opinion, it is therefore obvious, exists as to the nature of this discharge, the presence of seminal elements being denied on the one hand and affirmed on the other. Some years ago, in writing on this subject,³ I expressed the conviction that while in the majority of instances the secretion was entirely from the prostate, yet that facts were wanting to prove that involuntary seminal emission did not so occur, and, indeed, that my experience proved the contrary. Further observation entirely confirms me in this opinion. It seems to me immaterial whether the discharge be called prostaticorrhœa or spermatorrhœa (and if the presence or absence of spermatozoa is to regulate the nomenclature, the microscope will at once determine this), the main question being, whether this is a normal condition, whether it is injurious to health, its causes, and how to remedy it. I do not think it will be maintained that this is a normal condition; neither will it, I suppose, be denied that a constant drain of seminal fluid from the urethra is likely prejudicially to affect the health. In the following cases of prostaticorrhœa two groups are recognisable; in the one spermatozoa existed in the discharge, in the other these elements were absent; while the apparent causes were various, and bore out the propositions enunciated at the outset of these remarks.

Case 1 came under my notice in October, 1880. I have but few notes of this case, being that of a third-year's student of medicine. Patient complained of a frequent discharge of tenacious matter from the urethra during defecation. He felt confident that his health suffered, and he desired my opinion as to the nature of the discharge. Examination of the urethra revealed a certain amount of prostatic tenderness, and the microscope the abundant presence of spermatozoa in the discharge as represented in the subjoined diagram.

FIG. 1.

I advised the passing of a full-sized metallic instrument twice a week, and tonic treatment, requesting that I should be informed if the result were not satisfactory. Not having seen the patient subsequently, nor having heard from him, I infer that his ailment disappeared.

(To be concluded.)

THE TREATMENT OF GONORRHOEAL OPHTHALMIA.

By CHARLES BADER,
OPHTHALMIC SURGEON TO GUY'S HOSPITAL.

THE uniformly favourable success of this new treatment, and the serious nature of the disease, will, I hope, justify the publication of the following cases, which have occurred in the present year. See also THE LANCET for May, 1880.

CASE 1.—Miss S—, aged eight, when seen on Jan. 21st with Dr. Harrer, of Artillery-place, Finsbury-square, suffered from gonorrhœal ophthalmia (fifth day) of the right eye, probably through a servant with gonorrhœa using a towel in the child's room. The anæsthetic was necessary for examination, the child being most troublesome; this Dr. Harrer had to repeat each time when injecting the ointment.

³ On the Functional Diseases of the Urinary and Reproductive Organs. Second edition. J. & A. Churchill, London.

The purulent discharge, redness, and swelling of the lids were very great, and even under the anæsthetic only a glimpse of the lower margin of the opaque cornea was obtained. Similar examination on Jan. 24th and Feb. 7th showed the lower third of the cornea opaque. The ointment was injected once daily, and the eyelids kept bound with lint smeared over with it, changing the lint several times during the day. The left eye, which remained unaffected, was only bound up with lint and ointment, taking care to attend to this eye before the other was touched. The injection of the ointment was discontinued on Feb. 7th, when the lids opened sufficiently to see the entire cornea. When the child was seen in March, the surface of the cornea was smooth, and the opacity reduced to a small nebula.

CASE 2.—Mrs. E. B—, aged thirty-four, was admitted into the eye ward of Guy's Hospital on March 3rd, with gonorrhœal ophthalmia of both eyes. The lids of the right eye were too much swollen to admit of a view of the cornea; that of the left eye, on raising the red drooping swollen lid, was found to be transparent. The sister of the ward injected the ointment at 9 A.M. and 4 P.M. daily; both eyes were kept bound up with lint thickly covered with ointment; fresh lint was applied after each injection.—March 14th: Injection of the ointment at 9 A.M. only; the lids open fairly; the lower margin of the right cornea is opaque.—21st: Discharged. Advised to smear some of the ointment among the eyelashes at bedtime.—April 4th: All discharge ceased; right corneal opacity barely noticeable.

CASE 3.—Mr. H—, aged twenty, when seen on April 26th, 1882, with Dr. Blades of Kennington-park-road, was suffering from gonorrhœa and from gonorrhœal ophthalmia of the left eye. No inspection of the cornea was possible, the swelling and tension of the eyelids being too great; there was much purulent discharge, pain, and intolerance of light. Right eye not affected. Dr. Blades injected the ointment daily (about 11 and 4 o'clock) beneath the upper eyelid of the left eye; both eyes were kept bound up with lint and ointment.—April 30th: Less pus and swelling; eyelids of a dark blue-red hue; the lower part of the cornea, as far as visible, opaque. On receiving a telegram the next day that the right eye was also inflamed and discharging, I replied, "Inject both eyes." Five days later the discharge from the last attacked eye had greatly subsided. As the lids opened and discharge and swelling became less, the injection was made once daily, but the bandage with lint and ointment was continued. On May 25th the ointment was discontinued and weak alum lotion used for bathing. In July I saw the patient: both corneæ were clear, and the eyes well in all respects.

Remarks.—The ointment consists of one grain of the red oxide of mercury (supposed to destroy the contagious matter), of one-fifth of a grain of daturin or atropin (to combat iris complications), and of one ounce of vaseline (as the best vehicle to touch and saturate the entire surface of the conjunctiva with the remedies). In no case, however great the

swelling of the eyelids and conjunctiva, has any difficulty been experienced in injecting the ointment. For injection a small glass syringe, figured above, is used (made by Messrs. Krohne and Sesemann) with a flat nozzle, to pass readily beneath the margin of the upper eyelid. The ointment, passing beneath the margin of the upper eyelid, escapes, generally with some pus, at the inner canthus. About two drachms of the ointment suffice for one injection. No pain whatever is felt when manipulating gently.

At a meeting of the Medico-Chirurgical Society of Glasgow, held on the 6th inst. in the Faculty Hall, St. Vincent-street, the following gentlemen were elected office-bearers for the session 1882-83:—President: Dr. W. T. Gairdner. Vice-Presidents: Drs. Robert Grieve and Alex. Robertson. Council: Drs. George Mather, H. C. Cameron, Robert Forrest, Lapraik, D. Maclean, J. C. Woodburn, Wm. Whitelaw (Kirkintilloch), W. A. Wilson (Greenock). Secretaries: Drs. W. L. Reid, and J. W. Anderson. Treasurer: Dr. Hugh Thomson.