A plaster-of-Paris cast was applied to the wrist and lower arm for a period of ten days, at the end of which time passive motion and massage were instituted, and a roller bandage substituted for the cast.

The patient was discharged on October 20, and at the present time suffers from no disability.

The above case is recorded, not because of its importance from a clinical point of view, but because of its rarity and its absence from the surgical literature. Doubtless, the fracture occurs with greater frequency than we might be led to believe, since absence of deformity and lack of definite symptomatology lead the attending physician to treat the injury as sprain rather than fracture.

178 State Street.

A DIAGRAM FOR TEACHING THE VARIETIES OF REGULAR ASTIGMATISM

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With the accompanying diagram, I have been able to make the subject of astigmatism a little clearer to students. So far

ing the vertical meridian of the eye and brought to a focus at VF. Observe the interval between these foci. The kind of astigmatism present may now be said to depend on the length of the eyeball.

If the retina be situated as far back as A, we find one meridian of the eye (III) emmetropic and one meridian (VV) hyperopic. Result: simple hyperopic astigmatism.

If the retina be situated at B, we find both meridians hyperopic, but the vertical meridian (VV) more so than the horizontal meridian (III). Result: compound hyperopic astigmatism.

If the retina be situated as far back as C, we find one meridian (VV) emmetropic and one meridian (III) myopic. Result: simple myopic astigmatism.

If the retina be situated at D, we find both meridians myopic but the horizontal meridian (III) more so than the vertical meridian (VV). Result: compound myopic astigmatism.

If the retina be situated at E, we find one meridian (VV) hyperopic and one meridian (III) myopic. Result: mixed astigmatism.

I have not been able to find a like diagram in any text-book. The nearest approach to it is one by Dr. Edward Jackson. I offer this with an elementary legend, which approaches the subject in a brief way.

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Therapeutics

TRACHOMA

This disease of the eyes is becoming of more and more importance as it becomes more and more widespread throughout our country. Therefore a brief summary of the elaborate presentation of the subject by Dr. Clark¹ of Evansville, Ind., will be valuable.

In 1897 the Secretary of the Treasury declared trachoma a dangerous contagious disease, and denied an immigrant afflicted with it entrance to this country, because of the discovery that the disease was being introduced and disseminated by immigrants. It seems to be undisputed that no country is free from the ravages of the disease, the history of which goes back to ancient times, and that no race is immune from it and no age exempt, except the very young. Dr. Clark tells us that in young children the conjunctiva does not have sufficient adenoid tissue to give the disease an opportunity to develop.

Dr. Clark states that in spite of all the bacteriologic investigations, the cause of trachoma is not yet known, the specific germ has not yet been discovered. It has been clearly shown, however, that in most cases of trachoma there is a mixed infection. The disease occurs in groups, in localities, in houses, in factories, and in schools, and is spread by contact or by contamination with articles like common towels, which are handled conjointly by the afflicted patient and his fellows.

The inflammation is located in the lymphoid tissue in the meshes of the connective tissue of the conjunctiva, and is "an enormous lymphoid infiltration with cells aggregating into masses, forming papillae, which, after receiving a vascular supply, degenerate, rupture and undergo cicatrization with the formation of the characteristic scar tissue of trachoma."

Clark believes that a more or less acute inflammation always precedes this chronic process. The acute symptoms are "those of a severe conjunctivitis with lacerimation, photophobia, pain," and some swelling of the lids. He finds the ocular conjunctiva injected, and more or less chemosis present. The palpebral conjunctiva and the fornix are congested and turgid, and the follicles are swollen. Eversion of the lid causes pain. More or less purulent discharge develops and papillae form, varying in size, depending on the situation in the conjunctiva. The color of these papillae varies according to the looseness of the conjunctiva, and they may amalgamate, forming masses or folds. The next stage, which occurs after a longer or shorter time, is that of scar-tissue formation; at this stage the secretion diminishes and the ocular congestion and photophobia cease. Still later the scar tissue begins to form in the region of the aggregations of the papillae, and with the progress toward cicatrization the so-called granulations of trachoma become separated into bands or islands, a very characteristic appearance when the inflammation is well advanced toward spontaneous recovery. This scar tissue is less abundant in the lower than in the upper lid. Its formation soon causes a lagging of the lids on movement, and later may cause ptosis. The course of trachoma is chronic, and, although there may be varying degrees of intensity of the inflammation and therefore a variation in the appearance of the conjunctiva, Clark believes that trachoma is always the same, and that to describe different types is only to cause confusion.

1. Clark, T.: Trachoma, with Especial Reference to the State of Minnesota, *Journal-Lancet*, March 15, 1913, p. 150.