

take place. If there are present both forms, the fibrous will be healed while the caseating remains.

The healing of fibrous tuberculosis of the peritoneum by laparotomy is not due to an inflammatory reaction and development of connective tissue, but it is produced by a change in the epithelioid cells—a slow degeneration—which are then resorbed, while at the same time the normal cells and bacteria disappear, so that there finally remains nothing but the pre-existing connective tissue and its bloodvessels.

In caseous tuberculosis the connective-tissue capsule presents the same appearance both before and after operation, and is not thickened. The central caseous mass is thickened and may finally become entirely calcified.

The operation produces a change by which the tuberculous bacteria are killed or weakened or at least hindered from further development.

The protein of the killed or injured bacteria starts a slow degeneration of the epithelioid cells, which forms the basis of the histological degeneration of the tubercle.

The healing of tubercular peritonitis by a simple laparotomy may therefore be explained by the fact that as a result of the operation there is a fairly profuse serous exudate into the peritoneal cavity, which injures or destroys the tubercle bacilli and, under certain conditions, leads to healing through a retrograde metamorphosis.

The Technique of Suprapubic Lithotomy.—The feasibility of immediate suture after the removal of stones by the suprapubic method is discussed at length by STERLIN (*Deut. Zeitsch. für. Chir.*, Band xlv. Heft 3 u. 4), who comes to the conclusion that of cases in which this method of operating is indicated there are very few in which it is possible to secure primary union after immediate suture, and that the best method to pursue is that which he describes, as follows:

The patient is prepared by rendering the bladder so far as possible aseptic, and by two days of purgation. After narcosis the bladder is washed out repeatedly by a 3 per cent. solution of salicylic acid which is slightly warm. There should be great care exercised not to overfill the bladder and cause weakening of its muscular structure by that means. A two- to three-inch incision is made in the median line from the pubes upward, the recti muscles separated, and the left finger inserted, loosening the pre-peritoneal adipose tissue and gradually drawing the fold of perineum upward, as far as is necessary for the extraction of the stone. When possible the finger is allowed to remain while two silk sutures are inserted through the bladder-wall with a Reverdin needle and the bladder opened between them. The stone is now removed in the ordinary manner.

The next step is more difficult. He passes one or two sutures through the bladder-wall, the muscles, and the skin, thus forming a ventrofixation of the bladder. A soft catheter is now passed into the bladder, its tip cut off, a fenestrated drainage-tube passed over the tip, which is then drawn down into the neck of the bladder, while the drainage-tube is fixed by a safety-pin to the margin of the abdominal wound. There is thus secured ample drainage in both directions and a means of washing out the bladder. This washing is carried out twice daily, for the first two weeks, with the salicylic acid

solution mentioned above. The muscles, facia, and skin above the bladder-wound are united by silk sutures, and frequently from the pubes to the drainage-tube as well. The antiseptic dressing is changed twice a day at each washing out of the bladder. The patient should lie upon his side with the head of the bed raised. The fixation-sutures are removed at the end of two or three days and the drainage-tube one or two days later. The catheter remains in, on the average, one week. After its removal the patient has a bath daily, and a second retention-catheter is inserted and allowed to remain till no urine flows from the wound and the patient urinates himself. The washing out of the bladder through the catheter which is inserted late must be done with great care, in order not to rupture the union obtained in the abdomen.

The Antiseptic Value of Iodoform.—The results obtained by LOMRY (*Archiv für klin. Chir.*, 1896, Band xxxv. Heft 4) in a series of experiments conducted upon animals and by bacteriological cultures in natural fluids are in marked contrast to those obtained of late by bacteriologists, and tend to prove that the clinical observation of the value of iodoform as an antiseptic is fully justified, while the experimental bacteriological investigations which have been previously made were of little value.

The results which he obtained are the following:

1. When wounds in dogs or rabbits, which have been previously infected with the staphylococcus or streptococcus pyogenes, are treated the one with iodoform and the other without, it will be seen that the iodoform exerts a beneficial influence upon the wound. It has greater vitality and a better appearance. The leucocytes are at least as numerous and more active, the amount of secretion is decreased, and cicatrization is more rapid.
2. Credit cannot be given to the bacteriologists who declare that iodoform has no antiseptic action. They have attained their results by the use of culture-media which did not dissolve the iodoform. When natural media are used for tests *in vitro* an active antiseptic action is seen.
3. Iodoform decreases the virulence of the staphylococcus and streptococcus pyogenes.
4. The iodoform neutralizes or counteracts the microbic toxins, but this neutralization or counteraction is only partial.
5. The iodoform does not hinder, even to a slight extent, the amoeboid movement and phagocytic action of the white corpuscles; but, on the other hand, stimulates their amoeboid movement.

Exarticulation of One-half of the Pelvis for Extensive Caries following Coxitis.—In some cases of coxitis the disease extends far beyond the area of the hip-joint before it comes to operation, and in those cases where not alone the acetabulum but the bones which go to form the innominate are involved, the only method of preventing the spread of the disease, and certain death either by phthisis or amyloid disease, is a complete resection of the bones involved. WILFF (*Cent. für Chir.*, February 20, 1897) points this out most clearly, illustrating his subject by the report of a case in which the patient, forty-five years of age, was the subject of an extensive necrosis resulting