associated with iritis. The inflammation as a rule occurs about the period of the appearance of the joint complication of gonorrhea. As you know, the gonococci are carried by the blood stream to the joints, and there set up inflammation, and the same type of inflammation may occur in the eyes. It is an irritable form of conjunctivitis; the secretion is watery and has a tendency to chronicity and to relapses. No gonococci are found in the secretions of the eye, although they may be present in the tissues; there is considerable pain and photophobia. The local treatment must be mild, and if there be any urethral trouble present it, of course, must be attended to. The iritis that occurs in these cases possesses also the same tendency to relapses, but I have found that this tendency diminishes greatly with the improvement of the urethral condition. This form of gonorrheal eye trouble may be considered a sort of general toxemia, manifesting itself in some weak spots. In cases of gonorrheal conjunctivitis we sometimes get a mixed infection, streptococci and pneumococci being present, and it would appear as though the presence of the streptococci favors an increased severity of the infection.

Membranous conjunctivitis is, happily, of rare occurrence, at any rate the true diphtheritic type; in fact, during my career in Montreal I have not come across a true case of this (although I have seen many cases of membranous conjunctivitis); a few I have seen on the continent of Europe. The severe cases of membranous conjunctivitis which I have met with were at first very suggestive of true diphtheria, but on close investigation they proved to be due either to that allied germ, the bacillus-xerosis, or to staphylococci.

As being of interest in this connection, I might cite a case of my own which I saw not very long ago. The patient was an infant about nine months old, and suddenly developed an intense inflammation in the right eye; a gray membrane formed over the palpbral conjunctiva which could not be rubbed off, but left a gray surface beneath it; there was great swelling of the lids; a smear showed a bacillus which was at first considered to be the Klebs-Loeffler diphtheria bacillus. The culture, however, the next day, showed this not to be the true Klebs-Loeffler, but like the allied bacillus-xerosis (of which I will have a word to say to you later on). There were also staphylococci present. The treatment of this case was simple, the use of argyrol, twenty per cent strength, and mild boracic acid lotions. Recovery took place in about three weeks. I will not detain you with any details in regard to the diph-