In regard to Dr. Hepburn's paper, I am also very much interested in the subject he has spoken on. I do not feel that there is any particular risk in inserting a glass ball, nor do I fear that it will come out. I have operated on about fifty of these cases, using the glass ball and have only had one case in which the ball came out, six weeks after operation, and one following secondary infection a year after the operation, and one case in which it was removed on account of irritation.

As I understand it, in the injections of paraffin to restore deformed parts, the paraffin is finally replaced by connective tissue and I presume the same thing would take place if we inserted a paraffin ball into the sclerotic. I would think that the constant pressure of the glass eye upon the sclerotic would cause absorption of this connective tissue, for in some of the cases in which the Mules operation has been performed and a glass ball inserted we find considerable shrinking afterwards from absorption of the tissues pressed upon by the prothesis, and it is necessary to gradually increase the size of the glass eye to make up for this absorption.

DR. WEEKS—The object that I have tried to attain in introducing a graft made as I have described is fixation of the flap—or attachment of the flap to some fixed point. The periosteum is the fixed tissue to which I attempt to attach the lower portion of the folded flap. It is, in my opinion, absolutely necessary that some such attachment be made in order to secure a permanent cul-de-sac. In regard to the operation that Dr. Wood has spoken of, as the Doctor says, it would hardly apply to cases where the destruction of conjunctiva is so great as in the cases on which I have operated. In one case the area of conjunctiva was only 5 by 10 mm. Such an operation as splitting from canthus to canthus would not succeed in such a case as that. In regard to the use of paraffin rather than a shield of rubber, I would say, that in these cases after the flap is fixed in position the epithelial surfaces are in apposition and if you should place paraffin between them in a liquid form it would be reduced to so thin a film that it would do no good in maintaining the form of the sac. If paraffin were introduced it would have to be in the solid form and since it requires some little force to introduce the shield the paraffin would be too friable to effect the result desired.

DR. HEPBURN—I only want to say a word in regard to the absorption of paraffin spoken of by Dr. Todd. The conditions where paraffin is injected soft into tissues for the correction of deformity are different. These balls are held in position by the sclerotic which has very little absorbing power, to say the least. The method has not been used long enough, however, to subject them to clinical observation. The difficulty of having the Mules balls come out has been due to the use of too large a ball. We are now using smaller ones and allowing for contraction of the sclerotic. Some time ago the Mules operation was very fashionable on the Continent and in Great Britain. Suddenly they dropped it, and the reason given was that the balls caused considerable irritation, and it was dropped to some extent here about the same time, and for a number of years only a very few operations of that sort were done. Of late years, however, it has been resurrected and in the last four or five years I have seen seventy or eighty cases, and I think we are doing the operation better because we choose our cases better, where there is no risk of sympathetic irritation, and we are not using too large a ball.

The Word "Appendicitis."—The accounts of the case of the British king have led to some remarks upon the frequency with which the term "perityphlitis" is used in Great Britain to designate the morbid condition which in this country is almost universally called "appendicitis." Those who detest hybrids—and we confess ourselves among the number—dislike the last-mentioned term, but the purists would not accept "ecphyaditis," which was proposed several years ago by Dr. Lewis A. Stimson. As for "epityphlitis," it does not seem to strike the profession at large as sufficiently definite. So we fear that "appendicitis" has "come to stay."—*N. Y. Medical Journal.*

DESCRIPTION OF A NEW ANOPHELES.

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In carrying on the work on the mosquitoes of the Philippine Islands lately begun in connection with the study of tropical diseases by the Medical Department, U. S. A.,* some very interesting points have already developed. The *Stegomyia fasciata*, Fabricius, has been sent in from nearly every post where collections have been made, and five species of anopheles, one of which—a new species—is described below, were collected between Sept. 1 and Oct. 5, 1901. *Culex fatigans* Weid. is of course common and another mosquito which the English surgeons have in the last year proven a carrier of the embryo of *filaria nocturna, Panoplites* (*Mansonia*) *Africanus*, Theobald, was taken in large numbers in and near Manila.

ANOPHELES PHILIPPINENSIS.—*Ludlow.*

FEMALE: *Head* very dark brown, with white creamy (yellowish) scales scattered on top, and more thickly toward the front, long white tuft in front, a few yellowish scales on the sides, and very dark forked scales with fimbriated tops on the occiput; antennæ golden brown, some white scales, and some brown at the base with lighter tips; verticles white, pubescence white, first joint basally brown but white at apex; eyes dark brown or black, with very narrow white rim; palpi golden brown, some scales apparently darker tipped, the last joint white and a narrow white band at apex of each of the three preceding joints, a few white scales at the base; proboscis brown, not so dark as the head but darker than the antennæ, white or yellowish tip.

Thorax very dark brown (both it and the head are almost black) with scattered white flat and yellowish curved scales, no design apparent—cephalad the scales are much longer—scutellum dark brown in the middle and at each end, with a lighter spot between, on which are a few white scales; metanotum dark brown; pleuræ dark brown with white markings; when denuded thorax has ashy-gray reflections with dark brown median line.

Abdomen dorsally is ashy-gray, with golden brown hairs, a narrow brown apical band on each segment, much broader on the last two segments so that they are nearly brown instead of gray.

Legs, coxæ brown, all white tipped, femoræ dark, i. e., brown scaled dorsally, and yellowish on the ventral side, tibiæ same but a very small apical white spot on fore and mid legs; metatarsus and two following joints on the fore legs have heavy apical white bands, the mid legs have faint light bands in the same positions, that on the metatarsus much the heaviest, but still not by any means so broad as on the forelegs; hind legs dorsally brown and yellowish ventrally, much as in the other legs, but the apical half of the first tarsal and all the following joints, pure white; ungues of hind legs light (white), on mid and fore legs brown.

Wings cream colored, spotted with brown, reminding one of A. Jamesii. Theo. Two small and four large brown spots on costa, the distal extending back through anterior fork of second longitudinal; the next, somewhat larger, through first longitudinal; the third and largest of all, extends as a long spot on the costa and sub-costa and three small ones on the first longitudinal, so arranged as to resemble an overturned E (ᵐ), the middle of these is the largest and connects with one on the

* Classification and study of the Geographical Distribution of the Mosquitoes of the Philippine Islands, being done by the authority of the Surgeon-General, under the auspices of and with the assistance of the Medical Department.

second longitudinal; the fourth spot (counting from the apex of the wing) includes the sub-costa and first longitudinal, and even the two small ones include the sub-costa, making all these costal spots very distinct. The apex of the costa is, however, light. There are two dark spots on anterior fork of second longitudinal, and one on the posterior fork; two small spots at the base of the third longitudinal; one on the anterior fork of the fourth longitudinal, a small one near apex of the posterior fork and the stem is dark to posterior cross-vein, and about one-half the way beyond that to the base of the vein; anterior fork of fifth has three dark spots, and there is one on the posterior near the apex, also on the stem of fifth near base of wing; there are three dark spots on the sixth longitudinal, one at the apex, one near the middle and one near the base. A large part of the second and fourth are therefore dark, while the fifth has a large part cream-colored and a still larger proportion of the third is light. The fringe is mostly cream and brown —nearly equally to the sixth longitudinal—after which it is dark. Dark spots occur at the apex of the anterior branch of second longitudinal and at apices of first posterior, second posterior, third posterior, anal, axillary, and spurious cells (Theobald's naming) with light spots at the apices of each intervening vein. The first submarginal cell is a little longer than the second posterior, the base of the former being a little nearer the base of the wing. The posterior cross-vein is about one and one-half times its length nearer the base of the wing than the mid-cross-vein, and the supernumerary a little nearer the apex than the latter.

Length (including proboscis), 5 mm.

Habitat, San [illegible], Luzon, P. I.

Caught Sept. 1, 1901

No pathologic work has been done with this mosquito, so it is not known if the plasmodium develop in it or not.

SIX YEARS IN A DERMATOLOGIC CLINIC.

A REPORT OF SERVICE, WITH REMARKS ON THE TREATMENT OF THE MORE COMMON SKIN DISEASES.*

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CHICAGO.

The subject of this paper is an analysis of the dermatologic cases treated in the years 1896-1901 at the United Hebrew Charities Free Dispensary of Chicago. It is a story of the morbidity of the poor and partly, also, a mirror of their life.

The dispensary is located in the so-called Ghetto district of Chicago, where the chief unsanitary conditions are darkness, lack of air, uncleanliness and poisonous gases. Robert Hunter, in his publication, "Tenement Conditions in Chicago," thus describes the state of affairs in this district:

"Musty, fetid rooms, which can not be ventilated because of brick walls overshadowing the windows, inevitably accumulate in their dark corners dirt, mold and vermin. * * * Emanations from the body and foul air in dwelling and sleeping rooms have no outlet except by thorough ventilation. * * * An average of three persons living in one room with 200.64 cubic feet of air per person to breathe in. * * * Wretchedly clad and poorly nourished, fortunate if they have a basket of slate coal, they crowd together to economize the warmth which their bodies give out. * * * On hot nights it is common to see the people escape from their stifling houses and seek slumber and fresh air, stretched out over the festering contents of the sidewalk garbage box. * * * It will be possible to realize how much there is in all of these conditions to degrade the individual. Surrounded by foul conditions the people almost lose their desire for cleanliness. It is almost impossible for an individual to keep free from the filth of the streets and alleys, the yards, courts and passageways."

No wonder that the skin diseases of these unfortunate people are mostly of parasitic origin, the parasites belonging to every kingdom of God's wide world, human, animal and vegetable.

It has seemed to me worth while to classify all the cases which I treated during the six years, arranging them into groups of five years up to the age of twenty, and of ten years each above that age.

TABLE OF CASES TREATED AT THE DERMATOLOGICAL DEPARTMENT OF THE UNITED HEBREW CHARITIES FREE DISPENSARY FOR THE YEARS 1896-1901.

Age.	0-5		5-10		10-15		15-20		20-30		30-40		40-50		50-60		Over 60		Total.		Grand Total.
Sex...	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	
Acne & comedo.	.	.	.	.	2	5	30	42	9	13	1	6	.	.	.	.	.	.	42	69	111
Alopecia	.	.	.	.	.	.	2	3	3	2	.	.	.	.	.	.	.	.	5	5	10
Alopecia areata	.	.	2	1	1	1	.	.	2	1	.	.	.	.	.	.	.	.	5	3	8
Bromidrosis	.	.	.	.	.	.	1	.	1	1	.	.	.	.	.	.	.	.	2	1	3
Callositas	.	.	.	.	.	.	.	1	2	1	.	.	.	.	.	.	.	.	2	2	4
Chloasma	.	.	.	.	.	.	.	.	2	.	.	.	.	.	.	.	.	.	2	.	2
Combustio	12	4	10	3	2	.	1	3	1	1	2	.	.	.	.	.	.	.	26	15	39
Dermat. herp.	.	.	.	2	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	3	3
" medicam.	.	.	.	1	.	1	1	.	.	1	.	.	.	.	.	.	.	.	1	2	3
" venenata.	.	.	.	.	.	.	1	.	.	.	.	.	.	.	1	.	.	.	1	.	1
" repens.	.	.	.	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	1	.	1
Eczema	139	127	49	53	32	39	25	27	49	56	48	33	28	37	19	23	9	13	396	428	824
" marginat.	.	.	.	.	.	1	3	.	.	.	.	.	5	.	1	.	1	.	11	.	11
Epithelioma	.	.	.	.	.	.	.	.	.	.	.	.	.	1	.	1	2	.	2	2	4
Erysipelas	.	.	.	.	1	.	1	1	2	1	3	.	.	1	1	.	.	.	8	3	11
Erythema multi.	1	1	1	.	1	2	1	1	1	2	.	.	1	1	.	.	.	.	6	7	13
" nodos	.	.	2	.	1	.	.	.	.	.	.	.	.	.	.	.	.	.	3	1	4
Fibroma	.	.	.	.	.	.	2	.	1	.	.	.	.	.	.	.	.	.	3	.	3
Furunculus	2	3	1	2	.	1	4	3	1	3	5	5	1	2	.	.	2	1	12	20	32
Herpes simpl.	.	.	.	.	1	3	1	1	1	2	.	.	.	.	.	.	.	.	3	6	9
" zoster.	.	1	1	2	.	.	2	1	2	.	1	.	.	.	.	.	.	.	6	4	10
Herpes tonsur. maculos	.	.	.	.	1	.	1	2	1	.	1	1	.	.	.	.	.	.	4	3	7
Hyperidrosis	.	.	1	.	1	1	2	2	1	1	.	.	2	1	1	.	1	.	7	7	14
Ichthyosis	.	.	2	1	.	.	1	.	1	.	.	.	.	.	.	.	.	.	4	2	6
Impetigo c'ntag	54	51	38	39	9	12	2	3	3	6	4	5	.	.	2	1	.	.	109	127	236
Keloid	.	.	.	.	.	.	.	.	.	.	1	1	.	.	.	.	.	.	1	1	2
Lentigo	.	.	.	.	.	.	.	.	.	.	1	.	.	.	.	.	.	.	1	.	1
Lichen planus	.	.	.	.	1	1	2	.	.	.	.	.	.	.	.	.	.	.	3	1	4
" urticatus	65	58	9	16	.	1	.	1	.	.	2	1	3	1	1	.	.	.	74	97	171
Lupus erythem.	.	.	.	.	.	.	.	.	2	.	.	.	.	.	.	.	.	.	2	.	2
" vulgaris.	.	.	.	.	.	.	1	1	1	2	.	.	.	1	.	.	2	.	3	4	7
Milium	.	.	.	.	.	.	1	1	1	.	2	.	1	.	.	.	.	.	5	1	6
Pediculosis	11	11	10	14	8	9	3	5	.	2	.	.	1	.	.	.	.	.	33	41	74
Pemphigus	2	.	3	1	.	1	.	.	.	.	.	.	.	.	.	.	.	.	5	2	7
Pruritus	2	.	3	5	1	1	4	1	11	9	16	15	10	5	5	4	14	6	71	41	112
Psoriasis	.	2	3	3	2	4	5	3	10	8	6	10	3	6	2	3	5	1	36	38	74
Purpura hemor.	.	.	.	.	.	.	1	.	1	.	.	.	.	.	.	.	.	.	2	.	2
Raynaud's dis.	.	.	1	.	2	.	.	.	.	.	.	.	.	.	.	.	.	.	3	.	3
Rosacea	.	.	.	.	.	.	.	.	.	.	1	.	2	.	.	.	.	.	3	.	3
Scabies	15	12	18	20	24	18	17	12	17	10	14	11	8	7	3	5	2	.	112	96	208
Sudamen	4	6	1	2	2	2	1	.	3	2	4	.	1	.	1	.	.	.	10	21	31
Syphiloderma	.	.	1	.	2	1	2	8	2	3	1	1	.	.	.	.	.	.	11	7	18
Tinea favosa	.	.	7	4	13	5	.	.	.	.	.	.	.	.	.	.	.	.	20	9	29
" tonsurans	4	2	12	9	9	5	2	3	.	2	.	.	.	.	.	.	.	.	30	15	45
" circinata	10	5	5	5	2	6	.	1	1	1	1	2	.	.	.	.	.	.	21	15	36
" sycosis	.	.	.	.	.	.	4	.	8	3	.	.	.	.	.	.	.	.	15	.	15
" versicolor	.	.	.	.	2	3	3	2	6	1	2	.	.	.	.	.	.	.	6	14	20
Urticaria	1	2	6	10	1	2	2	3	3	6	1	.	1	.	1	.	.	.	15	30	45
Ulcus cruris	.	.	.	.	.	.	1	.	1	2	4	.	2	5	6	2	2	3	15	21	36
Vaccinia	5	6	1	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	6	5	11
Varicella	3	4	.	1	1	.	.	.	.	.	.	.	.	.	.	.	.	.	4	6	10
Verruca	.	.	1	1	2	3	1	1	.	.	1	.	.	.	.	.	.	.	5	6	11
Vitiligo	.	.	.	.	1	.	.	.	1	.	.	.	.	.	.	.	.	.	2	.	2
																					2365

Genito-Urinary Diseases.

Gonorrhea	.	.	.	.	2	1	4	32	5	41	4	8	.	4	.	1	.	.	37	15	102
Other genito-urinary dis.	2	.	1	.	.	.	3	.	9	.	10	.	6	.	2	.	5	.	38	.	38
																					2535

There are some interesting and I believe significant generalizations to be made from the observations.

1. Almost all of the cases reported belong to the classes of infectious inflammations or parasitic diseases. Living, as these people are obliged to live, in the narrowest quarters, where privacy is impossible and due

* Read at the Fifty-second Annual Meeting of the Illinois State Medical Society, Quincy, May 22, 1902.