In two weeks after the last series, the whole area became very much inflamed and painful, and continued so for a week, when a slough was formed, including the part exposed to the radiations. This, according to the patient, came away *en masse*, as dead, necrotic tissue, leaving a healthy-looking, granulated surface, which healed in a few weeks. After the last series of exposures, during the acute, inflammatory period and sloughing, including the healing of the granulated surface, the patient was at his cottage in Atlantic City; therefore I did not see him until he returned in the fall, at which time the tongue had entirely recovered. The site of the former nodule was marked by a smooth, perfectly flexible, superficial cicatrix; in other words, the whole area seemed almost normal, except on a very critical examination.

I have seen the patient many times during the last nine years, and at present the tongue seems absolutely well, the site of the former lesion being marked by a cicatricial line. To all clinical appearances, the diagnosis was that of epithelioma, although, as stated above, it was thought wise not to confirm this by the excision of a piece for microscopic examination, but I am absolutely convinced that the diagnosis of epithelioma was the proper one.

Although I have had such a favorable result in this case, I certainly would not recommend the x-ray as a usual method of treatment in epithelioma of the tongue.

In the case under discussion, the patient absolutely refused operation, and as the lesion was so favorably situated on the anterior portion of the tongue, near the edge, it seemed, under the circumstances, a favorable case for the rays. Therefore, on account of the nature of the lesion, rather prolonged exposures were given, at a short distance, until a very decided reaction was obtained in each series.

If one should undertake the treatment of such a case with the x-ray, I believe that the treatment should be as radical as possible. In other words, the exposures should be arranged so that a most decided reaction or burn would be produced.

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MALICIOUS AMPUTATION OF PENIS

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History.—J. C., a well-developed and vigorous man aged 25, a railway fireman, a steady and industrious worker of fairly good habits but not strictly temperate, had married a woman much older than himself, who had twice before been unhappily married. This couple had not been living very happily together for some time; each occupied a separate part of the house, up to July 4, 1911, at which time there had been reconciliation and they had agreed to live together as man and wife; accordingly they had occupied a common apartment on the night of July 4. About 4:00 a. m., July 5, the man was aroused by a terrific pain and a frightful hemorrhage, and he found himself in the middle of the floor holding onto a more or less completely amputated penis, the stump and wound bleeding profusely. The major part of the organ was on the floor and the bed and the room were very bloody. He was alone, but cries for help brought a neighbor to his aid. The woman had taken a razor and with a sweeping cut had cut a circle around the root of the penis coming down and going wide into the skin and tissues of the scrotum turning under the penis some distance down on the scrotum crossing the median raphe and extending the incision up the other side of the scrotum to the starting-place, making an elliptical incision of the most minute precision. After this the skin had been drawn down and out until it had been detached from the root of the penis for about 1 inch, at which place it had been cut square across leaving that much of the penis without a sign of skin. The woman, after completing the amputation, rushed to a physician's residence and sent the doctor hurriedly to him, saying he was hurt.

First Operation.—The doctor put in some stitches in the skin, and a bandage around the stump to control the hemorrhage and sent the patient in to the hospital on the first train, where he arrived about 1:30 p. m. About 2 p. m. he was anesthetized and we started a rather unusual operation, which taxed all our ingenuity to devise a method by which we could save the stump and cover it with skin. We decided on a two-step operation. First, by sliding the skin of the scrotum and pubes, we were able to cover it by bringing the skin together over the dorsum making a linear row of sutures down to the urethra, where we put in interrupted sutures, suturing the skin to the mucosa. The corpora cavernosa were closed with a mattress suture to control hemorrhage. Drainage was provided for, and a catheter was fastened in place, and a sterile dressing applied.

The catheter remained in place for four or five days, at which time it was removed and left out as the patient had no further trouble about passing urine. The method of covering the denuded penis drew it down somewhat into the scrotum, and the patient was bothered very much with erections, which caused the skin to separate slightly over the dorsum and necessitated a few more sutures about the tenth day. The progress was uneventful after this, and the healing was fine. When the wound was healed we still had the penis more or less buried in the scrotum which drew down on the penis and up on the testicles, producing more or less disagreeable symptoms, which we were able to relieve quite satisfactorily at the second operation.

Second Operation.—August 9, two methods were considered for freeing the penis and making a skin cover to go around the organ. First, two lateral incisions with skin enough to close underneath or a transverse incision sutured longitudinally underneath the stump. A combination of the methods to furnish skin to close a slight defect at the meatus was worked out and proved quite satisfactory; however, this meant the stealing of much skin from the scrotum and the placing of all parts under some tension. The most difficult part of the second operation was freeing the penis from the scrotum, and the hemorrhage which seemed to come from the penoscrotal union underneath was not alarming but interfered with such delicate work.

Course.—The result would have been all that could have been expected except for a hematoma which upset part of our fine adjustment. Present condition shows a short penis, covered with skin, much wider and thicker than normal at the root; the patient says that it is enormously widened when in a state of erection, and that has been a very troublesome symptom. The patient consulted a noted surgeon in Chicago who advised him that he could graft on a penis, and that he would do it free of charge as a surgical curiosity. From the reputation of the surgeon consulted we do not doubt his ability to make good, providing the grafting material is forthcoming; and as no such material is available in these parts of the country, I have advised the patient to accept the generous offer of the Chicago specialist, but requested him to return and report on the results.

Patient insists that he was chloroformed in his sleep. I suspected overindulgence in alcoholics, which I have not been able to confirm.

Therapeutics

BLEEDERS

Whether a patient should be classed as a hemophilic or as an accidental or temporary bleeder depends largely on the age of the patient, his personal and family history. There is a large hereditary influence in true hemophilia. Blood-vessel causes are probably rare in the true hemophilic, and the tendency to bleed seems to be due to an abnormality in the blood-plasma. Such abnormality may be almost permanent, as occurs in hemophilia, or temporary, as in those who show a sudden tendency to bleed. The lack of ability of the blood to