active stage. Dividing the outer canthus effects both local depletion and relief of dangerous pressure upon the cornea, and is often a valuable expedient. In sthenic subjects, depletion from the temple by leeching or cupping, practised early in the congestive stage, tends to relieve pain and mitigate the severity of the attack.

One word as to hygiene in conjunctival diseases, which, as a rule, are contagious. Greater precautions should be taken than are now in vogue to prevent their spread. All ways of transferring contagion, by towels, basins, handkerchiefs, pillow-cases, etc., should be provided against; and isolation or quarantining in public institutions, and the careful ventilation, etc. of dormitories should be insisted on.

Diphtheritic conjunctivitis is mentioned, merely to draw attention to the interesting fact of its extreme rarity in this country, where, unfortunately, diphtheria proper is not uncommon. And again, the infrequent membranous or croupous variety, in which there is a superficial and adherent plastic exudation, is, I opine, less often of distinctive origin than the result of too early use of caustics or strong astringents in cases of purulent or catarrhal conjunctivitis.

IRITIS.

The prompt recognition and proper treatment of iritis are, happily, becoming more common, but I fear its gravity is not yet duly estimated, and too little heed is paid to a disease which not seldom entails the life-long disability of impaired sight, abnormal sensitiveness to exciting causes, with tendency to relapses, and also to other morbid processes, as glaucoma, cataract, choroiditis, sympathetic ophthalmia, etc. The old-time diagrams of the eyeball, showing the lens at some distance behind the plane of the iris, are quite misleading. Were they true to nature the dreaded adhesions could hardly occur. The fact is, the central part of the iris is practically in contact with the lens capsule, and hence the facility with which the two become glued together by lymph, and also the area of the pupil invaded thereby. It is advisable to be always on the alert for iritis, as it is of common occurrence, either idiopathically, or traumatically, or secondarily to inflammation and ulceration of the cornea; is due to syphilis in from 60 to 70 per cent., sometimes to rheumatism, occasionally to gonorrhœa, and is also of sympathetic origin.

Fortunately, its diagnosis is comparatively easy: a rosy circum-corneal zone of injected vessels, finely meshed and lying beneath the larger, duller, and movable conjunctival set; a dull or discolored iris, contracted, sluggish, or immobile pupil; more or less photophobia, lachrymation, and dimness of sight, with reflex neurosis, the pain being most severe, or possibly only present, at night. Nocturnal pain or exacerbations in and radiating from the eye should at once arouse a suspicion of iritis. Sometimes the greatest distress is felt on the top of the head, and, indeed, towards the occiput, the seat of distribution of the pericranial and cutaneous filaments of the supraorbital nerve. Occasionally, this so-called neuralgia is so severe that it is mistakenly thought to be the cause instead of the effect of the eye trouble, and it is often present in specific cases, though the contrary opinion seems to be held by some. Again, iritis is sometimes confounded with conjunctivitis, with a premature resort to astringents, *et al.* which, of course, aggravate the mischief. The differential diagnosis is generally easily made:—The congestion of iritis is circumcorneal and ocular, attended by lachrymation, not blennorrhœa; that of conjunctivitis is mainly palpebral and in the cul-de-sac, and is soon followed by the hyper-secretion of mucus, mucopus, etc., while the pupil is generally active and the iris bright, and the vision unaffected, or not dimmed, save by passing shreds of mucus, etc.

I would urge the propriety, where any uncertainty exists, of using atropine, and not astringents; a slowly dilating or irregular pupil will give the desired clue. It will bear iteration that the main point in treatment is to secure and maintain throughout the fullest dilatation of the pupil. This often requires from 3 to 15 or 20 instillations in the 24 hours, of a 4 gr., or 1 per cent. solution of atropiæ sulph. The sooner resorted to the less required. In few instances does a remedy so fully meet the