prostration; stimulating tonics are here indicated quinine, ammonia and iron, alcohol and digitalis. Then again we find some develop a condition of nervous irritability with marked vigilance. In hese cases improvemen will follow the administration of musk, bromide of ammonium, or bromide of potassium, with sal volatile and hydrocyanic acid.

OPHTHALMOLOGY.

SOME POINTS IN DIFFERENTIAL DIAGNOSIS, BY R. A. REEVE, B.A., M.D., PROF. OF OPHTHALMOLOGY AND OTOLOGY, UNIVERSITY OF TORONTO.

Iritis.—As iritis is one of the most important diseases and conjunctivitis is one of the most common, it is of moment that they be not confounded. The frequency with which synechiæ are noted may be partly due to tardiness on the patient's part or defective treatment of recognized iritis, but there seems little doubt that the diagnosis is sometimes at fault. The facility with which the iris becomes glued to the lens capsule by lymph and the area of the pupil invaded, crippling the eye, impairing the sight and favoring further mischief, teaches that we should ever be on the alert for iritis, because early recognition is necessary to securing full mydriasis, the end always to be had in view. In syphilitic subjects who furnish 60 to 70 per cent. of iritis, any complaint regarding the eye should be promptly heeded; so also in the rheumatic, as well as where there is any danger of sympathetic ophthalmia. Though there are some cases free from pain, one fact often gives the clue to iritis without requiring a careful scrutiny of the eye, namely that pain is generally present only *at night*, and that even with intense nocturnal pain it is unusual to find more than discomfort in the day-time. Constant pain is more apt to occur when the ciliary body is implicated with the iris (cyclitis), and then the photophobia and lachrymation are excessive and the eye-ball is tender. In corneal ulcer, in which we should always expect and anticipate iritis, there is often intense pain both day and night. In cases of presumed simple conjunctivitis where nocturnal pain occurs, some mydriatic as ¼ per cent. solution atropia sulphate should be instilled; a resisting or irregular pupil would help if not settle the diagnosis. Sometimes the greatest pain is not in the eye but on the vertex along the pericranial and cutaneous twigs of the supraorbital nerve, and the trouble is mistakenly dubbed "neuralgia," and possibly treated as the cause rather than the effect of the ocular condition. Again, the congestion in iritis is sufficiently characteristic, for while externally it is circum-corneal or at least ocular, it also renders the iris dull or discolored and the pupil contracted, sluggish, or fixed. In conjunctivitis the hyperæmia is mainly palpebral and at the *cul de sac*, the pupil being active and the iris bright. Moreover, the primary watery secretion soon gives place to mucous or muco-purulent discharge, while in iritis proper there is no blennorrhœa, only lachrymation. Yet cases are not infrequent in which despite the absence of blennorrhœa the treatment of conjunctivitis is applied to iritis and permanent damage entailed.

In iritis, as a rule, the tension of the eye is not increased, but in cases of apparent iritis in subjects of fifty years and upwards gentle palpation should not be neglected, for at this time of life glaucoma occurs, which would be aggravated by atropine. Such symptoms as intense pain, hard globe, steamy cornea, dilated fixed pupil, blindness, and rapid onset point clearly enough to acute glaucoma, but the subacute and chronic inflammatory cases are not so evident. They are, however, preceded by the premonitory rainbow hues seen about artificial lights, with transient fogginess, which serve to distinguish them from the rare serous iritis in which with plus tension and enlarged pupil there are punctate lymph deposits against the lower half of cornea.

Phlyctenular Ophthalmia.—Phlyctenular and catarrhal conjunctivitis often co-exist but the distinctive vesicles or pustules of the former on the ocular conjunctiva can always be found. They serve as useful guides for though, as a rule, pain, photophobia and iritic congestion are absent, pure astringents have here to be used with caution. Phlyctenular keratitis, a sort of corneal herpes with resulting punctate excoriations or tiny ulcers, often occurs also with catarrhal conjunctivitis, and the latter is apt to be regarded and treated as the main affection, or the corneal disease may be overlooked, the phlyctenules being few and minute. As even mild cases are made worse by caustic or astringent collyria, and one phlyctenule may disable an eye and prevent the use of its fellow, the photophobia and lachrymation always present should lead one to look well at the cornea. (Small ulcers or facets are brought out by getting the window reflex upon them). The severe cases in young