The important fact, which will have come as a surprise to some of those who watched the eclipse with more enthusiasm than discretion, is that the resulting lesions may be to some extent permanent.

Treatment.

Regarding prevention of eclipse blindness, it is only necessary to repeat that the force of the direct rays of the sun, even when its zenith-distance is comparatively great, is very apt to be underestimated.

Once the damage has been sustained rest is the chief essential, as in all other injuries. In recent cases confinement to bed in a darkened room, a shade over the eyes, or protective glasses should be ordered, according to the severity of the symptoms. Miotics may be helpful. Various authorities recommend tonics, especially strychnine, others advise potassium iodide. Faradism is also suggested during the later stages. If the eye is ametropic, the refraction should be corrected, and Crookes's lenses prescribed. Any systemic affection likely to lower ocular immunity should be met by appropriate treatment.

Conclusion.

I have one final observation to make in relation to the symptom I have named metachromatopsia: I define it as that state of vision which imparts to an object a colour contrasting with that which it excites in a normal eye. Its presence in the central part of the visual field, in cases of eclipse blindness, signifies disturbances of the normal reflexes connected with colour vision, resulting from harmful stimulation by strong light.

This is simply a working hypothesis, put forward with the justification that:

"It is easier to evolve truth from error than from confusion."
Lord Bacon.

ADDENDUM.

Professor Whiddington of Leeds University kindly furnishes the following report with regard to the optical properties of the sample of blue glass:

"I should hardly have thought that there was any great transmission of extreme ultra violet light through glass of this nature, but I will settle the point by getting a photograph showing the absorption spectrum in the visible and ultra violet regions. One would expect the red end of the spectrum to be cut off completely, and perhaps an absorption band in the yellow-green region, and then again complete darkness in the extreme ultra violet. Since the eye is more sensitive to visible light in the yellow-green than to any other, one might expect damage to be done to the eye perhaps if the sunlight of this colour were not sufficiently strongly absorbed."

REFERENCES.

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THE TREATMENT OF URETHRAL STRICTURE.

BY

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URETHRAL stricture is one of the most difficult of surgical conditions to treat, and this perhaps accounts for the fact that so little has been done to modernize its treatment. This is well shown by the extraordinary paucity of papers which have been written on this subject during the last ten years; moreover, most of the papers that have been written only repeat old views and theories and add nothing to our knowledge.

The accepted teaching seems to be that urethral strictures are best treated by instrumental dilatation; this method, as we are all well aware, has been most disappointing, and that for many reasons—firstly, the difficulty of the operation; secondly, the long convalescence; thirdly, the pain produced; and lastly, the great frequency of recurrences unless the patient returns weekly, monthly, or yearly for the passing of sounds. The next method to be adopted in cases of failure by dilatation due to the stricture being impermeable or intractable is that of external urethrotomy. The same tendency to relapse follows this operation. The third method is internal

urethrotomy, but of this many surgeons seem afraid because of the excessive bleeding and extravasation of urine which follows the operation, and we might add the tendency to recurrence.

The greatest advance in the treatment of urethral stricture was made by Otis, who taught that dilatation should not cease with the passage of a No. 12 sound, but should be continued up to No. 20 or 24 (English measurements). He clearly showed that the normal male urethra will allow the passage of sounds of this size, and that it was due to the insufficiency of the dilatation that strictures relapsed whatever had been the method of treatment adopted.

This new doctrine did wonders for the treatment of urethral strictures, but still two drawbacks remained: the first was the pain involved and the length of treatment required in the passing of sounds, and the second was the length of stay in bed, and, after external urethrotomy, the difficulty of keeping the patient dry.

The new methods which I advocate are, I believe, a step forward, and certainly curtail the length of treatment, avoid all unnecessary pain, and keep the patient dry and comfortable in bed.

Unless a stricture can be easily dilated with sounds, or unless it is impermeable or does not allow of the passage of a No. 1 (English) catheter or sound, I believe that the correct treatment is internal urethrotomy. If the case is one in which this operation is indicated the internal urethrotome is passed into the urethra after the usual antiseptic precautions have been taken, and gas and oxygen are administered; the knife is then uncovered and the instrument withdrawn, and a number of previously oiled sounds passed into the bladder until a No. 20 or 24 is passed. The best instrument is Lockwood's modification of a Civiale's urethrotome. This enables any stricture to be divided from behind forwards, provided a No. 1 (English) bougie can be passed. I have now performed twenty-five operations of this nature, and have not had a single recurrence. Most of the cases have been seen six months after the operation, and a large proportion two years after. The after-treatment is simple. A catheter No. 20 is tied in for two days. A sound is passed once weekly for two weeks and then monthly for two months, and then after a year's interval. There has been no excessive haemorrhage or extravasation of urine, no rise of temperature, except occasionally to 99° F. at night, and no death.

Should the case be one in which external urethrotomy must be performed, the method I advocate is the complete suture of the urethra and skin after the performance of the operation. Such a method has, as far as I know, never been suggested before, probably because of the fear of extravasation of urine. I do not pretend that all cases can be dealt with in this way; strictures extending over a large extent of the length of the urethra cannot be so treated, but all others not complicated by abscesses or sinuses can. Out of a series of thirty-one cases of external urethrotomy I have performed this operation in twenty-five; of the remaining six, four were operated on several years ago. As soon as the No. 20 catheter is passed into the bladder the edges of the urethra are brought into contact by a continuous catgut suture passed through the muscles and tissues of the bulb, but not through the urethral mucous membrane. All oozing from the bulb now stops. The skin is sutured, and a small drainage tube left in for twenty-four hours.

I have seen no rise in temperature other than to 99° F. in a few cases. I have had no extravasation of urine, and with the exception of two cases early in my series in which urine passed through the wound for a week and ten days respectively, every case has healed by first intention.

In my opinion the operation saves so much pain and inconvenience, and so much loss of time, that I cannot imagine why it should not come into common practice. In only two cases has the patient been in bed for more than eight days.

A LABORATORY for mycological research has been founded at Oporto under the direction of Professor Froilano de Melo.

In Marseilles 4 per cent. of the school children are affected with trachoma, which has been introduced by labourers from North Africa.