The iodate of iron may be given in the form of bolus, electuary, powder, lozenge, or pill—the last form is probably the best, except, of course, in the case of children. The dose is from two to five grains. It may be used wherever iodide of iron is indicated, but it partakes somewhat more of the character of a ferruginous preparation than the iodide—a feature which may in many cases prove desirable rather than the reverse. A two-grain dose of ferric iodate may be given in a three grain pill. I have some pills each composed of two grains of the iodate and one of extract of gentian, which were prepared a month ago. They have undergone no change since their preparation.

ART. XXI.—*The Treatment of Gonorrhea by an Improved Continuous Injector.* By Mr. MORGAN, F.R.C.S.I.; Surgeon to Mercer's Hospital and to the Westmoreland Lock Hospital; Professor of Surgical and Descriptive Anatomy R.C.S.I.

THE practical difficulty of thoroughly applying a medicated solution to the male urethra has been frequently recognized by practitioners, and has led to many differences of opinion as to the absolute value of injections as ordinarily applied—some believing that they attain much more fully the deeper parts, and others, again, that it is sufficient to reach the first two inches, or the “specific region” of the canal.

The superior efficiency, however, of injections that fill the urethra and reach to the deeper parts, is generally admitted, and the experience of continental and other surgeons confirm this view.

The few instances of *post mortem* examinations that have occurred prove the inflammation to have extended deeply down the canal; thus Rokitansky gives as the pathological change, “that not only the fossa navicularis but every point as far as the prostatic portion, and specially the vicinity of the bulb, is liable to become diseased.” Sir H. Thompson, from *post mortem* observations, found “unusual vascularity at the bulb and fossa navicularis.”

The result of deep urethral injections have, in the hands of Bonnet, Diday, Bumstead, &c., proved the most successful, the chief method of applying them being by means of catheter-pipes attached to the syringe, Tiemann's “universal syringe” being that generally used and most applicable. In the using of this syringe, however, or, indeed, of any other, I have found inconveniences; and I think it will be admitted that, with timid and nervous

patients particularly, there is great difficulty, and that many who have just been the subjects of gonorrhea will not allow or bear the introduction of an instrument of any length into the passage when in a state of irritation.

I believe that the failure and uncertainty of most injections arises not so much from their composition as from their insufficient application and non-diffusion over the surface; and also that the frequent and large use of a diluted and weak injection is better than the more limited application of a stronger one. To carry out the latter object I have put together an arrangement for applying a diluted application to the deep parts of the urethra, using the principle of the chemical "wash-bottle" as the injecting force.

The injection-point is made rather abruptly tapered so as to plug the orifice with tolerable ease. The patient's hands are both left free, the one to hold and support the penis, the other to introduce and keep steady the injection-point. The mouth-piece leading to the bottle is to be held between the teeth, and by blowing more or less energetically, a continuous injection can be attained. The more fully the injection-point is introduced, so as to fill the orifice, the more deeply will the application penetrate by the filling of the urethra. The bottle holds about two ounces, which I find the most convenient and useful quantity for use. In the acuter stages, great relief can be given by the use of this application in introducing sedative solutions, such as $\text{℥ss. vel. } \text{ʒi. tinct. opii ad. } \text{ʒi. aquæ}$, or the ext. opii aquosi, $\text{gr. i. ad. } \text{ʒi. aquæ}$, which answers even better; the solution should be previously warmed by letting the bottle stand in hot water, and this may be used three or four times a day.

After the first few days I have found the bisulphite of lime solution (prepared by Medlock and Bailey) as the most useful medicament, added, according to the sensations of the patient, $\text{ʒi. vel. } \text{ʒii. ad } \text{ʒi. aquæ}$; it seems to influence specially the virulence and quantity of the discharge.

If any of the ordinary ingredients in use be preferred, such as sulphate of zinc, tannin, &c., they should be applied in very dilute form, chiefly to be regulated by the sensibility of the urethra and the feelings of the patient, as a large surface is brought under the influence of the application by the full and gentle distension of the urethra by this means.

In spermatorrhea, also, I have found the application of a sedative solution of $\text{tinct. opii } \text{℥ss. ad. } \text{ʒi. aquæ}$, used night and morning as

most efficacious in allaying hypersensibility, unless in such rare and severe cases as require the application of strong local applications by the *porte caustique*, or sponge.

Notwithstanding the frequency of the affection in the male, the following *Abstract of Cases under Treatment in the Westmoreland Lock Hospital for the Half-year ending December 31, 1868*, will show how seldom women are compelled to seek admission to hospital for uncomplicated gonorrhea.

One hundred and ninety-six venereal patients have been under my observation and treatment during the past half-year; 104 of these were suffering from sores on the genitals, with or without bubo or constitutional signs.

26	were admitted who never were before diseased.
21	„ who were once diseased previously.
16	„ „ twice „
6	„ „ three times „
8	„ „ four times diseased previously.
6	„ „ five times „
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83	

Five were uncertain, and had suffered mostly from gonorrhea.

Notwithstanding the difficulty of securing reliable data as to the occurrence of primary disease, I have, after not a little trouble, obtained the following tolerably accurate information as to the length of time during which several, the subjects of genital sores in a *virulent* form, have *admitted* they led an irregular life while suffering from the disease, even up to a period of three months previous to entering hospital.

13	cases existed before admission	.	.	1 week
14	„ „	.	.	2 „
5	„ „	.	.	3 „
9	„ „	.	.	4 „
2	„ „	.	.	5 „
2	„ „	.	.	6 „
4	„ „	.	.	8 „
3	„ „	.	.	12 „
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52, total.

The cases where the genital sores have existed for *over three months*, while leading an unvirtuous life, have not been infrequent.

In 3 cases the sore had existed	.	.	4 months
" 3 "	"	.	5 "
" 1 "	"	.	10 "
" 1 "	"	.	11 "
" 1 "	"	.	13 "
" 1 "	"	.	14 "
" 1 "	"	.	16 "
" 1 "	"	.	17 "
" 2 "	"	.	18 "
" 1 "	"	.	20 "
" 1 "	"	.	36 "

16, total.

These had assumed more or less the character of chronicity; they were not auto-inoculable, but of great extent and slow in their progress; there may be some question as to their special power of contagion; if they are contagious the mischief done is incalculable, and shows how disease may pervade the community at large.

The following table represents the periods during which the patients admitted they had been leading an irregular life, previous to their admission to the hospital as diseased.

For 1 month	.	.	3 cases	For 7 years	.	.	7 cases
" 2 "	.	.	1 "	" 8 "	.	.	5 "
" 3 "	.	.	5 "	" 9 "	.	.	2 "
" 4 "	.	.	2 "	" 10 "	.	.	6 "
" 5 "	.	.	1 "	" 12 "	.	.	1 "
" 6 "	.	.	6 "	" 13 "	.	.	1 "
" 9 "	.	.	5 "	" 14 "	.	.	1 "
" 12 "	.	.	8 "	" 15 "	.	.	1 "
" 18 "	.	.	12 "	" 16 "	.	.	1 "
" 2 years	.	.	4 "	" 17 "	.	.	2 "
" 3 "	.	.	8 "	" 20 "	.	.	1 "
" 4 "	.	.	7 "	" 25 "	.	.	1 "
" 5 "	.	.	9 "				
" 6 "	.	.	4 "				
				104			

Of these several had been diseased on previous occasions.

The cases admitted suffering from genital ulcers for the *first* time were 26 in number—mostly young girls, robust and otherwise healthy, aged from 15 to 23 years—the sores were, as a rule, non-indurated; the glands in the groin did not often suppurate, but were frequently swollen and painful on one side only:—

5	cases	were	followed	by	mucous	patches	only	
1	"	"	"	"				and laryngeal ulcer
3	"	"	"	"	papular	and	patches	
3	"	"	"	"	mucous	patch		
1	"	"	"	"	bubo	and	patch	
2	"	"	"	"	papular	eruption	only	
2	"	"	"	"	secondary	ulcers		
1	"	"	"	"	pains	and	ulcers	of fauces
1	followed	by	papular	and	severe	pains		
1	"	"	"	"	and	patch	of	fauces
1	"	"	"	"	and	erythema	of	throat
1	"	"	"	"	bubo	and	inoculated	sore
2	"	"	"	"	iritis	and	pains	
1	"	"	"	"	roseolar	only		
<hr/>								
25								

There is but one case which has not as yet shown constitutional symptoms.

General Tabulation of Cases under Treatment, not including Primary Sores:—

Papular eruptions,	.	.	.	.	10	cases
Papular and roseolar, mixed,	.	.	.	.	4	"
Ecthyma,	.	.	.	.	4	"
" Patches " of anus and genitals,	.	.	.	.	14	"
Syphilitic maculæ,	.	.	.	.	1	"
Tubercular eruption,	.	.	.	.	2	"
Iritis of one eye,	.	.	.	.	3	"
Do. of both eyes,	.	.	.	.	1	"
Pemphigus,	.	.	.	.	2	"
Anal fissures (severe),	.	.	.	.	1	"
Rupia,	.	.	.	.	2	"
Secondary ulcers,	.	.	.	.	4	"
Myringitis,	.	.	.	.	2	"
Ulcers of the mouth,	.	.	.	.	2	"
Ulcers (deep) of the tongue,	.	.	.	.	4	"
Extensive sloughing ulcer of pharynx,	.	.	.	.	2	"

Ulcerations of the larynx, . . .	7 cases.
Extensive ulceration of the rectum, . . .	2 „
Severe syphilitic pains, . . .	5 „
Large gummata, . . .	3 „
Gumma on the heart, . . .	1 „
Incidental abscesses, . . .	5 „
Prolapsus uteri and vagina, . . .	3 „
Urethra destroyed by ulceration, . . .	3 „
Nodes and Exfoliations, . . .	5 „

The comparative frequency of these manifestations where the subjects of them have been affected several times by genital sore, in contrast with the preceding table, where they have been but once the recipients, is interesting. The formation of patches and the development of the papular eruption being the earlier and more frequent evidences of constitutional infection. Several of these cases were the subjects also of gonorrhea, complicated with ovarian irritation, with abscess of the labium, or suppurating bubo.

ART. XXII.—*Disease of the Knee-Joint—Amputation—Recovery.*
By R. TUTHILL MASSY, M.D., L.R.C.S.I.

A GENTLEMAN aged twenty-three, when about five years old complained of pain in the knee-joint, which increased on motion, and gave evidence of what is usually called white swelling. He was treated for some time at a hydropathic establishment at Great Malvern without any benefit. Afterwards he had the usual starch bandage and iodine treatment at home. Lastly, he was placed under the care of a female rubber at Southport, in Lancashire, who took the case and promised, as all such persons do, “a cure” from her treatment by friction, &c., &c.

Much was not permanently expected, for by the father’s side there is some delicacy in the family. One of his aunts has disease of the bones in her fingers quite incurable, except by removal, which she would not submit to. His eldest brother died of acute diabetes at about the age of twelve.

After five or six years of ineffectual treatment in the case before us, amputation was decided on, but the surgeon at the last moment declined the operation, thinking there was some lung disease, although I had previously pronounced the lungs healthy, but has since said he feared the diseased bone was extending