conjunctival affection, only to be applied after epithelial regeneration is well under way. Yet I would make one exception to this last statement. In the fascicular form of keratitis it has seemed to me that calomel, applied somewhat freely during the progress of the band across the cornea, has sometimes checked its course. So erratic, however, is this variety, and the opportunity for studying it so comparatively infrequent, that I am willing to admit it may have been coincidence rather than effect that I observed. With the ointment of yellow oxide of mercury, much used in the same conditions as is calomel, my experience has been limited, and it has appeared to me at least less agreeable to the patient.

The sluggish, deep infiltration, whether at the edge of the cornea or more central, showing little or no tendency to the formation of vessels, demands, besides atropine, the application of hot fomentations, continued half an hour or an hour three or four times daily. These help to relieve the pain, sometimes considerable, and invite the vascular outgrowth from the conjunctiva needed to furnish material for repair. Should perforation occur, pain usually ceases as by magic, and the reparative process begins. The subsequent care after perforation does not differ from that required in similar circumstances arising from other cause.

Many and various have been the remedies recommended to promote the absorbtion of corneal opacities left by this or other diseases. My own belief is that none of them are of special value, and that the opacities are best intrusted to nature to reduce, as she certainly will in part. Our task, after the immediate attack has passed, is to see to it that measures to improve and preserve the general health are continuously carried out and thus recurrence prevented.

RINGWORM: ITS PATHOLOGY AND TREATMENT.

By R. M. Simon, B.A., M.B., Cantab.

The disease is undoubtedly contagious, but its contagion varies in strength at different epochs of life, and the ringworm of childhood is not the ringworm of maturity. The disease is essentially the same, but very different in its situation; in childhood the head, in mature life the body or rarely the hairy parts of the face are liable to be affected, and the cause in every care is the tricophyton consurares.

The best way to find the figures is to extract one of the broken short and thick hairs, and after maceration for an hour or two place it under the microscope.

On the body, where ringworm especially affects the face, neck, or chest, it commences with small red circular spots, and is often associated with the formation of minute vehisicles. These circular spots, gradually increase at their circumferences, while the centre becomes more or less normal, the subsidence of the original vesicles being followed by desquamation. The advancing edge is raised, and red, and is an important element in diagnosis, for the patch might, but for this elevation, be taken to be one of eczama. Should there be any difficulty about the diagnosis, the point may be settled by scraping some of the epithelium from the inner border of the advancing ring, and the finding of the characteristic mycelium. I may at once discuss the treatment of this condition, as it is quite distinct from that of the hair' and by far more easy; any parasticide will be effectual, but I have been in the habit of using a preparation of equal parts of sulphurous acid and glycerine with good effects; a free use of soft soap and water is important, and it will be advisable in every case to examine the hair to see if there be a coincident patch there also. If fortunate enough to catch a case as its commencement, we find a small ring of minute vesicles, on a red base; the fluid which is between the rete mucosum and the epidermics is quickly absorbed and there results, a brauney desquamation which spreads rapidly and we soon have round patches of a greyish colour, covered with scales, and but sparingly with stumps of hairs. There is a great amount of grey debris surrounding the base of the hairs, which are thick and stubby, with a fracture like the end of a broom, and full of fungus; they come out very easily, more often breaking in epilation, but without pain, and this is important. If you find a child objecting very decidedly to epilation you may be moderately sure that there is no ringworm in the hairs you are handling.

For practical purposes ringworm of the head may be divided (1) into recent cases; (2) cases of disseminated disease, where the head is practically covered; (3) cases in which there remain one or two old patches which are most intractable. The cardinal feature which underlies all indication for treatment, is the tendency of the fungus to penetrate deeply into the hair follicles. Bearing this in mind, it will easily be seen how useless is the application of medicamenta merely to the surface. Over much washing must be avoided, for if the scalp be soddened by water, ointments cannot sink deeply into the folicles.

For recent patches I use glacial acetic acid, painting it on to the affected parts, but I do not think it better than blistering fluid. I never shave the head in these cases, preferring to clip the hair all over where the disease is widely distributed, and for half an inch round the patches, where there are but few. One cannot so easily distinguish the diseased hair from the sound, where they first emerge above the surface, and I have repeatedly seen cases whete a child has been most unnecessarily tortured by the extraction of healthy hair, which would have been avoided had the