4. The want of adaptability of the patient to his surroundings.
5. Overcrowding in ill-constructed and ill-planned houses.
6. Second-rate food and wine.
7. The want of reliable English doctors.

These deficiencies it is the province of this Society to lessen and remove. Already your excellent *Journal* is disseminating a large amount of useful knowledge, and I have no doubt that the real wants of our expatriated invalids will be adequately provided if they should receive distinct utterance at the hands of a powerful Society like this.

A NOTE

ON

A METHOD OF OPERATING FOR ECTROPION OF THE LOWER EYELID.

By D. ARGYLL ROBERTSON, M.D., LL.D., F.R.C.S. Ed.,
Surgeon-Oculist to Her Majesty the Queen in Scotland; and Consulting
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THE operative procedures for the cure of ectropion of the lower lid that have been employed or recommended by various surgeons are so numerous that the following method of operating which I have recently adopted may have little claim to originality; at the same time as I am unaware of any surgeon having employed exactly the same procedure, and as the results obtained have been eminently satisfactory, I have deemed it advisable to report the method for the consideration of my professional brethren.

The operation consists in making an incision through the skin of the outer third of the lower lid, parallel to and about a line (2 mm.) distant from its margin. When the incision has been carried as far as the outer canthus the knife is directed a little more upwards, and the incision continued for about half an inch. It is then carried horizontally outwards for about 3 lines (6 mm.) and lastly downwards and inwards, nearly parallel to the upward incision, but diverging a little from it below, for the distance of about an inch and a quarter. Fig. 1 indicates the course of the incision.

Fig. 1.

Fig. 2.

The flap of skin thus outlined is then dissected from subjacent parts, and reflected back as shown in Fig. 2.

Next a suitable V-shaped portion of the whole substance of the lower lid is removed at a little distance (say 3 mm.) from the outer canthus. The "strap" of skin which had been reflected is now drawn upwards and outwards till the edge of the lid is brought up to its natural position, and the skin which it then overlaps is outlined by bringing the knife along the edge of the strap, and the portion thus outlined dissected off. Lastly, the "strap" is replaced and fixed in position by several sutures, as seen in Fig. 3.

It is advisable not to remove a large V-shaped portion of the lid at first, as a little more can easily be snipped away if on drawing the lid into position by means of the "strap" a puckering of the edge of the lid indicates that too little has been removed.

This operation is particularly useful in senile ectropion or in eversion of the lid from long-continued palpebral conjunctivitis, when the free edge of the lid has by traction been elongated and the curvature of the tarsal cartilage altered, but

it may be advantageously employed in other forms of ectropion also.

The chief advantages I have found in this method of operating are: (1) that the exact amount of lid tissue that should be removed is easily ascertained; (2) that by means of the strap of skin very efficient and permanent traction on the lower lid is obtained, thus bringing it and fixing it in proper position.

Fig. 3.

Instead of removing the skin that lies under the strap when it is drawn up so as to bring the lid into position, a small portion of the extremity of the strap might be cut off and the effect would be similar. But I prefer the method described, giving, as it does, a larger surface on which to fix the strap.

I have only had the opportunity of performing this operation on three cases, but in all (and one was a very severe and complicated traumatic case) the result was excellent.

For the sketches illustrating the operation I am indebted to the kindness of Dr. Jessie MacGregor.

AN ADDRESS

ON

THE PATHOLOGY OF ANTENATAL LIFE.

Delivered before the Glasgow Obstetrical and Gynaecological Society.

By J. W. BALLANTYNE, M.D.,

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[ABSTRACT.]

AFTER a preliminary reference to the relation between antenatal and postnatal life, in which he pointed out that the postnatal was not independent of, but, on the contrary, largely the direct continuation and outcome of the antenatal life, Dr. Ballantyne described

THE PHYSIOLOGY OF ANTENATAL LIFE,

subdividing it into three periods:

1. *Germinal Life*, about which little was known in the human subject, the period which ended in the mysterious phenomena of germ and sperm maturation, of the expulsion of the polar globules from the ovum, of the atrophy of the female element of the sperm-cell, and of the impregnation of the ovum by the spermatozoon with the resulting formation of the morula mass.

2. *Embryonic Life*, the period beginning with the differentiation of the blastoderm and ending about the end of the second month, the period of evolution or development during which the lines of future growth were laid down.

3. *Fœtal Life*, the period in which the organism showed its vitality chiefly by growth along lines which had been already definitely laid down.

It was necessary to point out, however, that these periods could not be sharply marked off from one another. One part might be in the embryonic stage while the others were in the fœtal. The third month of intrauterine life more than any other was characterised by readjustment and by change, most of the organs passing at this time from the embryonic into the fœtal state.

ANTENATAL PATHOLOGY.

Postnatal and antenatal life were both subject to disease and death, and probably all estimates of the antenatal death-rate fell far below the reality. Dr. Ballantyne then referred