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On Diseases and Injuries of the Eye: A Course of Systematic and Clinical Lectures to Students and Medical Practitioners. By J. R. Wolfe, M.D., F.R.C.S.E., Senior Surgeon to the Glasgow Ophthalmic Institution, &c. With Ten Coloured Plates and 157 Wood Engravings. London: J. & A. Churchill. 1882.*

The medical students and general practitioners of this country have certainly no reason to complain of any want of a manual on diseases of the eye adapted to their requirements. Several such works are already in the field, some of them of high merit. We can readily excuse Dr. Wolfe, therefore, for choosing a title that already figures on the back of one of the best known of these. It must be difficult to show originality.

The work now before us consists, as we are informed in the preface, of a résumé of courses of lectures, “so arranged as to form a complete practical treatise on diseases and injuries of the eye, . . . . in which every effort has been made to embody the latest investigations.” The aim is a high one, and our expectations are proportionately roused.

The author adopts the excellent plan of giving a short account of the normal anatomy and physiology of the structures before considering their pathological conditions. It may be doubted, however, whether the comparative anatomy of the eye has naturally a place in a work such as the present, when information has necessarily to be condensed as much as possible. But such facts, if they are to be given, ought to be given correctly, so as to be in accordance with “the latest investigations.” Thus we are told that in the visual organ of the echinodermata “nothing is found but a nervous cord and a pigment spot.” Yet, as long ago as 1876, Lange demonstrated that there is a distinct differentiated cell in connection with each nerve fibril in the eye of the asteridea. We are surprised to learn that the tubelaria (?tubularia) range in search of their food; did they do so they might possibly require the eye spots, “scattered about the head,” provided for them by Dr. Wolfe. Perhaps the turbellaria are meant. Did

* The Editor considers it right to state that this work was placed by him in the hands of a perfectly independent Reviewer, who is far removed from Glasgow and its concerns. Having done so, he has felt compelled to accept the notice as written, however he may regret the unfavourable nature of it.

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we wish to be captious, we might also find fault with the spelling of dorsibrachiata and arachnidce.

Köllicher's account of the anatomy of the human retina was no doubt an excellent one in its time, but our knowledge has advanced considerably since then. Yet Dr. Wolfe makes no mention of the external limiting membrane nor of the fibres of Müller, while he describes the pigment-epithelium of the retina as belonging to the choroid. "These peculiarly shaped pigment cells," he says, "behave very curiously. They seem to be migratory cells."* This observation is entirely original, though Kühne has described a migration of the pigment granules contained in these cells during exposure to light.

The effect of light on erythropseine or retinal purple constitutes, according to Dr. Wolfe, "the essence of perception of light and colour," and he eloquently describes how memory brings forth, when required, the "chromo-photographs" so produced. But how can our author reconcile this view with the well known fact that the retinal purple is only found in the outer segments of the rods, and is entirely absent from that part of the retina which has to do with central vision?

That accommodation is dependent on a compression of the rim of the lens by the circular part of the ciliary muscle is, we venture to think, not the view generally held and taught in this country.

The conjunctiva "consists of a dense layer of connective tissue, . . . with stratified epithelium, consisting of slightly nucleated cells on its surface." The conjunctiva oculi, again, is described as white. This is hardly correct. The secretory (sic) ducts of the lachrymal gland "penetrate the conjunctiva between the outer part of the upper eyelid and the ball." Where? The tears "are partly evaporated and partly sucked up by the upper and lower canaliculi, to be conveyed away into the posterior nares by the lachrymal ducts." Oh, ye tears!

The crystalline lens is described as a "circular transparent body," which is "placed behind the iris, in front of the vitreous body, to which it adheres by its posterior surface."

In his account of the vitreous body, Dr. Wolfe alludes to observations which, he thinks, tend to prove that this structure secretes the fluid of the aqueous chamber. Yet, why the generally received view, that the cells lining the inner surface of the ciliary regions are mainly instrumental in furnishing this secretion, should not satisfy the observers, it is difficult to understand. It will require not only many observations,

* The italics here and in other quotations will be understood to be ours.
but a decided change in the first principles of modern physiology before we can be induced to regard the vitreous as “a secreting organ.”

The account of the general anatomy of the orbit is excellent, but it is a pity that immediately afterwards we are told that, in paralysis of the third nerve, the eyeball is “entirely under the control of the external rectus and inferior oblique.” This is doubtless a mere oversight, but it constitutes a serious blemish in a work meant for students.

We cannot agree with the author when, in speaking of the examination of children, he says that hereditary syphilis may be an inheritance from parents or grandparents!

Dr. Wolfe uses atropine in conjunctivitis, even when there is no corneal mischief, because, he says, it has “an antiphlogistic effect on the inflamed surface,” and, by dilating the pupil, relieves tension. Has atropine been proved to have this antiphlogistic effect? We know that sometimes it increases tension, while also dilating the pupil. Lastly, does the tension in conjunctivitis require relief? In most other respects the treatment described corresponds with that generally adopted.

In gonorrhceal ophthalmia he recommends warm fomentations, and the application of a weak solution of lunar caustic to the everted eyelids, which is then washed off with solution of common salt. Commonly this affection is treated with cold applications, frequent cleansing, and strong nitrate of silver solutions, which are then washed off, but not necessarily neutralised. He adds, “I need hardly remind you that the prognosis is more serious when the urethral discharge is complicated with chancre.” Is, then, urethritis itself more severe when so complicated? He does, indeed, well to remind us.

The leech has a zoological interest for Dr. Wolfe. But, alas! this is all; “I could never see its applicability to eye affections.” Yet leeching is almost universally considered the most valuable means at our disposal for relieving the pain of acute iritis.

In catarrhal conjunctivitis, we are told, the temperature is not increased. Nettleship’s clinical investigations on this subject show most definitely that it is increased. Speaking of the discharge in this affection, our author defines mucus as “albumen mixed with imperfectly formed epithelial cells.” Catarrhal discharge, too, is “considered not contagious;” we were not aware of the fact.

The treatment recommended in granular conjunctivitis seems rather mild, but the results described are most satisfactory; it would be well, however, to mention when they may
be expected. Dr. Wolfe has "never seen any satisfactory result accruing from the use of argentum (sic) nitras or any other caustic." He has seen "patients rubbed with bluestone for eight or ten years until no trace of transparent cornea was left." It is almost a question whether it was not his duty to have stepped in and interfered in the interests of humanity!

Speaking of corneitis—which, by the way, may be caused by carious teeth!—Dr. Wolfe explains photophobia. The impression conveyed to the brain by the optic nerve is reflected through the oculo-motor nerve to the iris, and the pupil contracts. "At every contraction there is a dragging sensation communicated to the branches of the same nerve which supply the cornea, and hence there is a shrinking from light."

The most frequent causes of parenchymatous or interstitial corneitis are said to be "debility, bad nourishment, and scrofulous cachexia;" another cause is "uterine irritation." We are glad that he acknowledges the syphilitic taint occasionally, but it is not always marked by notched teeth, as he would lead us to suppose.

In keratoconus he says the cone is "situated generally in the centre of the cornea," the fact being that it is almost universally a little below this point.

We can find no mention of the comparatively common affection of the cornea called keratitis punctata. It is barely alluded to, but not described, under the head of serous iritis. The author observes that he has never seen a case of keratoglobus other than congenital, yet on the next page he gives a case of this affection that contradicts his statement.

His operation of corneal transplantation is described at great length. The results do not seem satisfactory.

In regard to the general symptoms of iritis, we learn that "when there is violent pain at the back of the head it shows the presence of irido-choroiditis." The term "condyloma" of the iris is a bad one, and should be discontinued. Under the heading "Functional Derangement of the Iris," Dr. Wolfe tells us that "dilatation of the pupil is caused by concussion of the brain;" this, without further explanation, is misleading. Idiopathic mydriasis may be "so complete that the iris is concealed behind the limbus conjunctivalis." The only explanation of such an extraordinary observation lies in the fact that no description whatever is given of irideremia. Comment is needless.

Immobility of the pupil to light is synonymous with
"abolition of tactile sensibility." "The operation for artificial pupil, if properly done, may even be practised on out-door patients." Very good practice too, we should think—for the surgeon. Before performing this operation in cases of occlusion from syphilitic iritis, "you should wait for more than a year, during which time mercury, alternated with potassium iodide, should be regularly administered, and you should make sure that no trace of the virus remains in the system." During all this period, too, there must not be a trace of eye inflammation—not even hyperemia of the conjunctiva. Does our author ever operate in these cases? He considers De Wecker's operation of iridotomy hazardous, but he does not seem to be aware that it was devised for, and is employed in quite another class of cases—viz., in so-called secondary cataract; when the pupil is drawn towards the cicatrix and occluded.

We can hardly agree with his account of sympathetic ophthalmia when he says that "generally very little pain or photophobia accompanies the affection, and the injured eye is blind before the disease is reflected to the other."

Lamellar or zonular cataract is said, at p. 132, to occur in children: at p. 166 we read, "This form of cataract is generally met with among adult persons." If all surgeons followed Dr. Wolfe's plan of treatment, the latter account might be approximately correct: he says, "the only operation applicable to it is the formation of a new pupil." The fact is, it is distinctly a cataract of early childhood, and on this account was called by Bowman infantile cataract: by many it is even considered to be congenital. It "generally occurs in both eyes at the same time, and remains absolutely stationary." In our experience it always occurs in both eyes, and frequently progresses slowly but steadily.

In pyramidal cataract "the central portion of the opaque lens is elevated like a pyramid, which is situated within the capsule." What a very curious condition it must be!

In describing the flap extraction he says, "the anterior hemisphere of the capsule is to be lacerated." Now, firstly, why not say "anterior capsule," as every one else does; and, secondly, why call that a hemisphere which is no hemisphere at all? The author's method of cataract extraction combines, the author thinks, "the advantages of all recent improvements without their risks." Is iridectomy downwards one of these improvements? The two main features of the operation are that he always does a preliminary iridectomy, and that a bridge of cornea is left undivided until after laceration of the.
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capsule. He orders "distance glasses about a month after extraction." This we think is decidedly too early.

Secondary cataract, in Dr. Wolfe's practice, forms in front of the pupil. This peculiar position may account for the startling direction which follows, that the membrane is to be "torn across in several places without the needle disturbing the vitreous"!

At p. 165 our author enunciates a new theory: "the lens itself may take on inflammation, and propagate it to the other structures." A few pages farther on we are told that, in as far as the lens has neither nerves nor blood-vessels, it cannot be subject to the inflammation which characterises other tissues. But Dr. Wolfe is equal to the occasion; "it is subject to a kind of vegetable inflammation, so well described by Sir James Paget." We must not conclude, of course, that Sir James Paget ever described such an inflammation in the lens;* our author only found the analogy useful in support of his theory. A case is recorded to show that violent inflammation may be set up by a foreign body in the lens, when the injury does not involve any other structure. In this case (p. 170) the lens was extracted, and some weeks later the eyeball enucleated on account of sympathetic ophthalmia in the other eye. The foreign body was then found lying in the ciliary region. Is this really a case—the only case—in support of the theory? It is well known, however, that after injury (such as needling) the lens swells up within its capsule, and may give rise to glaucomatous symptoms or to iritis. But is it good pathology to call such a swelling of lens inflammation? And does it not give rise to secondary symptoms merely by pressure upon neighbouring structures and interference with their nutrition?

The chapter on Refraction is one of the best in the book. But how can a burning taper be "placed in the centre of a spherical surface"? It is hardly correct to say that, according to the undulatory theory, light resembles sound, except

* At least we can find no such statement in the address to Brit. Med. Assoc., referred to by Dr. Wolfe. In Paget's Surg. Path., 1870, p. 336, we read "that injuries of parts that have no vessels or nerves are followed by altered modes of nutrition, which are more or less exact resemblances of inflammation. Thus, e. g., it is in the lens, vitreous humour, and the like after injury." And, though with some fear of straining an analogy too far, I believe that we may gather illustrations of the same principle from the formation of gall-nuts. May not the starting point of the changes occurring in the lens, after injury, be the action of the aqueous humour (containing chloride of sodium) on the globulin of the lens? We offer this as a suggestion.
that the waves of light are shorter and their velocity greater. Speaking of refraction through a concave lens, he tells us that rays "entering the lens in lines diverging from a principal focus will emerge from it parallel to the axis." This cannot be the case, and judging from the context it is no mere slip of the pen.

In hypermetropia, Dr. Wolfe paralyses the accommodation with atropine, and then gives the strongest glasses with which the patient can see distinctly. It is usual to reduce this amount by 0.75 D in ordering glasses.

We have never seen cyclitis caused by tension of the accommodation.

He recommends myopes not to use their concave glasses for near work. This is not good treatment in high degrees of myopia, nor indeed in low degrees in young subjects.

His method of determining the amount of astigmatism is simply unintelligible. After having found the best spherical lens for distant vision, and having determined the meridians of greatest and least curvature, he continues:—"Then we place in the graduated frame ... the cylindrical lens corresponding to the spherical one we have selected, so that the line making its horizontal meridian is at the zero of the scale, and then move the lens round in the frame, until all the lines of Snellen’s fan appear equally distinct. We can then read off on the graduated circular frame the positions of maximum and minimum curvature."

The advantage of having discs with convex and concave lenses fitted to the ophthalmoscope is that it "can be used as an optometer for trial lenses." Their real advantage is that they enable us to obtain a clearly defined erect image of the fundus in an ametropic eye; by their use, also, we can estimate the ametropia present. But, according to Dr. Wolfe, "the examination by this method does not yield a distinct and well defined image, since it is too large in proportion to the pupil, even at its maximum dilatation." If he will only bring his mirror closer to the patient’s eye, however, our author will have every reason (after a little practice) to be satisfied both with the extent and definition of the field. "Two inches or less" is rather an indefinite examining distance; certainly anything beyond one inch is too great an interval. Again, it

* The ophthalmoscope, which is made for Dr. Wolfe, by Crétès, in Paris, does not apparently differ much from De Wecker’s older instrument. We are told in a footnote (p. 221) that it is sold by Weiss & Son, London. On inquiry, we find that they have never had one in their possession, and have no recollection of ever having heard of the instrument.
is by no means "an essential condition for examination of the erect image that the accommodation of the eye, both of the examiner and of the patient, should be completely relaxed." Our disc of lenses enables us to neutralise any effect of accommodation that may be present.

After telling us of the occasional advantages of "clear sunlight" for focal illumination, he warns us against its use when the cornea is transparent or the deep structures diseased, "as it might cause some retinal mischief." He does not of course mean direct sunlight. Indirect sunlight, as the reflection from a cloud, is most useful and not more dangerous than artificial light: the reason we employ it so seldom is, that it is rarely obtainable in town practice.

Dr. Wolfe prefers the inverted image of the fundus. To direct the patient to look at your right ear, however, if his right eye be under examination, will not be successful in bringing the optic disc into view: the tip of the outstretched little finger of the right hand is a better fixation point.

It is wrong to describe the centre of the macula as "very prominent;" "conspicuous" is doubtless the word intended. We find no mention of keratoscopy.

Paralysis of accommodation is surely rather a post-diphtheritic affection than one occurring "in diphtheritis of the fauces." The assertion that "both eyes are very rarely affected" must be new to most observers: it is usually described as a distinctly bilateral affection.

Cholesterin is said to occur in the vitreous in the form of "fine white globules, sparkling like mercury."

In acute inflammatory glaucoma, Dr. Wolfe tells us that on ophthalmoscopic examination, the optic nerve presents a cup-shaped excavation. Now, this cupping of the disc is characteristic of long continued tension, not of the acute condition. Again, even were the disc cupped in the acute stage, we should be unable to see it on account of the cloudiness of the media. Our author believes that the efficacy of iridectomy in glaucoma is due to neurotomy, "for Nélaton obtained satisfactory results in tic douloureux by removing a part of the diseased nerve." Were we told that cutting through the sensory nerves of the eyeball relieved the pain of acute glaucoma, we should certainly give neurotomy the credit of the relief, and Nélaton's success would afford a good parallel. We think that such an argument, however, may be pushed too far. That cystoid union of the sclerotic wound relieves intra-ocular tension is believed by many. Dr. Wolfe thinks it cannot do so, since "a cicatrix, instead of becoming more pliable, is, on the con-
trary, harder than the natural tissues.” This depends upon the tissue and upon the circumstances. A cicatrix formed under increased intra-ocular pressure, in a fibrous structure so dense as is the sclerotic, may be both thinner and more readily permeable by fluids than the sclerotic itself. Our author is not an advocate for sclerotomy, but it is rather a sweeping statement to make that “no operation can be worth much that requires the help of drugs.” This is because De Wecker recommends the use of eserine in such cases.

In his description of the operation of iridectomy downwards, the patient is ordered to look downwards. There is no mention made of the use of eserine in glaucoma.

It is surely tautology to tell us, in reference to a case under treatment, “blindness of the right eye was complete. Luminous perception was abolished.” Indeed, in as far as the patient ultimately did well, the use of the word “abolished” here (p. 290), and in other similar cases, is open to question. Another case in which “vision was entirely abolished” recovered wonderfully after puncture of the sclerotic in one eye. “The remarkable feature was that the result was even more perfect” in the other eye! “This suggests the question—Did the effusion of this eye disappear spontaneously, or in consequence of the fluid being withdrawn from the other?” There is, we think, another question suggested—Did the vision return in either eye in consequence of the fluid being withdrawn, or spontaneously?

“Anæsthesia of the retina is a very marked feature in progressive retinal atrophy. This is manifest in various ways, according to the change it produces in a single optic band upon the middle part of the commissure, or upon a nervous cord in front of the commissure.” What does this mean?

In describing nasal hemiopia, reference is made to a diagram illustrating Charcot’s views (p. 297). The result of the lesion indicated will not have the effect described according to the diagram given—viz., that each eye, in fixing the arrow ab, will only see the part cb.

Dr. Wolfe is “inclined to regard retinitis pigmentosa as merely an exaggerated form of disseminated choroiditis.” . . . “This view is the more reasonable when we consider the causation. In both cases the cause seems to be too close intermarriage. In the case represented in Chromo. Plate ix, fig. 1, there was hemeralopia. Patient was the issue of first cousins.” We believe that no one but the author himself thinks that too close intermarriage is a cause of choroiditis disseminata. The chromo-lithograph referred to, which is described
as a case of choroiditis disseminata, is really a bad representa-
tion of retinitis pigmentosa. It is not the least like choroid-
itis disseminata. Is it possible that this mistake led our
author astray? We again read that the hexagonal pigment
cells "behave very curiously," and that "they seem to be
migratory cells." Once more, too, we are told that the retinal
pigment belongs to the choroid. A little more, perhaps, and
we might be induced to believe it. The deposition of pigment
in this form of retinitis generally takes place first at the
equator in our experience, not in the periphery, and it is
commonly associated with low, not with "strong" myopia.

Among the causes of amblyopia are mentioned constipation
and coldness of the feet. It is a wonder that it is not more
common! There is no mention made of the central colour-
scotoma in tobacco amblyopia, although it is one of the, most
important diagnostic features in this affection. "According to
Hutchinson, amaurosis may also occur in connection with
carious teeth, even when the teeth are not painful." We
cannot find this fact noted in that able observer's paper on
affections of the teeth as affecting the nutrition of the eyeball.

Can a glioma become a glio-sarcoma in consequence of delay
in operating?

Dr. Wolfe does not consider Holmgren's test for colour-
blindness reliable. But he might describe more accurately
how it ought to be applied. His knowledge of physics seems
rather to be at fault when he tells us that the wave of medium
length corresponds with the green of the solar spectrum: it
really belongs distinctly to the yellow.

The account given of the application of the perimeter is
good. It is not absolutely correct, however, to say that in
retinitis pigmentosa peripheric vision is first lost. There is
really first of all an annular scotoma corresponding to the
equatorial deposition of pigment.

Speaking of one-sided partial paralysis of the third nerve,
he says truly that, when the cornea is turned upwards, the
false image appears below the real; but it is quite incorrect to
add that, "when the cornea is turned downwards, the false
image appears on a lower level." "The use of prismatic
spectacles is particularly valuable in cases of paralysis of the
fourth nerve"; he does not tell us why, and when they are to
be used. He rightly advises prisms of equal strength before
both eyes, instead of one before the deviating eye alone; but
he ought to explain that each of these former ones should be
of one half the strength of the single correcting prism.

His account of the operation for advancing the internal rectus
is most unsatisfactory. We are told nearly everything except the manner in which the tendon is to be advanced and secured. Among the symptoms of orbital cellulitis, no mention is made of the immobility of the eyeball. In periostitis or necrosis of any part of the orbital wall, we must find out whether the patient is healthy, or serofulous, or syphilitic. "In the latter case the part must not be touched with an instrument." Why not?

Our author quite surpasses himself in his account of parasites on the lashes. "The ova of these usually give the lashes a *singed appearance*" (sic). "Put the crusts under the microscope and you will find them alive, though in different degrees of development." And then follows a hint for Pasteur; "they are the result of the disease of the lashes," and he thus accounts for their occurrence "among cleanly and well dressed persons." What is "tick of the face" with which, we are told, blepharospasm may be associated?

Dr. Wolfe does not seem to know what *epicanthus* is. He describes it as "an enlargement of the semilunar fold. . . . It may be temporary, and caused by erysipelas, purulent ophthalmia, &c. If congenital, a fold of the *enlarged conjunctiva* should be removed." This is nonsense. A good account is given of the operations for entropion and ectropion. Among the former, however, we should have liked to have seen a notice of Burow's excellent method. The credit of the operation for ectropion, described here as "the author's method," is due, according to a recent paper by Abadie, to Le Fort.

Throughout the volume the misprints and errors in spelling are very numerous. We find, e. g., *pinguicula, installation* (of atropine), *synchesis, emulation* (for enucleation), *iridemia, concaved, angioleucite* (for angeioleucitis), *steotoma, calosity,phemosis, dacro-cystitis, dacrolythes, douch, porte-caustic,* and a host of others. Again, a minute is defined as the sixteenth part of a degree; a *concave* lens is used for focal illumination instead of a convex; *divergent* squint is said to be induced by hypermetropia, when convergent is evidently meant; and so on. The following authorities are, we believe, new to medical literature:—Abadi, Makenzie, Wardsworth, Grenhaggen, Forster, Basdow, and Traumer. The author's style is generally clear and his terms well chosen. We must, however, take exception to such expressions as *ichory* and *exteriorate*. The following have too foreign a look about them to please us in an English work:—*Phlyctena, buphthalmia, sympathia, hematopia*. Sympathetic inflammation does not "set up" through a foreign body; it
may be set up by such an accident to the other eye. It is hardly right to say that the tout ensemble of the symptoms of glaucoma tends to blindness. The "study of the field of vision..." materially fills up the lacunæ left by the ophthalmoscope;" "gaps" is a shorter word, and would be more elegant. Why were the parents mentioned at p. 307 "recommended to lay aside all delicacy and put the child under my care?" Surely this is a peculiar expression.

The author's Latin is execrable: e.g., antrum maxillaris, ungentum flava, rectus inferioris, corpus quadrigeminus, and his prescriptions generally. It is unusual, too, to mix up bad (or even good) Latin and English in the same sentence, as our author is so fond of doing: e.g., "constitutinal treatment is most to be relied on—iod. potassium, syrup, iod. ferri, and pil. hydr. c. quinine;" "a plate of glass rendered sensitive to the rays of light by being covered with argenti nitras and gelatine;" "the infusion of anthemidis nobilis or collyrium sulphatis zinci is sufficient;" "a pencil dipped in solution argent. nitrat. grs. v to 3i;" "after the administration of pil. hyd. c. colocynthidis, order ol. terebinth, . . . in syrupi aurantii . . . . Then order pil. hyd. c. quinæ."

"The chromo-lithographic illustrations," to quote from the preface, "have been painted for this work by my excellent and esteemed friend, Dr. Hugo Magnus." There are twenty chromo-lithographs here in all, and we find eleven of them in Magnus's Atlas, published several years ago! Two of these are here represented upside down (pl. iii, fig. 4, and pl. vii, fig. 1) and are consequently rather difficult to recognise at first. Another (pl. x, fig. 2) appeared in a monograph by Magnus, making in all twelve that have been already published. Of the remaining eight, two (pl. ii, fig. 2, and pl. iii, fig. 2) appear in Jæger's Atlas, and are here reproduced without any acknowledgment. The remaining six possibly appear now for the first time: one of them (pl. ix, fig. 1) looks original.

We at once recognise many of the woodcuts as old friends: the source of some of them is acknowledged. Others are quite new to us. Figures 15 and 31 are two of the worst and most misleading we have seen for a long time; the latter is said to be from a case of keratoglobus, but instead of the anterior chamber being deep, it is absent altogether, and the iris is evidently lying against the cornea. Part of fig. 153 is wanting. We would draw special attention to fig. 61, representing a minute foreign body; the only possible end served by such a thing is, we suppose, to add one to the total number of woodcuts.
The publishers have done their work particularly well, and to them the volume is really most creditable: to Dr. Wolfe it may, or it may not, be a credit; to British ophthalmology it is certainly none.

Diseases of Women. By Arthur W. Edis, M.D., F.R.C.P., M.R.C.S. Smith, Elder & Co. London, 1881. Pp. 541.

This book opens with an introductory chapter on what is to be observed and done generally in the examination of a woman presenting herself for treatment. In regard to the somewhat difficult question as to what symptoms render a vaginal examination necessary, very sensible remarks are made. Where amenorrhœa is the chief point in the case, no examination is requisite unless a distinct molimen is present. On the other hand, where menorrhagia persists, and is not influenced by ordinary remedies, but produces marked anaemia, debility, and impairment of the general health, an examination should always be resorted to even whilst the hæmorrhage continues, more especially if the loss be excessive, for a polypus, fibroid tumour, or cancer may be present.

In cases of dysmenorrhœa the question of resorting to examination is often a very perplexing one. After the usual recognised means have been tried, on the supposition of its being neuralgic or congestive, and where the discomfort is so great as to unfit the patient for her ordinary duties, or her general health suffers materially from the frequently recurring paroxysm of pain, an examination with the view of detecting any flexion or obstruction is clearly indicated, and should be resorted to.

In cases of leucorrhœa in single women, it is well to try first what influence iron and aloes, with some astringent injection, or sea-bathing, will produce; but should the general health suffer, more especially where there is any phthisical history, and the discharge continues excessive, spite of all our remedies, an examination should be made.

Where patients complain of bearing down, dragging pain in the hips and loins, pressure upon the bladder, causing retention of urine or frequency of micturition, and there is no habitual constipation to explain the symptoms, or these persist after the former has been remedied, an examination had better be instituted. (P. 5.)

The chapter on physical diagnosis is very good. It is short, and yet both comprehensive and precise, and contains all that a student ought to know.