

favorable prognosis given. Most authors agree that anal fissures in children are more amenable to treatment than the same affection in the adult, and the heroic measures so frequently necessary in the latter are hardly ever called for in the former. Weak solutions of nitrate of silver and light touching with the solid stick of nitrate were employed, the parts were always kept well smeared with an iodoform salve and the bowels maintained in a soluble condition. But the fissures would not heal. At last, disgusted with the ineffectual results of this method, surgical interference was advised and accepted. Dr. E. W. Walker was called in consultation and practiced division of the sphincter. An iodoform tampon was daily introduced into the rectum by means of the speculum, and in two weeks the ulcers healed and masturbation was no longer indulged in.

At this period the child was, unfortunately, taken ill with chicken-pox. Not only was the skin studded with the characteristic vesicles, but the mucous membranes of the mouth and pharynx also participated in the eruption. The disease had scarcely subsided when the child resumed the former practice of masturbation. An inspection of the anal region revealed the same, if not a worse condition than before, and with out further temporizing, Dr. Walker was again called to divide the sphincter. The fissures healed as kindly as in the first instance, and with their disappearance masturbation also ceased. In searching the literature, Dr. Grimm was unable to find a parallel case. The *American Journal of Obstetrics*, vol. ix, 1876, contains the report of a case of masturbation, by A. Jacobi, in a female child nine months old. In this instance, however, the practice became established through a state of chronic constipation.

The remarkable features in the case just presented are the age and sex of the child, the severe measures that had to be adopted for the cure of the fissures, the entire absence of rectal symptoms, and, lastly, the rekindling of the disease during or immediately after an attack of chicken-pox. As regards the latter point, Dr. Grimm is inclined to believe, rare though it may be, that an eruption similar to the one existing in the mouth also invaded the rectal mucous membrane, and in this manner reproduced the pathological condition.—*Med. and Surg. Rep.*

THE BEGINNINGS OF JOINT DISEASE IN CHILDREN.

It daily becomes more evident that in the young, joint disease finds its primary origin either in the synovial membrane or in some portion of bone which enters into the articular surface of the joint and rarely ever begins in cartilages or ligaments, which are only secondarily implicated.

The relative frequency with which the various joints are affected by disease thus beginning, as against that originating in other neighboring structures, is of much importance, and generally it may be stated that the greater the area covered by the synovial membrane, the more frequently is it the site of commencement of disease, if we except the hip-joint. The apparent exception in the case of this hip-joint may be due to its anatomical peculiarities, the extent of the surface being not really large, the ligamentous union so firm and the movement so limited, that it is efficiently protected from injury. The bones of this joint ossify from one center at a much later period than that at which joint disease is most common, and are thus less liable to disease, and the membrane becomes less liable to injury. In reviewing the various joints *seriatim*, we find that a large proportion of cases in the surgical wards are described as diseases of the metacarpal bones either at the shaft or the distal extremity, involving of course the metacarpophalangeal joint, and in this instance, at least, we may lay it down as a fact that joint disease commences invariably at the end of the bone. Disease of the metacarpal bones, like disease of the wrist, is much less common in childhood, probably on account of its greater proximity to center of circulation or to its greater immunity from injury. But coming to the ankle, we have all the elements which predispose to the advent of disease—extensive synovial membranes, large proportion of cancellous tissue, and a large amount of active growth going on in epiphyseal ends of the tibia and fibula, besides the great liability to injury of these parts in the early efforts at walking. Hence we find that disease of the tarsus is of very frequent occurrence in children, and rapidly spreads to other parts. If we include all elements of the tarsus, the liability becomes greater still, and it is easy to understand when once the synovial membrane is implicated, that the other bones with which it is in contact will also speedily be involved. The origin of Chopart's amputation is due to this fact. But disease of any of these bones may not infrequently be recognized and dealt with early with the help of antiseptics, and the involvement of other parts avoided, but when once the synovial membrane is affected, amputation is hard to avoid, and generally the sooner it is performed the less is the danger of implicating other tissue. Disease of the astragalus is of great consequence to neighboring structures, and caries of the bone can scarcely fail to involve either the ankle-joint above, or the calcaneum or scaphoid below; hence the scant success that attends partial operations. The cuboid offers a greater chance of arresting disease by means of scraping or ablation of the bone. In disease of the scaphoid, partial operation is disappointing. Syme's operation is not now performed so frequently, because of all the