

one-half its previous dimensions. In a fortnight the bladder commenced to act, and in six weeks no occasion for a catheter existed.

In a case fifty-six years of age, with a complication of stone in the bladder and prostate, he divided the vas. Although no marked decrease was noted in the prostate, there was an amelioration in symptoms, more especially in regard to the diminished residual pool. Later, by a suprapubic incision, a large phosphatic calculus was removed from the bladder and another smaller one from the prostate, with considerable benefit.

The fourth case, though recent at the time of writing, showed marked signs of improvement, and the author says that his experience in castration for enlarged prostate, judged in the light and promise of four cases, is distinctly a happy one, and should, he ventures to think, encourage a more frequent recourse to it.

**Apophyseal Ligation.**—CHIPAULT (*La Méd. mod.*, October, 1896) describes an operation for the treatment of different forms of spinal curvature, which he has found very successful.

The operation he describes as follows: A longitudinal incision is made along the line of the posterior spinous process, extending two or three vertebrae above and below the curvature. Without injuring the intraspinal ligaments the muscles are dissected away and held apart by strong curved retractors. The posterior face of the vertebrae is thus exposed. Extension and counter-extension are now made by two assistants, one grasping the patient in the axilla and the other by the lower extremities, with the same care as would be exercised in placing in position a plaster-of-Paris jacket, until the curvature is obliterated.

When this reduction has been accomplished a silver-wire suture, of a size suitable to the individual case, is passed beneath the intraspinal ligament, above the first vertebra which it is desired to fix, and as near to the base of the spinous process as it is possible to come. The wire should be more than twice the length of the wound. Each half should now be made to cross the other beneath the intraspinal ligament in the next space, and this continued, the wires crossing in each intraspinal space, until the last vertebra is reached which it is desired to fix, when the wires are fastened by tightening them and securely twisting them together. It is essential to pass the wires in each case as close to the base of the apophysis as is possible, and to exert sufficient tension at each step to maintain the spines already ligated in a fixed position.

In dealing with a cyphoscoliosis the method is modified simply by reducing the scoliosis, and after placing the above ligature, returning with one end, which has purposely been left long enough, along the lateral spines of the vertebrae on the side of the former convexity, and maintaining them in such a manner as to prevent the return of the scoliosis.

The author has performed nine of these operations for the following conditions: six ligations for Pott's disease; one ligation for rheumatic arthritis of the middle cervical vertebrae accompanied by torticollis; one for a rachitic lumbar cyphosis; one for a severe form of infantile rachitic scoliosis.

The author does not intend to say that this should be the treatment for all

cases of spinal curvature. These ligatures are not applicable to all forms or cases of Pott's disease, of cyphosis, or of scoliosis; numbers of cases are cured by other more simple means, as by means of gymnastic exercises and other usual forms of treatment. This method is not sufficient of itself, but requires the use of well-applied splints and jackets, in accordance with the severity of the case.

**Two Cases of Nephrotomy for Anuria.**—CHEVALLIER (*La Méd. mod.*, October 28, 1896) reports two cases of nephrotomy for anuria. In the first case the patient was a man of tuberculous diathesis, whose urine decreased from three ounces to one and one-half ounces in spite of injections of serum and caffeine. Both kidneys were diseased, especially the left, and it was this one which he incised.

He did a nephrotomy, as it was impossible to make out the form of the kidney and reach the pelvis in that manner. He closed the wound after having introduced a drain. The patient died fifteen days after the operation, of pulmonary disease, caused by taking cold. The autopsy showed that of the two kidneys the only one whose ureter was patent was the one upon which he had operated, and that only after the operation.

In the second case the patient was a female, sixty-three years of age, the subject of lithiasis and of a lithæmic family. She came into the hospital in a state of coma, with myosis and an enormously distended kidney. He performed a nephrotomy similar to the one described above; his finger entered directly into the pelvis of the kidney. The pelvis was washed out and drained, and the patient made a good recovery.

The author concludes that nephrotomy is the operation of choice in cases of anuria which threaten life. They have the value of an *anus contra naturæ* in the case of gangrene of the intestine. They save the situation as Pousson has shown. The fistula is closed by a secondary operation.

**Comparative Value of Suprapubic Puncture and Cystotomy in Acute Retention of Urine.**—LEGUEN (*La Méd. mod.*, October 28, 1896) divides these cases according to the obstruction, as follows:

1. Acute retention due to prostatic lesions.

(a) In cases in which the bladder is distended and the urine stagnated, and attempts with different forms of sounds and with Gely's apparatus have been unsuccessful, and something must be done to relieve the pain, puncture should be resorted to. The puncture may be repeated two or three times a day for four or five days, if necessary. Frequently such treatment will make it possible to pass a sound later.

(b) In other cases catheterism is impossible. There are false passages and the prostate occludes the urethra; the patient should not be allowed to remain at the mercy of punctures; suprapubic cystotomy should be immediately performed, though in some cases it may be used only secondarily. This should be done even in cases of clear urine after puncture has been tried for four or five days without catheterism being made possible. It should also be done when catheterism is not well supported.

2. In lesions of the anterior urethra the course to pursue is to attack the obstacle by an external urethrotomy without a sound, if necessary, and the

posterior part of the urethra should be found. If the posterior end is not readily found, a suprapubic cystotomy should be performed and then by a retrograde catheterism the end found and the urethrotomy completed.

3. In case of a lesion of the posterior urethra he performs an external perineal urethrotomy with the aid of a staff. Cystotomy and retrograde catheterism are indicated in certain cases, as of traumatic origin, as in fracture of the pelvis.

In *résumé*, he says: 1. Hypogastric puncture is an excellent device; but it is expectant treatment to be used in emergency. It is without effect upon the lesion which is responsible for the retention.

2. Suprapubic cystotomy is a palliative and, at the same time, a curative measure. It is indicated in cases of infected prostatitis where there are false passages, and in cases where repeated catheterism has not re-established the urethra. It is the first step in many operations upon the posterior urethra. It is the second step in certain operations on the anterior urethra.

**Iodides in the Thyroid Gland.**—WEISS (*Munch. med. Woch.*, January 5, 1897) comments upon the richness in iodides of the glands of the inhabitants of Breslau, as shown by the researches conducted in the clinic of Prof. Ponfick. The amount of iodide was determined in the thyroid glands of adults who died from various causes, in persons suffering from goitre who died from an intercurrent disease, and in infants.

In fifty adults who died from sixty to seventy-seven years of age the desiccated thyroid weighed, on the average, 7 gr. 2, and contained 4 mgr. 0.04 of iodide. The average weight of the thyroid gland of the inhabitants of Silesia is, therefore, less than that of the inhabitants of Berlin (7 gr. 4), and of Freiburg (8 gr. 2), and greater than that of the inhabitants of Hamburg (4 gr. 6.) On the contrary, the average amount of iodide contained in the thyroid glands of the inhabitants of Breslau is greater than that of the inhabitants of Hamburg (3 mgr. 83) and of Freiburg (2 mgr. 5) and less than that of the inhabitants of Berlin (6 mgr. 6).

In the case of patients suffering from goitre the amount varied according to whether the patient had or had not been treated previously with the iodides. In those, to the number of nine, who had not been treated by the iodides, there were found traces, in two cases, and quantities varying from 6 to 11 mgr. In eleven cases treated by the iodides the amount found was from 12 to 18 mgr. In children under seven years the amount varied from traces to 0 mgr. 0.07 to 0 mgr. 0.78.

**Congenital Fibro-papilloma of the Sole of the Foot.**—DUIET (*La Méd. mod.*, November 4, 1896) reported the following interesting and rare case to the French Surgical Society: the patient, a boy, fifteen years of age, had a congenital tumor on the sole of his foot, which was painless, and of the thickness of four or five fingers; it occupied the entire sole of the foot and extended up on the sides and toes. It was traversed by deep furrows. The veins of the leg and thigh were exceedingly varicose, and were as large as one's thumb, and had the appearance of a cirroid aneurism. The neoplasm made its appearance in the patient's third year, as small white elevations, hard, and the size of a pin's head in the centre of the foot.

Extirpation seemed impossible on account of the tenderness of the scar and the attending contractions. The author decided to remove it by abrasion. He employed a histological section-knife, after having removed the greater part of the tumor in small pieces with strong scissors. At the end of a few weeks fresh healthy granulations sprung up, and he succeeded in covering them by Thiersch's method of skin-grafting, and the patient is now able to walk, two years since the operation, without any pain or injury to the surface, and without recurrence.

**The Causation of Chloroform Syncope.**—After a careful and comprehensive study, HILL (*British Medical Journal*, April 17, 1897) comes to the following conclusions:

1. Chloroform produces a primary failure of the circulating mechanism and a secondary failure of the respiratory centre. The respiratory centre fails to act not only because it is damaged by the drug, but because of the anæmia of the spinal hulk produced by the fall of arterial tension. This is proved by the fact that the action of the respiratory centre can be renewed by raising the arterial tension. The depth of anaesthesia depends, as does the paralysis of the respiratory centre, on the primary fall of the arterial tension.

2. Chloroform, more than any other known agent, rapidly abolishes the vascular mechanisms which compensate for the hydrostatic effect of gravity.

3. Chloroform abolishes these mechanisms by paralyzing the splanchnic vasomotor tone and by weakening the action of the respiratory pump. When these mechanisms are totally abolished the circulation is impossible if the subject be in the feet-down position.

4. Chloroform also produces paralytic dilatation of the heart. It acts directly like amyl nitrite on the musculature of the whole vascular system.

5. There are two forms of chloroform syncope: (a) during primary anaesthetization. The patient struggles, holds his breath, raises the intrathoracic pressure, congests his venous system, lowers his arterial tension, and finally takes deep inspirations and surcharges his lungs with chloroform. In the first stage the left heart becomes impoverished; in the second stage it is suddenly filled with blood. This is drawn from the lungs, and is full of chloroform. The chloroform passes into the coronary arteries, and the heart is thrown into paralytic dilatation. Respiration and the pulse either cease simultaneously or the pulse before respiration. (b) During prolonged anaesthetization this arises from gradually giving chloroform to too great an extent. The arterial pressure falls lower and lower, and, secondarily, the respiration ceases because of the anæmia of the spinal hulk. The heart is not in this case paralyzed by chloroform, because the drug is taken in gradually by the shallow respirations and distributed slowly by the feeble circulation.

6. Artificial respiration and the assumption of the horizontal position, if applied in time, will always resuscitate a patient from the second form of syncope.

7. Artificial respiration, established with the patient in the horizontal position, is also the treatment indicated in the first form of syncope; the heart should be rhythmically compressed by squeezing the thorax. If this does