

imprimatur as to his full acquirements and standing. It would only give ten opportunities for proclaiming his qualifications to the public, where there would otherwise have been but one.

There must be a *period of probation*. Nor need we go back to the old custom of debarring physicians from admittance for a length of time. Every one might be admitted as now, and enjoy at once the privileges of the Society, on graduation, but it should be *on probation*; and at the end of the prescribed time, the Censors, or some other authorized body, should declare whether he should be admitted to full fellowship, in view of having given satisfaction during his probation, of "approved practice" and "being of good moral character, *and not otherwise*." This would not abridge any of the privileges now enjoyed by graduates, and would require no modification in the relations of the Society and the Medical Schools, so long as they act up to the expressed conditions for conferring degrees. But if, as has been insinuated far and wide, departures from these conditions have been made, and are to be persisted in, then a separation is indispensable.

This is the best plan we can suggest to meet the existing grand difficulty; and we think the Society should lose no time in putting in train this or some other method of relief.

As to the summary expulsion of all heretics, which we know is strongly advocated by many, that is sooner said than done. It is matter of universal experience how difficult it is to eject a member from any Society. There are always deficiencies of proof, palliations and differences of opinion, which render conviction and harmonious action difficult and rare. This, in a Society which meets but once a year, must necessarily be slow work. At any rate, we believe that it is expedient, *first*, to shut the door, whereby we might exclude ten that would enter while we could eject one, and then the few traitors within could be readily managed, and the business of expulsion would be entered upon with a will, in the prospect that it would avail.

G.

STRABISMUS TREATED BY TENOTOMY AND LIGATURE.

BY J. F. NOYES, M.D., CINCINNATI, OHIO.

[Communicated for the Boston Medical and Surgical Journal.]

MESSRS. EDITORS,—The following case is forwarded to the *JOURNAL*, not because the operation is entirely novel, since it has been often performed in Europe, but as comparatively new in this country, and not likely, therefore, to prove wholly uninteresting to the profession.

Last April, Mrs. Gyld, æt. 33, of Waterville, Me., consulted me while at that place, respecting a very bad congenital squint in the left eye. The eye had been operated upon, she said, by a noted

surgeon in Lowell; but it resulted in no improvement, as the eye remained, immediately after the operation, in the same position as before. I found it so much turned in, that the greater part of the cornea was hidden from view behind the internal canthus. The patient could with difficulty bring the eye into a position directly forward or straight, while the other was closed; but any effort made to carry the eye further outward produced a zig-zag or oscillating, up-and-down motion of the ball, clearly showing an action or contraction of the oblique muscles, while the abductor itself appeared quiescent or inactive.

From the examination thus made, the method of operation judged necessary and resorted to, especially in the manner of using the ligature, was the same as that first practised, if I mistake not, by Dr. Graefe, of Berlin, by whom I first saw it performed. It was as follows.

An incision was made through the conjunctiva, a little more than an eighth of an inch from the verge of the cornea, sufficiently large to introduce a blunt hook. The adductor tendon was raised upon the hook, and with the aid of a curved needle ligated very near to its insertion on the ball, and then divided immediately beyond. Tenotomy of the *abductor* was next made in the same manner, sub-conjunctival. The eye being thus set free, the ligature was carried, turning the eye strongly outward, over a bridge or roller of cloth placed on the temple or outer side of the eye, and secured by adhesive straps. In this position the eye was securely held for more than thirty-six hours, allowing sufficient time for the divided muscles or tendons to re-attach themselves, when the ligature was removed, and the eye remained straight. It healed kindly, and resulted in a permanent cure. Since the above operation was performed, I have met with three other cases requiring the same mode of treatment, and all attended by like good results.

ON THE RECOVERY OF DROWNED PERSONS.

[Communicated for the Boston Medical and Surgical Journal.]

MESSRS. EDITORS,—It has surprised me that no mention is made by Marshall Hall, or Dr. Bell, of any application to the nose in the treatment of persons drowned.

One of the instances of longest submersion followed by recovery, of veritable authority, which I have read of, was by this method. To be sure, other means were not omitted at the same time, such as rubbing, warm blankets, and under these, in contact with the body, dry mustard; still the first signs of life were shown by pouring into the nostrils half a drachm of aromatic spirits of ammonia, and then dipping the feathered part of a quill into *aqua ammoniac*, and thrusting it into the nostril as far as it would go.