aphasia. Mental condition good; answered questions intelligently; was rather anxious about outcome of his illness.

Hospital History.—During his illness in the hospital the patient's chief complaint was headache. He vomited only once, had no chills, and never complained of vertigo. Potassium iodid had no effect. Two lumbar punctures drew no fluid whatever, though needle was clearly in spinal canal. Edema of optic nerve head increased only slightly, never became great, and examination of eye grounds three days before death showed no retinal hemorrhages. Central vision remained good up to two days before death. Temperature ranged from 96.4 F. to 100.5 F.; pulse from 60 to 110; respiration 16 to 24. For twelve days before death he would have several hours of coma alternating with periods of consciousness. The latter gradually becoming shorter, the periods of coma longer until 24 hours before dissolution, when deep coma set in. Death occurred May 25, 1909, on the twenty-second day of his residence in hospital.

Autopsy.—Brain with enveloping dura came out easily. There was no pus on outer or inner surfaces of dura. Vessels of pia on left hemisphere congested. There was discoloration with slight bulging of the cortex high up on left parietal lobe extending to the longitudinal fissure. Incision into this fluctuating area released from 6 to 8 ounces of foul-smelling pus. Abscess cavity involved the greater part of the parietal lobe and extended well down into the temperosphenoidal. The cortical wall of the abscess lay just posterior to the fissure of Rolando. No pus in any of the ventricles. Decided softness of brain tissue surrounding abscess cavity. Roof of petrous portion of temporal bone was found intact. No communicating channel between middle ear and abscess was made out. Mastoid and cerebral sinuses unfortunately were not opened. General section was not permitted.

The staff was divided in regard to diagnosis. Internists were for meningitis until this was negated by lumbar puncture, the neurologist was for inoperable brain tumor, the otologist for brain abscess. In deference to the greater experience of the neurologist in intracranial affections, diagnosis of tumor prevailed. Headache, constipation, slight motor and sensory involvement on the right side and double choked disc were the chief symptoms. Abscess had probably existed for some time, patient's illness of March and April being due to this and not other causes. Although no direct route of suppuration was made out between middle ear and cerebral abscess, it is highly probable that the abscess was of otitic origin, infection occurring, if not by direct extension, by metastasis.

INGUINAL HERNIA OF THE BLADDER

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Hernia of the bladder through the inguinal canal, while rare, is a condition that must be borne in mind when operating on any hernia, either femoral or inguinal. Failure to recognize this rarity has led to disastrous results. Cooley, in Keen's "System of Surgery," says that but three cases of hernia of the bladder were encountered in a series of over 1,900 cases of hernia in patients operated on at the Hospital for Ruptured and Crippled.

History.—Miss H., aged 20, first noticed a small bunch in the right inguinal region last April. This did not disappear and was painful at times, but she continued teaching school. The mass felt like a fatty growth. At times it was thought that an impulse on coughing could be felt and at other examinations no impulse on coughing could be detected. There were no bladder symptoms. Symptoms were similar to that of an enlarged tender gland.

Operation.—This was performed at Hurley Hospital, July 13, 1909. On cutting down to the mass it looked and felt like a lipoma except that the walls could be moved on each

other as though there were a cavity in its center. The mass extended down into the inguinal canal. After separating the mass from the adhering structures it appeared as a diverticulum of the bowels. A sound passed into the bladder easily passed into this diverticulum, making the diagnosis of an extraperitoneal direct inguinal hernia of the bladder. The bladder was returned to the abdominal cavity and the abdominal wall closed with silk-worm gut sutures, with layer suturing with catgut.

The case of Justo is interesting because, after making a diagnosis of vesical hernia from the patient's symptoms, he cut into the fatty mass and opened the bladder because he was unable to distend this portion of the bladder by fluid, concluding that no vesical hernia existed.

New and Nonofficial Remedies

SINCE THE PUBLICATION OF THE BOOK "NEW AND NONOFFICIAL REMEDIES, 1909," THE FOLLOWING ARTICLES HAVE BEEN ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION. THEIR ACCEPTANCE HAS BEEN BASED LARGELY ON EVIDENCE SUPPLIED BY THE MANUFACTURER OR HIS AGENT AND IN PART ON INVESTIGATION MADE BY OR UNDER THE DIRECTION OF THE COUNCIL. CRITICISMS AND CORRECTIONS TO AID IN THE REVISION OF THE MATTER BEFORE PUBLICATION IN THE BOOK ARE ASKED FOR.

THE COUNCIL DESIRES PHYSICIANS TO UNDERSTAND THAT THE ACCEPTANCE OF AN ARTICLE DOES NOT NECESSARILY MEAN A RECOMMENDATION, BUT THAT SO FAR AS KNOWN IT COMPLIES WITH THE RULES ADOPTED BY THE COUNCIL.

W. A. PUCKNER, SECRETARY.

(Continued from page 530)

IODONE SURGICAL DRESSING AND DUSTING POWDER—*Pulvis Iodoni Compositus*.—Iodone surgical dressing and dusting powder consists of four parts of iodone ($(C_6H_4C_2O_3)_2KI.I_2$), a periodide of phthalic acid anhydride and 96 parts pure sterile talcum.

Iodone is prepared by treating a solution of phthalic-acid anhydride in acetic ether, with a solution of iodine and potassium iodide, and crystallizing the product from suitable solvents.

Iodone occurs in the form of dark green prismatic crystals which melt with decomposition at $163^\circ C.$ ($325.4^\circ F.$). When freshly prepared it is odorless, but on standing, traces of iodone are liberated, giving it a faint odor of iodine. It is gradually decomposed into phthalic acid, iodine, and potassium iodide by water, in which the decomposition products dissolve until a saturated iodine potassium iodide solution results. Any excess of iodine remaining in contact with the supernatant liquid remains unchanged. Alcohol, chloroform, and ether decompose iodone, but more slowly than water. Iodone crystals are stable in dry air; exposed to damp air, they gradually liberate iodine.

When 0.1 Gm. iodone is heated in a crucible at not more than a dull red heat, the compound chars, iodine vapor is driven off, and a residue of white potassium iodide remains. At a bright red heat, the latter is dissipated, leaving no weighable residue (absence of metallic impurities).

About 0.1 Gm. iodone, accurately weighed, is allowed to react, with occasional agitation, with a solution of 1 Gm. potassium iodide in 50 c.c. water. At the end of 15-20 minutes the titration of this solution with tenth normal thiosulphate solution should indicate the presence of not less than 51.1 per cent. iodine.

Iodone surgical dressing and dusting powder, assayed by the above process, should yield not less than 2 per cent. of available iodine. (About 2.5 Gm. should be taken for the assay.)

Actions and Uses.—Like iodine, iodone is a potent germicide and stimulant to the processes of repair in wounds. It is said to be useful in all conditions in which the local use of iodine is indicated, also as an antiseptic dressing in wounds and all local affections.

Dosage.—Its employment as a surgical dressing and dusting powder should be regulated on the basis of its containing 2 per cent. of available iodine, slowly liberated on contact with the moisture of wound secretions, etc.

Manufactured by The Henry C. Blair Co., 800 Walnut St., Philadelphia, Pa.

U. S. patents applied for.

PEPTONE—*Peptonum*.—Peptonum (Pharm. Belgica., edit. 3); *Peptona Medicinalia* (Pharm. Francaise, 1908).