SIMPLE EYE WORK FROM THE POINT OF VIEW OF THE NON-SPECIALIST.

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These notes have been written entirely from the point of view of assisting the medical officer who in the absence of any one with special training in the subject on whom he might call for advice, has to deal with eye cases in a medical inspection room or the ordinary wards of a hospital.

Only the common diseases, which are likely to be met with under these conditions, have been considered, and the general line of treatment applicable to the average case indicated.

The notes are consequently rather elementary in parts and more of the nature of helpful, if scrappy, "tips" than otherwise.

INSTRUMENTS.

Almost all the work discussed here can be carried out without any special instruments, or with the help of those available in the ordinary hospital.

A few special instruments and appliances which are a comfort in the routine examination and treatment of simple eye conditions will be mentioned.

Electric Ophthalmoscope.

For the kind of work we are discussing, the most useful type is probably the May's electric ophthalmoscope. It is cheap, strong and easy to manipulate. When buying this instrument it is most important to see that the handle is sufficiently large to take the large-size unit cell used in the ordinary cylindrical electric torch. This will save infinite trouble in battery replacements, especially abroad.

It is possible to get an electric auriscope to fit the handle of the May’s ophthalmoscope and the two together form a very valuable combination. The cost is about £5.

A set, of excellent London make, is available, containing in a case an electric ophthalmoscope, an auriscope and three specula, a nasal speculum, a tongue depressor, a laryngoscope, retinoscope and condensing lens. The price is £7 15s.

Spare bulbs for electric instruments should not be forgotten when going abroad.

When new batteries are used a resistance should be employed to cut down the current, otherwise the bulbs are apt to burn out rapidly. Bulbs cost about 5s. each. If not overrun they last a long time.
The May's ophthalmoscope, although by no means the best for fine work, has the advantage that by merely removing the head containing the lenses it can be used to illuminate the eye. If the condensing lens on the stem is then pulled forward until it almost drops off, a simple and wonderfully efficient "hand slit lamp" is obtained. One of the earliest signs of appearance of an iridocyclitis and one of the latest signs to disappear when the inflammation subsides, is the "flare" in the aqueous when illuminated by this simple "slit lamp." The normal aqueous is almost optically inactive; but the highly albuminous aqueous of an iridocyclitis shows up the passing beam of light, just as the beam of a torch, invisible on a clear starry night, becomes very obvious when the air is laden with mist.

The slit should be first adjusted by focusing on the finger nail and the light then thrown obliquely through the cornea and lens. The beam passing through the aqueous is observed from in front between these two fixed points of illumination. This examination is easier against the large black background of a dilated pupil and is also easier when magnified, but the effect can be seen with the naked eye and undilated pupil. By the same means the depth of the anterior chamber and opacities in the cornea and lens may be examined. The ophthalmoscope, when used in this way, should be held like a pen, being gripped close to the lamp bulb, thus ensuring good control over the light.

Magnifying Apparatus.

A single loupe, magnifying 10 diameters, is useful for eye work (as well as for entomology), but should be of good quality. Such a magnifying loupe costs 25s.

A Zeiss binocular prismatic loupe magnifying three diameters gives an excellent stereoscopic view of the eye, but costs about £4.

Neither of these, although very useful, is essential for the work we are discussing.

Focusing Electric Torch.

An ordinary cylindrical focusing electric torch is invaluable for illumination of the eye in detecting disease, testing pupil reflexes inside a dark ward, in the removal of foreign bodies, etc. I have found the Winchester two-cell torch the most suitable. It can be focused to any distance or intensity of illumination required. The same unit cell batteries used for the torch should fit the ophthalmoscope handle.

In using such a torch for eye illumination a short focus should be employed and the light thrown on the eye obliquely from the side. Incidentally a similar light of less intensity gives quite a good illumination for operative work.

Eyelid Retractors.

In dealing with cases, especially babies, suffering from an acute conjunctivitis or corneal ulcer, when it is essential to inspect the condition of
the cornea, pain, photophobia and blepharospasm may make the use of eyelid retractors necessary, even after the instillation of a drop of cocaine. The simplest retractor is that made of bent silver wire. These can be bought for a few shillings in England and copied for a few annas in India.

When using such a retractor avoid injury to the corneal surface or pressure on the eyeball (which might rupture a deep corneal ulcer) by lifting the lids forwards away from the cornea at the same time that traction is exerted, so as to expose the corneal surface.

In babies the employment of a retractor is also often necessary to admit of efficient irrigation of the conjunctival sac.

**Irrigating Bottles.**

Undines are sometimes difficult to obtain in a hospital and are easily broken. A small enamelled iron tea-pot makes a fairly effective irrigator. Quite a good irrigator can be made from an eight-ounce bottle, preferably with a rubber cork, fitted with glass tubing of three millimetres (or more) internal diameter, arranged as in the distilled water bottle used for flushing microscopic slides.

The fluid used for irrigation should be at blood temperature. Normally if both lids are strongly pressed back over the orbital margins, while the patient looks alternately up and down, the lids will lift sufficiently away from the eyeball for effective flushing of the whole conjunctival sac. The upper lid can be everted if required.

**EXAMINATION OF THE EYE.**

**External Examination.**

If ordinary daylight illumination is insufficient a more concentrated light can be obtained by focusing on the eye with a condensing lens the light from a window or from an electric bulb held about three feet away. The ordinary Morton’s ophthalmoscope case contains a suitable condensing lens.

The patient should be so placed that the light comes from above the level of his head and from the opposite side to the eye which is being examined. This obliquely incident light allows of a clear view of the eye being obtained from the front, and of unobstructed magnification if required. A focusing electric torch as already suggested gives a very satisfactory illumination.

For those of us who are approaching the presbyopic age and who do not possess such an instrument as the prismatic binocular loupé, a Bishop Harman spectacle loupé (price about 18s.) or one of its modifications will be found a great convenience. It consists of a pair of spectacles fitted with plus 5'00 dioptre lenses combined with prisms, base in, to relieve the convergence effort, and allows of clear vision up to about four inches from the object looked at.
Eversion of the Upper Lid.

To make this manoeuvre easy and painless the patient must keep looking downwards, and the lid, firmly grasped by the central lashes, must be pulled well down and away from the cornea before it is hinged up rotating on the upper border of the tarsal cartilage. A touch with a finger or a match at the upper border of the tarsal cartilage provides a fulcrum for this rotation. So long as the patient continues to look down the faintest pressure on the free margin of the lid will maintain eversion. The lid will automatically return to its normal position when he looks up.

Examination of the Cornea.

Local ciliary injection will often point to the situation of a minor corneal lesion or foreign body. A minute corneal lesion not otherwise obvious may be discovered by directing the patient to follow one's moving finger, until the injured area shows against the corneal light reflex. Small ulcers, abrasions and foreign bodies, invisible against the coloured iris background, may often be seen when by a similar manoeuvre they are brought opposite the background of the "black" of the pupil. In difficult cases, dilatation of the iris with homatropin will render this much easier.

Any condition, abrasion or ulcer, resulting in an injury to the corneal epithelium, may be readily demonstrated by staining with fluorescein. A quarter of a drop of this solution is placed in the lower conjunctival sac by means of a match, glass rod or pipette, and the patient instructed to blink a few times, or the solution is placed on the upper margin of the cornea and allowed to flow down over it. After a few seconds it is washed out with a few drops of any innocuous solution and the cornea is examined. Any area, denuded of epithelium, from whatever cause, will be found stained a brilliant green.

Fluorescein solution is difficult to make up satisfactorily. It is exceedingly cheap and is best bought ready made. A few pennies-worth will last for a year.

The staining is more easily seen with daylight illumination or with the use of a "daylight" electric bulb.

Hypopyon and Hyphaema and K.P.

The crescent of sterile pus lying in the bottom of the anterior chamber (as the result of a severe corneal ulcer or severe iridocyclitis) and that of blood (from an injury) in the same situation are usually easily seen unless very small in amount, but the aggregation of cells plastered on the lower half of the posterior surface of the cornea (keratitis punctata or keratic precipitates, one of the most important signs of an iridocyclitis) may require magnification unless gross, before they can be seen. They are much more easily seen against the black background of the dilated pupil.

The brightness, colour and mobility of the iris to light, irregularity of its pupillary border or adhesion to the lens capsule (posterior synechia) are important points to look for when examining a questionable iritis.
Cataract in an elderly person should not be diagnosed by direct inspection. An old lens may be so dense as to reflect much of the light falling on it, and this white appearance gives the impression of its being opaque, when in reality it may be perfectly transparent, e.g., when examined by the transmitted light of a mirror (retinoscope) or the ophthalmoscope in the dark room.

External Examination of the Eye in Infants.

The following applies also to the treatment of infants and young children.

The best method of immobilizing infants and young children for examination and treatment is as follows:

For Treatment.—The nurse and doctor sit facing each other. The child is placed on the nurse's lap so that she can control its arms and legs. The child's head is held between the doctor's knees, leaving both his hands free to open the lids or to put in retractors.

For examination of the eye this position will be found to be too low, and the doctor's feet should rest on a box about twelve inches high. This will raise the child's head to the correct level for examination.

In all cases of acute conjunctivitis in infants it is essential to inspect the cornea and note whether ulceration has or has not occurred. It is quite easy to do this if the child is immobilized as described above and a retractor or retractors and an electric torch are used.

Use of the Ophthalmoscope.

With practice much can be done with a pearl electric bulb held in the hand and an ordinary Morton's ophthalmoscope, used in a partially darkened room. For the type of work we are considering, however, an electric ophthalmoscope is simpler to use.

First dilate the iris with homatropin (formula given under "Prescriptions"). One drop of this solution in each eye, repeated every ten minutes, should produce sufficient dilatation for examination in thirty to forty minutes. The eyes must be kept gently closed while dilatation is proceeding. In persons over thirty-five years old a drop of half per cent oily eserine should be instilled afterwards to avoid any possibility of precipitating a glaucoma. Watery eserine may be used if the oily solution is not available. Atropin should never be used for diagnostic purposes, as its effect, once established, is uncontrolled by any drug, whereas the dilatation of homatropin can be neutralized in an hour by repeated instillations of eserine.

The patient should be seated in a chair, the observer carrying out the examination standing. The room should be darkened as much as possible, but the fundus can be seen fairly well in a brightly lit room.

After the cornea had been examined by the illumination of an electric
torch or by the ophthalmoscope with the lens head removed and used as a torch as already described, the condensing lens should be adjusted and the cornea, aqueous, iris and lens swept with the "slit lamp" so obtained. Corneal damage, aqueous abnormalities, synechiae, lens opacities, etc., will be seen in this way. A good view is obtained of anything in front of the posterior capsule of the lens.

The condensing lens of the ophthalmoscope having been pushed home and the lens head replaced, ophthalmoscopic examination proper is begun. The observer uses his left eye to examine the patient's left eye. The highest plus lens available is turned into the sight hole (plus twenty in the May) and the head of the ophthalmoscope firmly fitted into the observer's eye socket like a monocle. Any further movements will then be carried out by moving the head and the ophthalmoscope in one piece. The ophthalmoscope is then brought up to the eye under examination until the cornea appears clearly in focus. If the observer is unaccustomed to use the instrument in this way, it should be tried on a wrist watch or thumb nail. Corneal opacities, corneal vascularity, etc., show up well by this method.

By maintaining the same distance from the eye and putting up plus lenses of decreasing strength the whole eye media from cornea to retina can be successively brought under observation. The state of the patient's refraction and the accommodation exercised by the observer will determine with which lens the retina will be brought most clearly into view.

To focus a blurry retina the habit should be acquired of whirling the lens wheel rapidly to and fro just as in focusing a microscope slide, until the required focus is obtained. When the end point of focus is nearly reached individual lenses may be brought one by one in front of the sight hole till the best definition is obtained.

The fundus should be examined systematically, starting from the optic disc. The periphery of the visible portion of the retina can be reached by asking the patient to look in various directions while the observer inclines his head and ophthalmoscope in the diametrically opposite direction.

If at any time the observer "loses his way" in the fundus he should trace a vessel back to the disc and start again. The macula lies two and a half disc diameters to the temporal side of the disc and a little below it. If the actual little pin-point macular reflex cannot be seen, the macular area can always be recognized by the absence of blood-vessels.

Such fundus conditions as disseminated choroiditis, gross papilledema, retinal hemorrhages, albuminuric and diabetic retinitis, the retinitis of pregnancy, signs of injury, such as choroidal tears and subretinal hemorrhages, are all easily seen with the ophthalmoscope.

The importance of early recognition of such conditions as papilledema, albuminuric retinitis or the retinitis of pregnancy need not be stressed.

It is comparatively easy at any rate to determine whether a fundus abnormality is present and requires investigation or not, and in the course
of the routine use of the instrument one learns to recognize such "normal" and unimportant abnormalities as the "angry" looking hypermetropic fundus, the "stretched" looking fundus of the low degree myope or the "grenade" of white medullated nerve-fibres which are so disconcerting when seen for the first time.

**SQUINT.**

We need not here concern ourselves with such conditions as paralytic squint, adult concomitant squint, or the relation of muscle balance errors (heterophorias) to squints. Concomitant squint in children only will be considered.

**Spurious Squint of Infants.**

During the first few months of life, before the fusion faculty has made much progress in development, an infant's eyes may converge for a few seconds at a time in response to some gastric or other disturbance. This is of no importance. If, however, one eye converges while the other steadily fixes an object after the child is six months old the case is probably a true squint and requires investigation. The child should have developed binocular fixation and should not squint by the time it is from six to twelve months old.

**Apparent Squint of Children.**

It is common to have a young child with no apparent deviation of the eyes brought by its mother with the story that "the child sometimes squints" or "the neighbours say I should have the child seen to as it squints." It is well to remember in these cases that a young child with undeveloped nasal bones, and consequently a broad, flat nasal bridge, may have a fold of skin (almost an epicanthus) covering the internal canthus to such an extent that when the child looks sideways one cornea partly disappears from view, thus producing the appearance of an internal squint.

In these cases, if the corneal reflex of a door or window is observed to occupy the same relative position in each eye of the patient, the eyes are not squinting. A more accurate rough test in such cases is to shine the light from a focused electric torch into the child's eye from several yards distance. If, when the child looks at the light from various angles, the corneal reflex of the light is seen to be central in each pupil the child's eyes are straight at the time of examination.

The best method of doing this test is to place the child (in the mother's lap if necessary) in the dark room with the light behind its head, and reflect the light from the mirror of an ophthalmoscope or retinoscope into its eye. Even an infant will at once look at the light, and the bright spot of light—the image of the mirror—is seen on the patient's cornea. This reflection should be almost in the centre of each pupil; actually it is slightly to the nasal side of the centre of the pupil. If a squint is present the deviating eye can be noted and a rough guess at the angle of deviation made.
Concomitant Squint of Children.

Seventy-five per cent of squints occur between the first and fourth year, the commonest age being between two and three years.

A premonitory occasional squint in a child over one year old is probably the precursor of a constant squint, and will usually become constant in two or three months if neglected.

A child which has a definite squint should be brought under treatment without delay at whatever age it is seen. Glasses, if required, can be worn when the child is about one year old.

The vision of the non-fixing eye in a squinting child is suppressed, leading to an acquired amblyopia, and the younger the child the more rapid is the deterioration of vision.

If, for any reason, the child cannot be seen by one with special "eye" experience, it is important to try and keep the vision of the squinting eye from deteriorating.

This can be done by bandaging the "good" (or fixing) eye during a third of the patient's waking hours. This is, however, a very troublesome method, and it will be found more convenient to place a drop of one per cent atropin sulphate solution in the "good" eye once a day.

By paralysing the ciliary muscle of the fixing eye in this way the partial use of the squinting eye is ensured, at least for near vision, and thus deterioration of vision from disuse avoided.

There is no danger of causing permanent impairment of accommodative power from the use of atropin, however long continued.

Growing out of a Squint.

With the advent of puberty the angle of a convergent squint often tends to become less—the patient may "grow out of a squint." The squinting eye has, however, unless specially treated, become amblyopic from disuse. The advice to "wait and see if the child will grow out of a squint" should therefore never be given.

Diseases of the Eyelids.

Styes.

These abscesses of the sebaceous glands in the lid margins usually point near the site of an eyelash. Eyelid tissues are very lax and the edema and pain are out of proportion to the size of the lesion. The treatment is obvious, but it should be remembered that the repeated occurrence of styes indicates the possibility of a chronic blepharitis requiring treatment, or the investigation of the possibility of a refractive error keeping up the condition. In chronic cases the use of stannoxyl, collosal manganese, and autogenous vaccines may be considered in turn.
Simple Eye Work from point of view of non-Specialist

Blepharitis.

The early form of this is characterized by fine scales round the bases of the eyelashes at their points of emergence. One might describe it is a dandruff of the eyelashes. These scales may require to be stirred up with a match (the tip of which has been tightly wound with a wisp of cotton-wool) to become visible, unless magnification is used, and yet such a mild scaly blepharitis may be the underlying cause of a persistent chronic conjunctivitis, or "tired" or "irritable" eyes.

In the later stages this infection of the follicles (which is by no means confined to children) may result in ulceration, loss of eyelashes and deformity of the lid. If this stage has been reached, treatment, to be of any avail, must be conscientious and persistent.

Treatment.—The scales or crusts must be completely removed by hot bathing, and if necessary by rubbing them out from the roots of the lashes by a cotton-wool-armed match-stick dipped in three per cent sodium bicarbonate. To facilitate access to the lid margin and to avoid the entry of the medicaments used into the conjunctival sac, the lid should be well retracted by hand pressure on the eyebrow.

Slight bleeding, if it occurs in the ulcerative cases, must not be allowed to interfere with the removal of all the crusts. It is useless merely to rub ointment on the surface of the crusts. The lid margin is then thoroughly dried, and a trace of unguentum hydrarg. ammon. dil. on another match-stick is well rubbed into the roots of the eyelashes. Any excess of ointment is afterwards removed.

This treatment, or modifications of it, may, in the ulcerative cases, have to be continued for weeks, months or even years.

If the patient is to carry out the treatment at home, it may be simplified as follows: He should carefully bathe the edges of the lids with a piece of cotton-wool, or clean rag dipped in hot water, until all the scales between the eyelashes have gone. The lids should then be well dried and a little of the ointment taken on the tip of the finger rubbed thoroughly into the roots of the lashes.

Chalazion (Meibomian Cyst).

This, due to an infection of one of the meibomian glands of the upper or lower lid, produces a swelling in the substance of the tarsal cartilage at some distance from the lid margin. On palpation it feels like a small hard pea, the skin of the lid being freely mobile over it. Gradually increasing over a period of weeks or months, it may suddenly become acutely inflamed. A vertical incision through the conjunctival surface of the everted lid and the scraping out of its granulomatous contents is usually required for its removal. The area to be incised may be anaesthetized by a few crystals of solid cocaine, or the lid may be injected from the conjunctival surface with novocain, using a fine needle.
CONJUNCTIVITIS.

When a casual examination indicates a comparatively mild conjunctivitis of one eye only, the possibility of a corneal lesion, a foreign body under the upper lid, or an early iritis should be eliminated before the diagnosis of conjunctivitis is made.

Bacteriological investigation of a platinum loop smear, or of a culture from the conjunctival sac is often helpful in determining the type of organism responsible for the inflammation and, consequently, the line of treatment to be adopted.

Gonorrheal Conjunctivitis.

A simple smear is usually sufficient for immediate diagnosis. The inflammation is a very acute purulent one, accompanied by severe pain, swelling of the lids, and swelling (chemosis) of the conjunctiva. The danger is that of rapid corneal ulceration. The disease may occur at any age.

Treatment.—In the early stages the eye literally drips pus. Irrigation must be almost continuous in this acute stage, say every half hour by day and every hour by night. For this purpose normal saline is probably as good as anything else. Protective goggles must be worn when treating the case. If oedema and chemosis make it necessary, retractors must be used to obtain effective irrigation, but injury to the cornea must be avoided during their use.

The everted lids are thoroughly painted with two per cent silver nitrate solution once a day during the acute stage only. The lid margins are smeared with a bland ointment to facilitate the escape of discharge. The patient should lie on the affected side, and the other eye should be protected with a Buller's shield, which can easily be improvised from a watch glass and sticking plaster. Watch for signs of corneal ulceration.

Mucopurulent Conjunctivitis.

This, although an acute inflammation with a markedly injected conjunctiva and even subconjunctival hemorrhages, accompanied by a variable amount of discharge, does not usually produce corneal ulceration. It is generally caused by the Koch-Weeks bacillus, but may be caused by the pneumococcus, a streptococcus, or even a staphylococcus. Its treatment will be discussed under that of Acute Conjunctivitis.

Chronic Conjunctivitis.

There is little that can be usefully said here about this trying condition, of which those of us who have spent much time in the tropics, with its glare, wind, dust and flies, have plenty of experience. Treatment is indicated later.

Angular Conjunctivitis.

This slight persistent inflammation, caused by the Morax-Axenfeld bacillus, is characterized by a "plum bloom" colour at the inner and outer...
angles of both eyes, the lid margins also being reddened in that situation. It is best seen from a distance of two or three feet. Treatment is indicated below.

**Self-inflicted Conjunctivitis.**

This is usually produced by evertting the lower lids and placing an irritant such as soap, sand or cigarette ash in the exposed conjunctival fornix. It may be caused by simple repeated friction. The results are characteristic. The conjunctiva of the lower lid is red and inflamed, as is also the conjunctiva of the eye covered by the lower lid. On pulling down the lower lid a sharp line of demarcation between this angry infected conjunctiva and the normal pale conjunctiva of the remainder of the eye is noted. The upper lid and the conjunctiva covered by it are normal. There is relatively little discharge from the eye.

**Treatment of Conjunctivitis.**

That of gonorrhoeal conjunctivitis has already been considered.

**Acute Conjunctivitis.**

As a routine treatment for acute conjunctivitis the following may be adopted:—

1. Irrigation of the conjunctival sac sufficiently often to keep the eye free of discharge. Traction over the orbital margins will lift the lids away from the eye and enable the whole sac to be washed out. The height of the irrigator should be gradually raised to about four inches so that a forcible stream of fluid directed on the eye and into the fornices may flush away the discharge. The fluid should be at blood-temperature.

A note on the fluids used for irrigation is appended.

2. Paint the everted lids with two per cent silver nitrate solution once a day only for two or three days in the acute stages. This painting, if done early, may abort an attack of conjunctivitis and should at any rate cut short the disease.

To paint the lids evert the upper and lower lids and press together to shut off the cornea. (No harm is done, however, if the solution does reach the cornea.) Dab the exposed lid surfaces for five seconds with a match stick the end of which has been wrapped in cotton-wool dipped in the silver solution. Mop off the excess with a pledget of dry cotton-wool. Irrigate immediately with normal saline and instil a drop of two per cent cocaine.

The pain is fairly acute for an hour. Painting of the lids can be done with benefit even in small children. (It might be mentioned here that for the application of ointments, the cleansing of the lids of cases of blepharitis, the application of silver nitrate solution to the lids, etc., if neither proper "wood applicators" nor solid glass rods are available, ordinary matches may be used. In India the midribs of the cocoanut palm, used for making...
sweepers brooms, are excellent substitutes. They are tough, easily sterilized, and cost practically nothing. A wisp of cotton-wool wrapped round the end adheres well and forms a good swab.

(3) A little plain vaseline rubbed along the edges of the lids at night will prevent them sticking, and allow of the free escape of the conjunctival secretions.

(4) The eyes should be left unbandaged and freely open in all cases of conjunctivitis with no corneal ulceration. An eye shade or dark glasses may be comforting.

(5) A drop of twenty per cent protargol or argyroil may be used twice a day. It is doubtful if these preparations are of much value. No silver preparation, organic or inorganic, should be used for more than a fortnight or three weeks, because of the risk of producing indelible brown conjunctival staining (argyrosis). Silver preparations should never be prescribed for home use for the same reason.

Note.—A clean fountain-pen filler makes a good eye dropper. In its absence a piece of glass tubing of three millimetres internal bore, fused to smooth the ends and used as a pipette, is satisfactory. In the more chronic types of conjunctivitis, when the patient is given drops for home use he will find the following method of introducing the drops easiest. Standing eight inches from a mirror, pull down both lower lids at the same time, using two fingers of the left hand, suck up a few drops of the solution in a pen filler and looking in the mirror lay one drop in the lower fornix of each eye; allow both eyes to close.

The Use of Fomentations in Acute Conjunctivitis.

Fomentations in simple conjunctivitis probably do more harm than good, producing a sodden effect on the tissues and increasing the risk of corneal ulceration. Hot bathing and hot fomentations are comforting and of therapeutic value in deep inflammations such as iridocyclitis, but not in superficial inflammations.

In cases of acute conjunctivitis, especially in babies and in children, the cornea should be inspected daily for commencing ulceration.

(To be continued.)