understand what I think about the matter. You are an antivaccinator? Applicant: Well, yes, sir. Mr. Plowden: Well, you may be right or you may be wrong; I express no opinion. At the same time, I cannot shut my eyes to the fact that you represent the voice of a very insignificant minority. That is a fact. Therefore, before granting you any certificate I must be well satisfied that you have what the Act calls a conscientious belief; not a mere loose opinion, but something well founded upon personal experience. You see the Act requires that the magistrate granting the certificate must have a conscience in the matter as well as the antivaccinator. I cannot grant these things carelessly, but must be satisfied. If the views of the antivaccinators are wrong, granting you a certificate might mean the encouragement of an outbreak of small-pox. I want you to understand these certificates will not be granted as a matter of course because a person says he objects; it must be a real conscientious belief; the sort of belief that would send a man cheerfully to the stake. Now that I have explained and pointed out the grave responsibility cast on the antivaccinator I hope you will take the opportunity before the certificates are printed to further consider the matter. If you remain of the same opinion you shall have the certificate cheerfully.

The effect of Mr. Plowden's good advice may, however, be gauged from the fact that the applicant demurred at having to lose further time, and asked that the certificate might be forwarded to him, and finally succeeded in persuading the Court to give him a manuscript certificate, with which he departed.

It will be seen from the letter of our Liverpool correspondent that in that city a certificate was granted to a person who merely stated emphatically that he did not believe in the efficacy of vaccination, but gave no reasons for his disbelief.

This, it should be noticed, is the view which is taken by the metropolitan stipendiary magistrates alone, the ordinary justices and other stipendiaries being unrepresented at the meeting. The interpretation thus put upon the Act is undoubtedly consistent with the intention of the Legislature. Upon a little reflection it is difficult to imagine what other meaning can possibly be attached to the words of the clause. No mention of an oath is made, and there is no suggestion that a medical certificate of a doctor shall be forthcoming. Supposing for a moment that the magistrates had decided to require a statement on oath from the conscientious objector, what value could be attached to it? It might be of the form: "I swear that I conscientiously believe, etc.," or "I swear that A.B. told me that vaccination is prejudicial to the child's health." The former would be a mere expression of opinion, the latter mere hearsay evidence, and neither would be of any value as evidence in a court of justice.

In spite of this manifesto from the stipendiaries of London, other stipendiaries and justices of the peace also are, it is submitted, entitled to go their own way, and may, if they cannot feel satisfied without it, demand from a parent or other person a declaration on oath, or possibly a statement on oath, of the existence of certain facts upon which he grounds his opinion. But let us consider for a moment the value of such a declaration. However true the facts may be, however logical the deductions which the parent or other person has made from them, the magistrate is bound to grant the certificate if there is *primâ facie* evidence of a conscientious objection. It does not rest with him to decide whether a parent's reasons for conscientiously objecting are sound; his function is merely to ascertain the existence of the objection. To take a simple instance. Suppose a man were to refuse to allow vaccination on the ground that a former child of his had died soon after the operation, and that he believed it was killed by the communication of some disease. His reasoning no doubt is unsound—any one of a hundred other causes might have brought about the death—but it is nevertheless a conscientious reason, and the magistrate must treat it as such.

UNIVERSITY OF VIENNA.—The number of students in the several faculties of the University of Vienna in the last semester was 4,425, exclusive of 1,285 who entered for particular courses. The number of students in the Medical Faculty was 1,192; in addition to these there were 636 who attended special courses.

NOTES ON OPHTHALMOLOGY IN VIENNA.

By REGINALD E. BICKERTON, M.B., Ch.B.Vict.

THE following remarks apply more particularly to the operative methods and procedures followed in Professor Fuchs's Clinical Department in Vienna, and are all written from personal observation, in most cases as one of the assistants.

ASEPSIS AND ANTISEPSIS.

Sterilisation of Hands and Dressings.—All hand towels, cotton-wool for sponging, dry and wet, for dressings and pads are first sterilised in a hot-air steriliser for at least one hour, usually two. During the process the cotton-wool for sponging is contained in cardboard cases; the cotton-wool pads used for dressings immediately after operations, in porous porcelain jars; the towels and gauze used for dry sponging being put in round metal cases with perforated tops and bottoms. After sterilising, these dressings are never touched by hand again till the operator places the dressing in position after the operation. The cotton-wool which is used for wet sponging is put into corrosive sublimate lotion 1 in 5,000 by means of a pair of sterilised forceps. After washing their hands and sterilising, more or less, with corrosive sublimate lotion 1 in 1,000, the operator and his assistant dry their hands on a sterilised towel, which is then laid across the patient's chest close up to the chin, so that, if any instruments are laid upon it, they do not necessarily become infected.

Irrigation Lotions. — Corrosive sublimate lotion of two strengths (1 in 2,500 and 1 in 1,000) is used. Carbolic acid lotion 1 in 40 is used only for laying instruments in and for boiling and keeping silk ligatures in. Saline solution 1 in 1,000 is used for irrigating conjunctival sacs before operation. Separate irrigation nozzles are kept for purulent cases and for trachoma cases. Boracic acid 1 in 500 was used in one case for syringing out the anterior chamber, the wound having become purulent after an operation.

PREPARATION OF PATIENT.

Treatment Previous to Operation.—All cataract cases are kept in the hospital for a day before the operation is undertaken. In many unclean-looking cases the eye to be operated on is syringed out with corrosive sublimate (1 in 2,500) the night before the operation and a pad applied. The syringing is repeated on the morning of the operation, and a simple rubber pad is put on without any further dressing.

Immediate Preparation for Operation.—When the patient is on the operating table, immediately before the operation is commenced, the eye is again thoroughly well sponged and irrigated, either by the operator himself or his assistant. If the case happens to be a particularly unclean-looking one, the eyebrows, lids—especially the ciliary margins—and surrounding skin are well washed with a neutral soap and sponged with corrosive sublimate, then dried. In all cases the upper lid is everted and the palpebral conjunctiva well sponged with cotton wool dipped in sublimate—1 in 1,000 first, then 1 in 2,500—particular care being taken to cleanse thoroughly the fornix conjunctivæ. The lower lid is then cleansed in a similar manner, the lachrymal sac being always pressed upon to make certain that there is no retained secretion or abnormal secretion which might regurgitate under the slight pressure of the pad after the operation. The lids are then allowed to fall back into their normal position. Irrigation of both conjunctival sacs is next performed by means of a flattened irrigation nozzle, the fluid used being contained in glass bottles placed some 10 feet from the floor. Saline solution is usually employed, the nozzle being placed well up into the fornix. A thin layer of sterilised gauze dipped in sublimate lotion is now placed over the patient's face, eyebrow, and nose, a hole being made previously in it for the eye. These preparations apply to all operations.

INSTRUMENTS.

For Aseptic Cases.—All instruments, except those reserved specially for purulent conditions and trachoma, are kept in a glass instrument cabinet with glass shelves and metal racks for holding them. Knives and all cutting instruments are kept in the same way, and not in separate cases, and they do not seem to become rusted from exposure.

For Septic Cases.—All instruments used for abscesses,

Saemisch's operation, and purulent conditions generally are kept in a separate wooden box, being well boiled both before and after every operation. Instruments used for trachoma cases of any kind, whether for lid operations or for bulb operations, also Knapp's roller forceps, are kept in a separate wooden case, and not in the general instrument cabinet.

Preparation of Instruments.—The instruments about to be used for any operation are placed in a small metal rack with their points and part of the handles projecting; the whole rack with instruments thereon is then placed in a tin steriliser containing 2 litres of boiling water with 5 grammes of sodium carbonate dissolved in it to prevent rusting. They are boiled in this for two minutes, or never less than one minute. A separate steriliser is kept for abscess and trachoma instruments, similar to that used for non-infective operations. Immediately before use the rack with instruments on it is taken out of the steriliser by means of a wire carrier, and the whole thing placed on a sterilised porcelain plate and covered with a double layer of sterilised gauze dipped in corrosive sublimate lotion. The operator and his assistant are the only persons then who touch the instruments, which are used usually while still warm. If any unusual number of instruments are required they are first sterilised by boiling, then placed in carbolic acid lotion (1 in 40), and used wet. All the knives used, and most of the other "handled" instruments have bone handles, and the boiling for this length of time seemed to have very little effect in loosening the handles. The handles of the instruments used for abscesses always became loose sooner than any others, as these instruments were boiled for a longer time both before and after each operation, sometimes for half an hour after the operation.

SUTURES AND NEEDLES.

Sutures.—Catgut is used for all conjunctival sutures, and various thicknesses of silk for plastic operations, adjustments, Snellen's sutures. Catgut sutures are kept in a spirituous corrosive sublimate solution, and are not boiled or put into any watery solution before use, but simply laid between the folds of sublimate gauze. The silk used is first wound on to a big reel, and the reel and silk then boiled for an hour and a half in carbolic lotion 1 in 40. It is then removed from the big reel on to smaller glass reels, on which it is kept and from which it is cut off as required. These smaller glass reels are then boiled for another hour in 1 in 40 carbolic, and are afterwards transferred to glass dishes, in which they are kept in 1 in 40 carbolic. These repeated boilings have very little effect in making the silk lose strength.

Needles.—The needles used have patent and split eyes, which facilitated threading. The needles about to be used are first boiled, then the silk threaded, and the needle together with the silk again dipped in boiling water for half a minute. They prove absolutely aseptic, and suppuration never took place round a suture.

COCAINE AND ANÆSTHETIC SOLUTIONS.

A 3 per cent. solution of cocaine is used for all operations where cocaine is required. A separate bottle and drop tube are kept for all trachoma cases, the bottle being labelled "trachoma" and coloured. Another bottle labelled "abscess cocaine" is kept for all abscess and purulent cases. Thus the risk of carrying infection by contact of the drop tube or bottle from infective cases to non-infective cases is eliminated. All the cocaine used is in sterilised solution, and all cocaine used during an operation, after an incision had been made into the eyeball, is to commence with a sterilised solution put in sterile drop bottles, which are then put in a glass beaker uncovered; the beaker is then placed in the hot-air steriliser for an hour, then taken out and a solution of acid thymol, 3 to 1,000, poured over the bottles till they are completely submerged; they are kept in this, and no one touches them without first sterilising his hands. Atropine and eserine are kept in the same way, being in drop bottles with "turn off" stoppers. Cocaine is instilled a quarter of an hour before any operation, and no fewer than four times during this time.

Hypodermic Solutions.—The solution of cocaine used for hypodermic injections is of the strength of 3 per cent. The syringes and needles are kept in glycerine, and filled with glycerine when not in use; this prevents rusting, and also the entrance of extraneous matter into the barrel of the syringe. Cocaine injections are employed in extirpation of the lachrymal sac and gland, in operations for trichiasis, entropion and ectropion, Panas and Spencer Watson's and von Arlt's operations for advancement of muscles, for Meibomian cysts, styes, Knapp's roller forceps operation for trachoma, and in all small plastic lid operations. The quantity injected is 15 and 20 and 30 c.mm., and in the ten months during which I witnessed several operations performed every day I never saw any ill after-effects from its use. A solution of cocaine with morphine is also occasionally used. Separate hypodermic needles are kept for trachoma cases. Before use the needles are in all cases held in boiling water for half a minute. General anæsthetics, pure chloroform, pure ether, and A. C. E. mixture are employed. Skinners' mask is used in every case.

THE OPERATIONS.

Position of the Operator.—The operator stands in front of the patient, rarely behind. Right eyes are operated on by the left hand, and *vice versâ*.

Light.—Operations are performed by daylight in most cases. When the light is very bright it is admitted from above the level of the operator's head only, so that the light comes from above and not directly from the side, by this means much of the corneal reflection is done away with. A small hand electric lamp is usually used for discissions, and when the daylight is insufficient.

Speculum.—This instrument is not usually used in cataract extractions or iridectomies unless the patient is very refractory. The lids are held apart by the assistant, and allowed to close immediately the primary incision is completed, and also between each step of the operation. The speculum generally in use has an automatic spring, without adjusting screw, and tends to separate the lids always wider and wider apart, in this way causing undue pressure on the eyeball. Desmarre's lid elevators are used in enucleation and exenteration of the orbit.

Cataract Extraction.—The complete operation is always done at one time. A large conjunctival flap is made. The operation with iridectomy is performed slightly more often than the operation without; for example, out of 400 extractions 206 were performed with iridectomy. The number of cases in which prolapse of the iris occurred was very small. Graefe's knife was always used. The lens capsule was opened by means of capsule forceps having teeth on the under side of bent arms. The lens entire, in its thickened capsule, was occasionally removed in this manner. If the forceps failed to open the capsule the cystotome was used. The lens was expressed by pressure applied by means of the finger through the lower lid, the edge of the lid being used in much the same manner as a cataract spoon. The iris almost invariably required reposition after the lens had been removed, when the operation had been done without iridectomy. One or two drops of eserine solution (1 per cent.) sterilised were instilled after reposition of the iris and of the conjunctival flap. This was done only in operations without iridectomy. Both eyes were covered by soft dry wool pads; no head bandage was used, but a Snellen's aluminium shield was placed over the operated eye. If any difficulty was experienced in removing the lens, or of the vitreous presenting before it was removed, a small pair of forceps with curved arms terminating in each in a small hook was used as a vectis; the forceps were passed behind the lens, closed, then opened and drawn forwards, the two hooks being thus driven into the lens, and holding it securely while it was drawn out of the wound. In some cases the vectis (Weber's) was used in place of the hooked forceps. In some four or five extractions a couple of very fine silk sutures were used after the operation was completed, with the object of bringing about union of the conjunctival flap more rapidly, and of lessening the amount of astigmatism after the operation. The results, however, were not considered sufficiently satisfactory to warrant a continuance of the practice. The small electric lamp was used, invariably after the lens had been removed, to examine for any soft matter left behind; if any was seen Daviel's spoon was introduced, and an attempt made to remove it.

Discission.—Discission for high myopia was never done for a less degree than 15 or 16 dioptrics. The speculum was used in the majority of cases; a crucial incision was made through

the anterior lens capsule with a somewhat sickle-shaped cutting needle, cutting both in concavity or on convexity (Knapp). In one of the clinics discission in the above cases was always performed by means of a Graefe knife, held on the flat, that is to say, with the blade parallel to the plane of the iris. The knife was introduced into the anterior chamber, and a single vertical incision made through the whole length of the anterior capsule of the lens if possible. It was held by the supporters of this method that the wound so made in the cornea healed better, and left a slighter scar than that left by the needle.

Discission of secondary cataract was frequently done *per scleram*, but also *per corneam*, with one needle and with two. The operation *per scleram* was performed well behind the ciliary region with a single needle, and gave very good results in cases of obstinate thickened capsules. In no case did any severe reaction follow the operation. In some cases of very much thickened capsule, an incision to remove this was made with a keratome as for iridectomy in the margin of the cornea, the capsule seized with a pair of capsule forceps, as used in extraction, and torn out perhaps with the help of a cystotome. In cases of occluded pupil, the operation with a Graefe's cataract knife as described below—iridotomy—was sometimes performed.

Punction and Linear Extraction.—Punction for removal of swollen-up partially absorbed lens matter, following a previous discission, was done usually on the third or fourth day, when the tension had become slightly raised. A very small incision was made usually at the lower and outer margin of the cornea, with a narrow keratome. Much of the lens matter came out at once with the aqueous, which was let out as gently and as slowly as possible. A Daviel's spoon was then placed in the wound and pressure gently applied backwards, more lens substance escaping. After a short pause, during which the anterior chamber was reforming, the spoon was again introduced and more of the lens matter expressed. If necessary a second spoon was used to express the lens from above down towards the wound. The vitreous not infrequently filled the anterior chamber before all the lens matter had been removed. By this operation the period of absorption of the broken up lens is, it is contended, very much diminished, the risk of acute increase of tension in the eyeball done away with, and very little, if any, corneal astigmatism results.

Syringing Out the Anterior Chamber.—This operation was performed in only one case, in which suppuration had taken place in the anterior chamber following on a cataract extraction. The wound was reopened, and the bent and flattened nozzle of a syringe made for the purpose introduced into the anterior chamber, which was then thoroughly syringed out with a sterilised solution of boracic acid 1 in 500. This, though performed two or three times, had very little, if any, effect in checking the course of suppuration.

Iridectomy.—This operation was performed either with a Graefe knife or a keratome. The incision with the latter was always begun in the sclera. The iris was drawn into the wound with small iris forceps, and cut off by means of De Wecker's forceps scissors. In two cases following an iridectomy performed in cases of glaucoma, intraocular hæmorrhage took place, the lens, vitreous, and entire contents of the eyeball being gradually extruded through the wound, in spite of considerable pressure applied by means of pads and in a head bandage. The patient suffered great pain at the time.

Transfixion for Iris Bombé.—This operation was performed with a broad Graefe knife held on the flat, that is, parallel with the plane of the iris (normal), and introduced from the outer side in the cornea. Two incisions were made through the iris on both sides of the pupil, four small holes in all being made. Care was taken not to injure the lens or lens capsule while the point of the knife was passing in front of the pupil.

Operation for Synechiæ.—This operation was performed with a view to loosening adhesions between the iris and the back of cornea. Lang's synechiæ knives were always used. In two cases in which extensive and very firm adhesions were present, most excellent results followed, the iris after the operation being quite unhindered in its movements, and the pupil later on becoming very nearly normal in shape.

Operation against Commencing Staphyloma with Incarcerated Iris.—This operation, which I have twice witnessed, consisted in the trephining of the cornea with the part of the iris involved, and the complete removal of the commencing staphylomatous part of the cornea, with the piece of iris. The loss of substance in the cornea was then filled up by a piece of healthy cornea of similar size trephined from another eye, which was about to be enucleated. In one case the piece of transplanted cornea, which retained its transparency to some extent, was slightly raised above the surrounding cornea. In both cases the iris was successfully freed, and the cornea given a much greater chance of retaining its shape and nutrition.

Operation for Prolapsed Iris after Injury; Ulcer.—The staphyloma resulting in these cases was carefully punctured by a conical sharp sound, the aqueous allowed to flow away as gradually as possible, the iris then freed all round its adhesions to the corneal wound, drawn out from the wound as far as possible, and cut off with De Wecker's iris scissors. As much of the iris as could be got hold of through the wound was then seized, drawn out, and cut off, until it was in every part completely out of danger of again becoming incarcerated.

Iridotomy.—This operation was always performed by means of a Graefe knife, somewhat narrow, held and introduced through the cornea with the blade at right angles to the corneal surface and with the cutting edge backwards, that is, towards the interior of the eyeball and iris. The point was entered through the cornea from below, and advanced in the anterior chamber till it had reached the opposite limit of the chamber. The handle was then brought upwards, thus depressing the point and blade, and the iris and occluded pupil cut through; the knife was then withdrawn perpendicularly, cutting the iris completely through immediately below the point of puncture. The very best results were thus obtained, and the reaction was slight. This was only done in cases in which the lens was absent; if any of the lens happened to be present, as in many complicated cases, an attempt was first made to extract it by means of an iridectomy and the usual operation, the pupil, if still occluded, was afterwards dealt with in the above manner. Capsulotomy after this method was done also in cases of adherent, thick, secondary cataract.

Optico-ciliary Neurotomy.—The rectus internus was divided and sutured, and the optic and ciliary nerves cut through with a pair of strong, curved, blunt-pointed scissors. The eyeball was meanwhile rotated outwards as much as possible. The internus muscle was then sutured to its tendon, unless it happened that the bleeding was very great, with great protrusion of the eyeball. The bleeding and protrusion in most cases seemed to be considerable.

Enucleation.—This was always done after the Vienna method. No muscle hook was used, but simply two pairs of large straight scissors, with a small curve, one pair of forceps, a strong catgut suture, and a pair of Desmarre's lid elevators. The operation was done from the left always. In the case of the left eye the externus muscle was first cut through, and the eyeball held in the forceps by means of this muscle's attachment throughout the operation. The internus muscle last severed, the last after the optic nerve had been divided. With the right eye the internus was the first muscle divided, and the eyeball was held by means of its attachment, the externus muscle being the last cut through, after the optic nerve. A single thick catgut running suture was then placed in the conjunctiva, and just before it was drawn tight and tied, the cavities were well syringed out with corrosive sublimate solution (1 in 1,000). Iodoform powder was then dusted in, a dry dressing, and head bandage applied.

Mules's Operation.—This was very rarely performed, some three times during ten months. The artificial vitreous used was not spherical, but a flattened, four-cornered, silver-gilt spheroid, with the corners well rounded off. The cornea and sclera were cut away just behind the ciliary processes, and the scleral cavity scraped out with an ordinary Volkmann's scoop. The interior was well irrigated with corrosive sublimate (1 in 1,000), and the wound closed, after inserting the artificial vitreous, by a catgut suture passed through the conjunctiva and sclera at the same time. Dry dressings and a somewhat tight head bandage were applied. Simple evisceration of the globe, without the insertion of artificial vitreous, I never saw performed here during the ten months.

Tattooing for Leucoma.—This operation was performed in the ordinary manner in many cases, but in some the trephine was used to remove the epithelium and upper laminæ of the cornea. A somewhat large trephine, equal to the size of the pupil of the other eye when at rest, was chosen. The piece so marked out was then dissected off, taking as little of the corneal laminæ as possible, and placed on cotton-wool. A few drops of a solution of cocaine (5 per cent.) were then dropped into the wound in order to stop the bleeding. When this had ceased the indian ink was applied with a spatula, and well rubbed and scraped in by the point of a Graefe cataract knife, taking care that the edges of the trephine wound were not notched in so doing. The trephined piece of cornea was then replaced in the wound, but this procedure did not appear very satisfactory, as some bleeding invariably took place under the piece of replaced cornea, raising it up, and it very soon shrivelled and dropped off. The resulting appearance, even if this did take place, was very good indeed, the sharply-defined margin of the tattooed portion giving quite the appearance of a normal pupil.

Extirpation of the Lachrymal Sac.—This was an operation of every-day occurrence. A cocaine injection only was employed. An incision almost vertical in direction was made through the skin on the site of the sac, the wound then kept open by means of Müller's spring wound dilator, and the incision deepened until the internal tarsal ligament was reached. This was then cut through with scissors and the sac dissected free all round; the upper end was raised forwards from the bone with forceps and the sac well cleared of all its attachments, and in most cases of inflammatory adhesions. The lachrymal duct, or rather the mucous membrane lining it, was cut through as deeply as possible with scissors, the duct being put on the stretch meanwhile. The cavity thus left by removal of the sac was well scraped out with a Volkmann's small scoop, syringed out with sublimate lotion (1 in 1,000), iodoform dusted in, and the edges of the skin incision united by three or four silk sutures. Union by first intention was as a rule secured; but, if any of the sac had been left behind, this did not occur, and often rendered a second scraping necessary. This operation was done invariably when ulcus serpens was present. Bowman's sounds were used, but lachrymal styles never.

Removal of Lachrymal Gland.—This was performed in many cases after the above operation. The theory was that the lachrymal gland should not secrete more than could be removed by evaporation. If it did secrete more, then it was held to be abnormal and was removed. The operation was performed through the conjunctiva, the cavity being scraped out afterwards and the conjunctiva sutured by two or three catgut sutures.

Knapp's Roller Forceps Operation.—In trachoma cases in which the palpebral conjunctiva was very rich in trachoma granules, the upper lid was everted and cocaine was instilled, as well as injected in several places under the palpebral conjunctiva. The granules were then punctured with the point of a Graefe knife, the roller forceps applied, and the contents squeezed out.

Extraction of Steel and Iron Foreign Bodies.—When such were lodged in the interior of the eyeball, and known to be present, the patient was at once taken to the big electromagnet (Haab's), and the piece of metal drawn into the anterior chamber if possible, and then removed by a corneal incision, and the smaller point of Hirschberg's magnet. When it was not known for certain whether a piece of metal was present or not, the patient was taken to be tested by means of the sideroscope, which appeared to give only very doubtful results. With Haab's magnet the diagnosis was made absolutely certain, and in many cases the piece of metal could, when it was lodged behind the iris, be actually seen drawing it forward. If the piece of metal were lodged in the posterior chamber, it never came forward through the lens, unless there happened to be a hole in the posterior lens capsule, but always slipped round it, till it reached the suspensory ligament, which it tore through, with a sufficiently powerful magnet, and came up against the iris. From this position it was with a little manipulation readily brought forward, into the anterior chamber where it fell. Since this magnet has been in use, it has never failed to extract a splinter of iron or steel from the interior of the eyeball, no matter how deeply it had been imbedded.

Sclerotomy.—Both anterior and posterior sclerotomy were constantly performed. Posterior sclerotomy after Priestley Smith's method was invariably performed on glaucomatous globes, in which intraocular hæmorrhage might be expected to occur if an iridectomy were undertaken.

Plastic Operations.—Of the many and various plastic operations I will not attempt any description, as the number is far too great, due to the great amount of trachoma, the resulting scarring and deformities being relieved, or attempted, by all the various typical and atypical operations which suggest themselves. Thiersch's skin grafting is a very favourite method in the case of extensive burns.

Number of Operations.—Of the total number of operations of all kinds performed, some idea may be gathered from the fact that between November 1st, 1897, and July 9th, 1898, 1,499 operations were performed and written up in the operation books, 400 of which were cataract extractions. This number does not include such operations as scraping hordeola, Meibomian cysts, etc.

In conclusion, I will only say that I am greatly indebted to Professor Fuchs for his kindness in having given me a post and duty in the operation theatre, whereby I have been enabled to make the above notes, and also to his assistants for the many opportunities I was given of operating myself.

CLINICAL REPORT OF THE ROTUNDA LYING-IN HOSPITAL.[1]

DR. PUREFOY, the Master of the Rotunda Hospital, has laid the profession under a debt by publishing a clinical report on the work of the Rotunda Hospital for the year ending October 31st, 1897. It is a statistical account of the cases treated in the hospital during the year, with details of the cases of especial interest. Seventeen pages are devoted to the obstetrical part, forty-four to the gynæcological. The obstetrical account gives not only the mortality but also the morbidity; that is, an account of the number of cases of fever, little or much, from all causes, during the year. Such statistics ought to be published by every lying-in hospital. The fact that puerperal fever can be suppressed in lying-in hospitals is now so well established that there is no need to publish reports in further proof. The prevalence of puerperal fever in a lying-in hospital now only proves incompetent management. The true comparative test of good management now is the amount of fever following delivery. Some febrile illness is preventable, some apparently fortuitous. Statistics are needed to help us to distinguish between these two kinds of fever. We hope that in this point other lying-in hospitals will follow the example of the Rotunda, for it is a shame that English accoucheurs should have to look to Germany for information on such points as this.

In the gynæcological report we are struck by the number of cases treated for conditions which are by many regarded as either not disease, or disease too trivial for treatment. Thus we find 39 cases admitted into hospital, and treated for what is termed "pathological anteflexion." Now statistics have been published which show that anteflexion occurs just as often in healthy women as in those who apply for treatment; and there are writers and teachers of high repute who say there is no such thing as a "pathological anteflexion;" that no specimen has ever been exhibited or described showing any morbid effect resulting from anteflexion, and that an ill-effect from anteflexion has not in any other way been demonstrated. We find also 32 cases admitted for "laceration of the cervix." This is, of course, in a sense a morbid condition, being a result of injury, but it is present in nearly all women who have had children, and is by many regarded as such a trifle, that its repair is not worth the cost and trouble of operative treatment. Dr. Purefoy is quite competent to form an opinion on these points, and quite justified in holding it; but we submit that one who practises and preaches the systematic local treatment of such common conditions, so

[1] *Clinical Report of the Rotunda Hospital* for one year, November 1st, 1896, to October 31st, 1897, by R. Dancer Purefoy, M.D., Master; T. Henry Wilson, Henry Jellett, R. P. R. Lyle, Assistant Masters. Dublin: Fannin and Co. 1897. Demy 8vo, pp. 52. 1s.