final result was so perfect that I was induced to repeat the experiment in a number of cases until I was forced to the conclusion that I had needlessly restrained a great many patients to their discomfort.

Now I never close the eye not operated upon. My cataract patients are not restricted in seeing by undergoing an operation for cataract extraction. The sight which they had the day before the operation they continue to enjoy during the entire treatment. This revolutionary act in eye dressing has not only proved itself of immense comfort to the invalid, but has actually added materially to the rapidity of the convalescence; so that now I am able to liberate the eye operated upon as early as the fifth day, and in many cases have done so on the fourth. In one or two cases in which the adhesive strip had become detached prematurely at the end of the third day after operation, I found the corneal wound so perfectly healed that I did not reclose the eye. I now in cataract extractions leave the seeing eye open with the same confidence that I formerly had when I securely closed it up. An experience of over 400 cataract extractions has given me conclusive evidence that by this course of treatment I not only do the eye operated upon no harm, but, on the contrary, positive good. However forcibly we may theorise on this subject, the fact still remains that, in my experience, the movements of the exposed eye do not disturb injuriously the cut one. The corneal wound heals quite as promptly as when both eyes are shut. I have also found that the eye operated upon, and closed only by a diaphanous strip, has its final healing much advanced when, through the whole treatment, the other eye is exposed to moderate light. Neither eye then becomes over-sensitive, as when the dark treatment is followed. When the adhesive dressing is removed, on the fourth or fifth day, the eye operated upon will be found much less red, watery, and sensitive than when closely confined by heavy coverings. Convalescence, as a rule, will be so rapid that ten days after the operation patients can walk about the house without inconvenience from the light and without the desire for the protection of smoked glasses.

For the past two years I have operated upon all simple senile cataracts without iridectomy. I clean the anterior chamber as carefully as possible, and replace the iris so as to establish a round well-contracted pupil, with the lips of the corneal wound thoroughly adapted. A few drops of an eserine solution half per cent. strength are instilled into the eye operated upon. Both eyes are temporarily closed for the adjustment of the adhesive strip over the lids of the one operated upon. As soon as it dries it holds the lids very securely together. The patient is then told to open the other eye. The patient gets out of the operating chair, and, if he has sight enough in the exposed eye, walks unaided from the operating room to his chamber. He reclines on the sofa, sits upon or lies upon the bed at will. He eats his regular meals. At bedtime he undresses himself, and unaided makes his own toilet in the morning. He walks about the room, escapes the annoyance of being fed by the nurse, receives the visits of his friends, and in many respects is unrestrained in his movements. The diaphanous character of the dressing admits of the daily inspection of the lids. If no excessive discharge appears, there can be no trouble going on, and the dressing is not disturbed. As an additional security for pupillary shrinkage I instill at bedtime, on the day of operation, a drop of the eserine solution. It finds its way from the inner canthus under the plaster, and by capillary action gets on the cornea. This ensures the removal of the iris from the corneal wound, and tends to prevent prolapse. On the fourth or fifth day, when the adhesive strip is finally removed, I use locally atropia to expand the pupil. I remove the adhesive strip by detaching a corner and pulling the whole dressing off dry. Should the patient complain of the traction, the lids are moistened, when the adhesive piece comes off without effort. The eyelids are then cleansed of adherent secretions with warm water. The daylight of the room permits of a perfect examination of the eye. The corneal wound is found healed and the eye much less congested than when treated by the old method with heavy compresses, a proof that much of the irritability of the eyes, as seen after the usual method of dressing cataract cases, should be charged to the exclusion of light and not to the corneal wound. When the adhesive plaster has been removed on the fourth or fifth day the newly exposed eye needs no further protection. The eye not operated upon and never closed had all along accommodated itself to the

moderate light of the sick chamber, from which only sunlight had been excluded; and the newly exposed eye, on account of the previous exposure of its companion, speedily does the same. In two weeks after operation the period at which cataract patients usually leave the hospital, very few need the protection of smoked glasses on going out upon the street. The majority go out without them. Prior to four years ago every eye operated upon and treated in the then dark wards of the hospital had to be supplied with smoked glasses, which the hospital authorities purchased by the gross. On account of the change made in the eye dressing, smoked glasses are no longer an article of hospital purchase.

In conclusion, I would say that my experience of the past four years in several hundreds of cataract and iridectomy cases has shown conclusively to myself and to a large number of professional friends who have adopted my methods that the leaving of one eye open for the comfort of the patient in no way detracts from the final success of the operation. Also that treatment in a moderately lighted room is conducive to a more rapid convalescence. Also that freedom from restraint and the varied movements of the patient have in no instance in my knowledge endangered the very large percentage of cures which we all individually are carefully studying to secure. In drawing attention to these radical changes in the after treatment of cataract extractions and other eye operations, I know that I am acting safely when I advise a trial of this new line of treatment, feeling assured that personal experiences, regardless of preconceived theories, will lead to the adoption of this better and more advanced method of treating cataract patients.

INFLUENZA: ITS CLINICO-PATHOLOGICAL ASPECT.

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INFLUENZA, like all similar diseases, is viewed from three standpoints—that of the medical officer of health, of the pathologist, and of the practical physician. Under the first two heads probably nothing has been learnt from the late epidemic. The sanitary officer has failed to arrest its advance, or even to determine its mode of progression. The labours of the post-mortem examiner to detect any specific lesion in its victims, and of the bacteriologist to discover the ultimate cause of the disease, have been equally fruitless. When, however, we regard the disease from the practical physician's, or from what may be called the clinico-pathological, point of view, the case is quite different; the late experience has largely modified the opinions concerning influenza generally held, as far as this department of medicine is concerned. Although the list of symptoms handed down to us from former epidemics will serve perfectly well for the late one, they were arranged in such a manner that a month or more passed after the beginning of the visitation before the presence of the disease amongst us was universally acknowledged. The cause of this was not far to seek, for the disease was described as being chiefly incident upon the respiratory tract; in fact, observers were on the look out for a disease of the nature of a bad cold attended with an unusual amount of depression. The object of the following remarks is to show that the poison of influenza attacks chiefly the central nervous system, and that the damaged state of this tract is impressed upon all the phenomena observed in this interesting disease, and constitutes a connecting link between them. The importance of determining the parts of greatest incidence of a disease need not be insisted upon.

In a letter to Dr. Sisley, Professor Proust writes: "D'ailleurs les divers symptômes observés dans la grippe révèlent bien plus tôt un trouble nerveux général qu'un état d'inflammation franche."

1. The simplest form of the disease displays itself as follows: The patient suddenly finds himself incapable in mind and body; he is unable, except with the utmost exertion, to finish anything he may be doing, the slightest effort being followed by an extreme feeling of fatigue. Within a few hours follow intense pain at the back of the

eyeballs, in the head, and down the spine; pain and tenderness occur in various muscles, chiefly those of the back, neck, and calves. The pains in the head and back are peculiar; they are deep-seated and resemble those caused by concussion. Percussion of the spine, as Dr. Bezly Thorne points out, is painful; indeed it produces a deep-seated jarring sensation. Prostration (contrary to what was described formerly) is out of all proportion to the general severity of the disease. Now, except the symptom referred to the muscles, the above description points to one pathological condition only—i.e., a damaged state of the brain and spinal cord. The muscular pains in the symmetry of their position and the variability of their intensity suggest that they are myalgias projected from the nerve centres.

2. If the attack be more severe the symptoms referred to the central nervous system directly become more pronounced and numerous, and, in addition, symptoms referred to other parts of a very characteristic and interesting nature arise, and then we have the fully-developed disease. At whatever part of the body these symptoms occur they always possess certain qualities; they are symmetrically placed, their duration and intensity from moment to moment are exceedingly variable; they manifest, if on the surface, and indicate, if deeply seated, a congestion of the part affected and a disturbance of its functional and sensory condition; in other words, the outlying symptoms point to a loss of vascular, functional, and sensory tone, and not to true inflammation. If the part affected be a surface, hæmorrhage is likely to occur, and if the condition persist for a certain time a state approaching inflammation is induced, which when it affects a mucous membrane constitutes catarrh. If the nose be involved, we get violent sneezing, with suffusion of the nasal mucous membrane, and often of the surface of the head. This condition sometimes passes off in a few minutes, or remains in a slighter degree for an indefinite time, producing the coryza, which seems to have been more common in the epidemic of 1847 than in the late one. Epistaxis would naturally often occur. If the bronchial tubes are attacked, there is a rapid development of a feeling of tightness in the chest, with the occurrence of a spasmodic cough, ending in the expectoration of a little mucus tinged, perhaps, with blood. This condition, again, usually passes off after a few minutes, but sometimes remains for a longer time, causing bronchial catarrh. When the proper tissue of the lungs is affected there is a feeling of intense fulness in the chest, with lividity of the face and struggling for breath. These symptoms usually disappear with remarkable rapidity, but sometimes continue and become so severe as to cause death. The stomach very commonly displays symptoms due to loss of tone, there is violent vomiting with loathing for food, and great pain in the epigastrium, and often a little blood is vomited. This state usually clears up in a few hours. Referred to the central vascular system, we have temporary fits of præcordial oppression or pain, the latter sometimes intense. Symptoms of a similar nature to the above may occur, referred to almost every part of the body. A third class of symptoms sometimes arise which seem to prove that the vital centres do not escape the poison of the disease. The respiratory movements are often performed with greater effort than the local conditions will explain, and sometimes cease altogether. The pulse does not rise with the temperature, and there is sometimes great depression of the vascular system, suggesting involvement of the centre controlling its function.

3. Even in the complicated cases, when actual inflammation has occurred, there seems something superadded to the local lesion. Sir Peter Eade notes that the cases of pleurisy display more pain than is usual in ordinary pleurisy, and that the difficulty of breathing, when pneumonia has been established, is greater than the local mischief will explain.

4. During the tedious convalescence from the disease nervous symptoms are very persistent, as also is a general loss of tone of the body, slight causes producing disturbance out of proportion to their magnitude. There is often, as Dr. Wilks points out, a depression of the heart's action unexplained by local conditions.

With all these considerations in mind, it seems to me that the following pathological conception naturally suggests itself. Influenza attacks primarily and chiefly the central nervous system, hence arise three groups of specific phenomena:—1. Those referred directly to the nerve centres. 2. Those referred to other parts, consisting of

loss of vascular functional and sensory tone, due to a damaged state of the tonic centres, in the central nervous system. 3. Those consisting of disturbances of the vital functions due to involvement of vital centres.

In conclusion, if the above views be correct, rest of body and mind would be specifically indicated in the treatment of influenza. Experience has amply proved this line of treatment to be the right one. The best advice was found to be, when practicable, "Thou art inclined to sleep; 'tis a good dulness, and give it way."

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NOTES OF A CASE OF PARAFFIN DRINKING.

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MRS. A. M.—, aged thirty-six, came to the Royal Infirmary at 9.55 A.M. on March 15th, 1890. She stated that she had been drinking for a fortnight, and that that morning, while still not thoroughly sober, she had intentionally drunk a good half-cupful of paraffin oil. The time could not be accurately ascertained, as her clock had stopped, but it seems to have been before 6 A.M. After about half an hour had elapsed she began to suffer pain and to vomit; she vomited twice or thrice, a mouthful or two at a time, and on the first occasion she says there was more than a tablespoonful of blood in the vomited matter. (During the previous week she had had several attacks of vomiting, due to drinking, but no hæmatemesis and no pain.) The pain increased rapidly, and became so bad that she thought she was going out of her mind.

On admission, her hands and tongue were very tremulous; the tongue was distinctly red and glazed-looking at the tip and edges, and the dorsum covered with a thick white fur. The right pupil was somewhat dilated, the left normal; both reacted rather sluggishly to light. She complained of pain in the pit of her stomach. Temperature 98.6° F.; pulse 120. One-tenth of a grain of apomorphine was given hypodermically, and six minutes later she vomited about six ounces of matter, which emitted a strong odour of paraffin. It consisted almost entirely of yellow mucus floating in a golden-yellow fluid. She then drank a large cupful of water, and thereafter the dose of apomorphine was repeated; two minutes later she vomited material similar to the last, but diluted with the water just swallowed. There was no blood on either occasion. About midday she passed a scanty stool, consisting almost entirely of red blood. Her menstrual period had ceased normally almost a week before, but there occurred a slight return of the flow that day. At 1 o'clock she was ordered a simple warm water enema (a pint and a half), to be repeated after an hour's time. On each occasion the enema brought away a stool having an intense odour of paraffin, but containing no blood. She passed twelve ounces of urine, which also had a very marked odour of paraffin; by allowing the urine to stand, the paraffin was rendered visible, floating as a thick scum on the surface.

At 7 o'clock she complained of abdominal pain. Another warm-water enema was given, and brought away a stool without any blood; the odour of paraffin was present to a less degree than before. Shortly after this she passed forty ounces of turbid urine, lighter in colour, but with a marked odour of paraffin. The temperature at 4 P.M. had been 100.2°, but at 8 P.M. it was a degree lower. Mr. Charles Arthur, the dispenser to the Royal Infirmary, kindly undertook to distil ten ounces of the first sample of the urine, and ten ounces of the second. As the result of distillation and redistillation about 6 c.c. of pure paraffin were collected; and Mr. Arthur estimated that at least an equal quantity was lost in the process, owing to the want of sufficiently delicate apparatus. The two samples were kept separate during the first distillation, and it was found that the first contained about twice as much paraffin as the second; thus a total of at least 25 c.c. of paraffin must have been excreted by the kidneys.

At 9 o'clock the patient was found lying with her knees drawn up, complaining of severe burning pain, chiefly at the epigastrium. There was marked tenderness on pressure over that region, and over the left lumbar region; she said her abdomen was swollen, but it was not at all notice-