day and the patient

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