Finally, there is the question of mortality. Here the results are:

	Deaths.
Operation	5
Non-operation	0

Two of these deaths immediately followed the operation. The absence of deaths among the non-operation cases is noteworthy, seeing that haemorrhage occurred fairly often. Probably this immunity can be accounted for by the peculiarly favoured position of medical men, as mentioned above, which ensures them prompt diagnosis and treatment.

To sum up, the special value of these figures extracted from the registers of the Medical Society is that, though they represent a relatively small series of cases, they are a business, and therefore impartial, record of the after-histories of the cases. They show that duodenal ulceration entails long periods of sickness, and, though not often mortal, is very liable to recur even after many years; but that the majority of cases recover after one attack, and remain free from relapses. The figures give no support to the claims to greater effectiveness of either surgical or medical treatment; on the contrary, they show that the results of the two methods leave little to choose between them.

From an actuarial point of view it becomes necessary to regard proposals for sickness insurance, where there is a history suggestive of duodenal trouble, as highly unfavourable. Such cases should be rejected as uninsurable, though in proposals for life assurance the risk is less.

GONORRHOEAL IRITIS.

BY

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THE object of this short paper on gonorrhoeal iritis is to point out that, with correct and adequate treatment, not only can the disease in most cases be permanently cured, but, by clearly understanding its origin, entirely prevented.

The iris may be the only organ in the eye involved, but in the more intense cases the uveal tract, which includes the ciliary body and the choroid, and even the optic disc, may show signs of inflammation. The infection is endogenous, reaching the eye by the blood stream, but whether toxic or due to the direct action of the gonococcus has not been determined. The gonococcus has only once been isolated from the aqueous humour of the eyes and then only in a case of gonorrhoeal septicaemia; still I think that a disease of the eye which so constantly occurs with untreated or improperly treated gonorrhoea, and is so rapidly cured with the appropriate venereal treatment, can be definitely ascribed to this venereal disease.

According to some authors 8 and to others 20 per cent. of all cases of iritis are due to gonorrhoea. These statistics include the male and the female, but so convinced am I that if the cases occurring in the male subject alone be taken the percentage would be very much higher, that I never treat iritis in the male without carefully considering a gonorrhoeal history. Syphilis is, of course, a cause of iritis, but in my experience it falls very far behind gonorrhoea in the frequency with which it produces iritis in the male, and differs very considerably clinically from the gonorrhoeal variety.

Gonorrhoeal iritis is never seen during the acute stage of the urethritis; it may make its appearance some months after the gonorrhoeal infection or may be delayed for years. Only a few weeks ago I saw a patient who consulted me for an acute attack of iritis; he had had three previous attacks within the last three years, had received appropriate local treatment to the eye, but no attempt had been made to elicit a history of gonorrhoea, which I found, on questioning, he had contracted sixteen years ago. Dr. Kingston, to whom I referred him for opinion, found the gonococcus in the fluid expressed from the prostate, and this patient is now receiving appropriate venereal treatment. The Wasser-

mann reaction was negative, and I have no doubt that this is a case of gonorrhoeal iritis, which would have continued to recur had the venereal infection not been looked for. That sixteen years should have elapsed between the one and only attack of gonorrhoea and the appearance of the iritis is nothing extraordinary. How long the gonococcus can remain active in the posterior genito-urinary organs of the male is difficult to say, but it has certainly been discovered after a lapse of twenty-seven years, and now that more careful attention is being paid to its activities, and its presence more often sought for, I expect that even this long duration will be exceeded.

Gonorrhoeal iritis has certain definite characteristics, the most important being its tendency to recur. The term "recurrent iritis" is unfortunate, as if the venereal disease had been properly treated in the first place no iritis at all would have occurred, and if the first attack had been correctly diagnosed and adequate venereal treatment carried out the first attack would have been the last from this cause. I would emphasize the importance of regarding with suspicion all cases of recurrent iritis in the male and of endeavouring to persuade the patients to undergo a venereal examination.

The actual attack of iritis often differs but little from that produced by other causes, but is usually very severe, with considerable pain; its duration varies from a week or ten days to a month or more; it is often of a plastic nature, and this fibrinous exudate may be of such a degree that practically the whole of the anterior chamber is filled with a fibrous mass often greenish in colour; when this occurs it is said to be pathognomonic of gonorrhoeal infection, but its occurrence is far too rare to be relied on for a definite diagnosis. In those eyes in which a recurrence has taken place it is typical of a gonorrhoeal infection that, in the early recurrences, very little ocular damage has been done, and it is often only by careful examination that the results of a previous attack are demonstrated; in many cases nothing remains but one or two fine posterior synechiae binding the iris to the anterior capsule of the lens, and then often only seen on artificial dilatation of the pupil; but the damage, though slight at first, is constantly being added to by the recurrences, until in the later stages vision is very materially reduced.

In the differential diagnosis syphilis, rheumatism, tubercle, and sepsis must be considered.

In syphilis the iritis is, in the majority of cases, characteristic; it is either a secondary or tertiary manifestation, and does not show that pathognomonic symptom of the gonorrhoeal variety, for recurrences are not observed. If the attack occurs during the secondary period, if once recovery ensues, no other attack will occur until the tertiary period. Definite yellowish-red nodules, about the size of a pin's head, will be seen in many cases. These may be looked upon as papules or condylomata in the secondary stage, and in the tertiary as gummata. The attack lasts longer than the gonorrhoeal variety and leaves very marked evidence behind. The Wassermann test helps, but a positive reaction is not sufficient to exclude gonorrhoea. I have seen cases in which the original iritis was undoubtedly syphilitic and was cured by appropriate treatment, but in which later recurrent iritis was gonorrhoeal, though its origin was quite unsuspected and it was attributed to the original attack of syphilis.

It is to the condition known as "rheumatic iritis" that the gonococcus owes its long and undisturbed life in the past, for we now know positively that the vast majority of these cases occurring in the male are undoubtedly gonorrhoeal in origin. In the present state of knowledge it cannot be denied that rheumatic iritis does exist, yet I do not think many years will elapse before we can show that it is a comparatively rare affection and that gonorrhoea is responsible for most of the cases. It is, I think, a mistake to look for definite characteristics with gonorrhoeal rheumatism; it is true that certain joints tend to be affected, such as the knees, but in most of the cases that have come under my care for the ocular lesions, if they have had rheumatism at all it has been of a very vague character, not attacking any joints in particular and having a tendency to wander.

Most textbooks on eye diseases state that gonorrhoeal

iritis is always preceded or accompanied by articular pains. I am convinced that this is not correct; there is little reason why it should be when we consider that only about 2 per cent. of all cases of gonorrhoea develop this complication.

Tuberculous iritis can usually be diagnosed from gonorrhoeal without difficulty by its occurrence in younger subjects, the presence of tubercles on the iris, the very considerable damage done to the eye, the absence of true recurrences, and the diagnostic tuberculin tests.

The so-called septic iritis due to an endogenous septic infection may closely simulate the gonorrhoeal variety. Recurrences are frequent and the condition of the iris may give no clue as to the cause. The damage to the eye is greater than in the gonorrhoeal variety and rheumatism may occur. It must not be forgotten that thorough investigation is necessary in these cases, and that the gonococcus may be at the root of the matter.

Although a venereal history and a careful and accurate inspection of the eye will give us valuable assistance, yet it is to the genito-urinary organs that we must turn for a definite diagnosis, and it must be remembered that the absence of a urethral discharge cannot be relied upon to exclude gonorrhoeal infection, nor does the absence of threads in the urine preclude this disease. With the absence of discharge and a clear urine many of us have in the past given the patient a clean bill of health so far as gonorrhoea is concerned. But we now know that it is to the prostate and seminal vesicles and the fluid contained therein that our attention should be chiefly directed, for I believe that gonorrhoeal iritis rarely if ever occurs apart from an infection of these organs, and I do not consider that a case has been properly investigated until the prostate has been expressed and the fluid carefully examined microscopically. It is, of course, an objectionable procedure, but there is no doubt that it is most essential if we are to deal adequately with the type of iritis under discussion.

The microscopical examination in many cases shows either the gonococcus or an involution form, but even where the actual organism is not present and only a few pus cells found the case should be treated as gonorrhoeal. Very little need be said of the ophthalmic treatment of gonorrhoeal iritis, which should be conducted on the usual lines; for the intense pain which occurs in so many of these cases salicylates internally are of great use. The venereal treatment, which is so often omitted, should be handed over to one thoroughly versed in it, for attention must be directed to the posterior urethra, prostate, and seminal vesicles; and unless the treatment is adequate we cannot expect a cure of the iritis, and by a cure I mean the absolute prevention of recurrent iritis—a term of which I hope we shall hear little in the future as we learn more and more to direct our attention to the actual cause.

I have been able to follow up five cases of recurrent iritis for nearly five years. In all the gonococcus was definitely found in the fluid expressed from the prostate and seminal vesicles. The Wassermann reactions were negative. The last attack of gonorrhoea had occurred 4, 5, 9, 10, and 13 years ago; the number of attacks of iritis were 2, 2, 1, 5, and 3 respectively, not including the attack for which the patient was seeking advice. None of these patients had received adequate venereal treatment at the time of the original attack of gonorrhoea and all stated that they had had a gleet for some time after the attack; during the previous attacks of iritis no investigations had been made into the state of the genito-urinary tract, although the iritis had by itself received correct treatment. Two of these patients had had many teeth removed, probably on the assumption that the iritis was septic in origin.

All these patients, after the presence of the gonococcus was confirmed, received appropriate venereal treatment, with the result that no recurrent attack of iritis has taken place during the past four and a half years.

I hope in the future recurrent iritis will not be looked upon as a purely local affection, as in the past, but that an attempt will be made to discover the actual cause, and that in our investigations a chronic gonorrhoeal infection of the prostate and the seminal vesicles will not be overlooked.

A METHOD OF INTUBATING THE OESOPHAGUS FOR MALIGNANT STRICTURE.

BY

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CARCINOMA of the oesophagus is by no means uncommon, and few conditions are more distressing. If left to himself the patient has nothing to look forward to but death by slow starvation, unless a perforation into the mediastinum, the pleura, a bronchus, or perhaps a large blood vessel, cuts matters short. For practical purposes he need have no fear of extension of the growth or of secondary deposits, for these occur late and develop very slowly. The problem of his relief is the purely mechanical one of relieving his obstruction.

The truth of this statement and the urgent nature of these cases have been brought home to me by a series of patients who have recently passed through my hands. Most of them were elderly, some were acutely ill, in none could an extensive operation be contemplated, and in many it was obvious that the simplest surgical procedures involved a grave element of risk. It is characteristic of the condition that after perhaps a long period of dysphagia total obstruction should suddenly occur; and so often does this happen that I have come to regard all cases of dysphagia as urgent, and take every precaution that they do not linger on a waiting list. In spite of this I have several times had to deal with patients who had swallowed absolutely nothing for three or four days, and an elderly man who has been deprived of fluid for four days is in a very dangerous condition.

Theoretically gastrostomy affords a rapid and complete method of relief, but it presents serious drawbacks. In the first place, the mortality is far higher than is generally supposed, owing to the bad condition of these patients, especially where complete obstruction has supervened. In the second place, feeding by a tube is a miserable substitute for eating, and in the case of hospital patients it is rarely practicable for them to obtain and prepare food in the necessary form, whilst the management of the tube is often quite beyond them. And finally, not only can they not chew their food, but they cannot swallow their saliva.

Treatment of oesophageal conditions has been revolutionized by the oesophagoscope. It is now possible to see carcinomatous strictures by direct vision and to dilate them with a reasonable degree of safety. A passage having been formed, it is possible to maintain it by passing bougies at regular intervals, but this is troublesome and somewhat risky. Progress has therefore been directed along the lines of maintaining the lumen so formed, and of the methods used none have been more successful than Symonds's tubes and Hill's probe.

The former is a gum-elastic tube with a conical upper end which prevents its sliding completely through the stricture, and it is customary to tether it with a silk thread brought out through the mouth and fastened round the ear. The object of this is the periodical removal of the tube, which tends to become very foul and to block if left in long without cleaning. Hill's probe is of silver wire covered by a fine rubber tube, brought out of the mouth in the same manner and acting as a permanent dilator alongside which food can pass through the stricture.

It occurred to me that it ought to be possible to devise a flexible metal tube which could be passed through the stricture and maintain the lumen, and that as such a tube ought not to become foul it need never be removed. After several experiments I have adopted a simple close spiral of German-silver wire, expanded at the upper end. It is extremely flexible, absolutely incompressible, is very light, and occupies very little room. Food does not tend to cling to it, and it therefore does not become foul. The metal turns black, but this can be prevented by gilding. It appears to be possible to leave these tubes in position indefinitely, and they do not show any tendency to ulcerate through the oesophageal wall. The tube simply canalizes