of this form of iritic inflammation. Wells,[2] however, states that this is not the case, and that they are met with in persons free from syphilis. The cornea is generally clear, though sometimes keratitis is present. The aqueous humor is generally cloudy and has a peculiar dirty look; shreds of lymph may sometimes be seen floating in it. More commonly the lymph will be seen adhering to the iris, which is swollen or discolored, or the anterior chamber may be more or less filled by brownish, red or gray tumors. These are, according to Colbert, the gummata of Virchow; they spring from the fibrous groundwork of the iris, (parenchymatous iritis), and pushing the loose fibres aside, enter the anterior chamber. There may be two or more, and they may vary in size from that of a pin's head to that of a growth sufficient to completely fill the anterior chamber, and considerably raise the tension of the eye. I saw such a case at Galezowski's clinic in Paris in 1876. It was mistaken at first for diffuse corneitis, so perfectly was it applied to the inner surface of the cornea, and so uniformly grey was it. The oblique light, however, revealed its true nature. These tumors consist of fusiform cells, of newly formed cells and free nuclei. They do not differ in structure from ordinary gummy tumors. These tumors are considered characteristic of syphilis, but Wells[3] reports having seen a case of Mr. Critchett's, in which there were "well-marked tubercles, (*i.e.* gummata), without the slightest evidence of syphilis." May it not have been a collection of fluid in the parenchyma of the iris, which did not go on to suppuration? The existence of other affections of the eye at the same time, as retinitis, neuritis, corneitis, etc., tends to confirm the diagnosis.

To resume, the *diagnosis* depends on the insidious and painless onset; if there be pain, it is principally at night; a muddy aqueous humor, the existence of gummy tumors, the presence of other eye affections, and a history of chancre, skin eruptions, etc. The pupil is contracted as in other forms of iritis.

The *treatment* consists in the early and persistent use of a solution of atropine (grs. iv., ad. ℥i). This gives rest to the iris, and by dilating it, prevents central adhesions Of mercurials, I prefer, as taught by Mr. Hutchinson, hydrarg. cum cœta, in grain doses, three times a day, until slight tenderness of the gums is produced. The pain should be combated by hypodermic injections of morphia, if very severe, or in ordinary cases, by an ointment to the brow, containing Ext. bellad. ʒi., ung. simp. ℥i. When atropine cannot be obtained, or is unreliable, these drops may be used, (Ext. bellad. ʒss. aq., dest. ℥i.) If the atropine does not seem to act well, two to four leeches should be applied to the temple. It will then be found to dilate the pupil rapidly. If the atropine, however, should still cause much irritation and swelling of the lids, it should be stopped at once, and sod. bibor. grs. x. aq. dest. ℥i. used instead, and when the irritation has subsided, atrop. sulph. zinci sulph. aa, gr. i., aq. dest. ℥i., should be used. When not contra-indicated by the irritation produced, atropine must be used frequently, every three hours, and in strong solution, grains iv—vi. to the ounce. If symptoms of poisoning should arise through idiosyncrasy, or from swallowing atropine by mistake, the best and most rapid antidote will be found to be subcutaneous injections of morphia (gr. ⅛,—¼), to be repeated, if necessary, several times in the course of a few hours.

Occlusion of the pupil, or iritic adhesions, may necessitate an iridectomy subsequently, and breaking down of a gumma, excision of the globe.

The *prognosis* depends on the diagnosis being made early, and energetic treatment being adopted. Under atropine and mercurials, the recovery is often complete. Should, however, in spite of treatment, occlusion of the pupil take place, or the gummata break down, then the prognosis is very grave as regards the eye. A mild case of iritis may only last three or four days, whereas a more severe one will exist for weeks. There is much less liability to relapse in specific iritis than in the rheumatic and gouty forms.

2. Soelberg Wells' Treatise on Diseases of the Eye, 1873.
3. Op. cit., p. 167.

IMPERFORATE RECTUM—OPERATION.

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Mrs. C—— gave birth to a male child November 15th, 1878. After the birth the child was examined, and all the apertures found apparently normal. On the following day, 16th, I received a