The conclusions I would put before you as worthy of consideration in respect of the anatomy of the parts relative to fracture of the clavicle are: 1. That no pressure, or very little, is transmitted through the acromio-clavicular joint, even when blows are struck upon the outer edge of the acromion process. This absence of direct pressure through the acromio-clavicular joint is explained by the presence of the trapezoid ligaments and their attachment to the coracoid process of the scapula and the clavicle. 2. That the pressure which passes through the coracoid process and the trapezoid materially affects the internal structure of the clavicle, and the obtuse angle of the adjacent surface faces the acromio-clavicular joint, through the absence of the triangular fibro-cartilage still further diminish shock. 4. That by direct impinging of the coracoid process against the clavicle fractures of the clavicle between the conoid and trapezial ligaments are produced, and that, with most cases not only is displacement possible but that impaction may also take place. 5. That by bending of the clavicle over the coracoid process fracture of the shaft of that bone may be produced.

**SEPARATED EPHYSES.**

The question of separated ephyses and the influence of pressure lamellae upon the line of fracture is well illustrated by a reference to these diagrams. Frequently when a separation of an ephysis takes place the lines of solution of continuity does not carry the total area of the epiphyseal line. Thus a portion of diaphysis may be broken off from the main part of the shaft and produce considerable difficulty in reduction of the deformity. If we refer to these diagrams (those representing the clinical features have copied from the work of Professor Hoffa upon fractures and dislocations) we shall find that the fracture producing separation of the ephysis in these diagrams of separated ephysis of the lower end of the tibia, the upper end of the femur, and of the lower end of the humerus has passed along the epiphyseal line for two-thirds of its breadth, and has then been deflected along the course of the pressure lamellae of the bone—in other words, along the grain of the bone.

**ON SO-CALLED RHEUMATIC IRRITIS.**

**By C. HIGGENS, F.R.C.S. ENG.,**

**SENIOR CONSULTING OPHTHALMIC SURGEON, GUY'S HOSPITAL, ETC.**

IRITIS dependent on rheumatism no doubt frequently occurs, but my experience is that a very large number of cases so called are due to the poison of gonorrhoea and the worst cases with few exceptions have this origin. The history of the case is usually a variety of the history of a man, comes to the ophthalmic surgeon with iritis, and it is probably not the first attack. His age is generally over 50, but he may be younger, and he will give a history of gonorrhoea some years before. He had had iritis in both eyes previously on more than one occasion, his left eye being considerably damaged, and years before he had suffered from gonorrhoea frequently. When I saw him he had severe iritis in the right eye, with conjunctival and episcleral congestion, and a good deal of photophobia. The patient had no notion of anything being wrong) becoming infected, not with an ordinary gonorrhoea, but by salpingitis, followed in some cases by septic peritonitis. Here it would appear that the virus, though too weak to infect the mucous membranes, is powerful enough to infect that of the fallopian tubes.

The results of gonorrhoeal iritis include all those consequent on iritis in its worst forms; synechiae more or less extensive, cataract of the lens, and synechiae more or less extensive, capsular cataract, glaucoma, with posterior synechiae; and the lens capsule, bombe iris, with its attendant evils, capsular cataract, glaucoma, with changes in structure of the iris, and loss of vision varying from slight impairment to total blindness.

**Case 1.**—A man, aged 42 years, first consulted me in 1894. He had had iritis in both eyes previously on more than one occasion, his left eye being considerably damaged, and years before he had suffered from gonorrhoea frequently. When I saw him he had severe iritis in the right eye, with conjunctival and episcleral congestion, and a good deal of photophobia. The patient had no notion of anything being wrong) becoming infected, but by salpingitis, followed in some cases by septic peritonitis. Here it would appear that the virus, though too weak to infect the mucous membranes, is powerful enough to infect that of the fallopian tubes.

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**Case 2.**—The patient, a man, aged 42 years, first came under my care in September, 1893, with a history of severe gonorrhoea some years before. He had had many attacks of iritis, mostly in the right eye. Iridectomy had been performed in the right eye; there were total posterior synechiae and iris adherent to the lens capsule; vision = 6/60, c. = 1.25 cyl. axis horizontal. Glasses for reading and distance were ordered. During 1894 and 1895 the patient remained free from iritis. Towards the end of 1895 and in the first week of January, 1896, he had a few posterior synechiae, with a nodular pupil which strongly resisted the action of mydriatics, with much ciliary and conjunctival congestion. There could with certainty say was gonorrhoeal iritis in a female, that an attenuated virus capable of infecting which causes no inconvenience to the person affected by it may exist seems to be proved by cases of purulent ophthalmitis in female children who are found to have a vaginal discharge. It seems that the eyes have been inoculated when the attention has been made. In some of these cases I have the authority of the late Dr. J. W. Washbourn and of Dr. J. W. Eyre for saying that gonococci exist both in the conjunctival and vaginal discharges. As further proof I may instance cases of gonococcic iritis, in which I may have no notion of anything being wrong) becoming infected, not with an ordinary gonorrhoea, but by salpingitis, followed in some cases by septic peritonitis. Here it would appear that the virus, though too weak to infect the mucous membranes, is powerful enough to infect that of the fallopian tubes.

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From this time up to October, 1905, he had at least seven attacks, but only two of them were severe, the earliest of which was on July 15, and the last one (probably the seventh) on August 17, 1907, when the worst attack I have attended. He had come in commenced and lasted till the middle of October. Up to this attack I had always been able to keep the pupil dilated with caution. I have used atropine, daturine, homatropine, and adrenalin. They are constantly ordered to be used frequently in cases where pain is a marked symptom or where there is increase of tension. They are positively harmful, for they cause paralysis of the constitutional treatment I have employed has been intended to extinguish. I have no hesitation in saying that of excluded or occluded pupil and bimed iris its performance is imperative.

Remarks.—Syphilis is responsible for a large number of the lues to which flesh is heir, but I am not certain that gonorrhoea does not run it pretty closely; at any rate, a large amount of misery and suffering may be caused by it beyond the subject of this paper. We have only to look at the multitude of persons blind or partially so from ophthalmia neonatorum and gonorrhoeal opthalmia later in life. Then there are the pain and inconvenience of its initial stage, and if it ended there no particular harm would be done, but it does not. Urethral stricture with all its attendant complications would scarcely exist if it were not for gonorrhoea. Men crippled and incapacitated by gonorrhoeal rheumatism, with women, health ruined from tubal and uterine affections or dying from septicaemia, are a few of the evils which result.

The question must present itself to all well-balanced thoughtful minds. Is it certain that these things? Gonorrhoea and syphilis are prevalent and can be stamped out. Why is this not done? It is from motives of morality, in this case synonymous with hypocrisy, cant, false modesty, fear of interference with the liberty of the subject, or what? Whatever may be the cause the fact remains that men and women are allowed to go about will suffering from highly contagious and easily communicable diseases without let or hindrance and this in an age when preventive medicine is so well understood and prevented and I would suggest that, as a beginning to the attainment of this much-to-be-desired object, gonorrhoea and syphilis, whether occurring in men or women, should be placed on the schedule of notifiable diseases.

Brook-street, W.

THE INFLUENZA BACILLUS AS A CAUSE OF FATAL ENDOCARDITIS AFTER EIGHT YEARS? (AN INFLUENZA CARRIER?)

B. FREDK. J. SMITH, M.D., Oxon., F.R.C.P. Lond., Physician to the London Hospital.

To Mr. Candy, the ward clerk to the case, I am indebted for the following details of the patient and his last illness.

A man, aged 45 years, married, was admitted to the London Hospital on Dec. 2nd, 1907, in a condition supposed to be a relapse from typhoid of the subject, or what? Whatever may be the cause the fact remains that men and women are allowed to go about will suffering from highly contagious and easily communicable diseases without let or hindrance and this in an age when preventive medicine is so well understood and prevented and I would suggest that, as a beginning to the attainment of this much-to-be-desired object, gonorrhoea and syphilis, whether occurring in men or women, should be placed on the schedule of notifiable diseases.

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