and whether the etiology of erythema multiforme lies in a trophic disturbance or some toxic irritation, the physiologic action of the cacodylate of soda remains the same.

From the failure of Fowler's solution of arsenic to affect the lesion favorably, and the success of the arsenic treatment in the form of cacodylate of soda injected intramuscularly, it would be reasonable to suppose that Fowler's solution undergoes some chemical change in the stomach, while the cacodylate is absorbed directly into the blood-current.

I received a letter from the patient on Oct. 30, 1911, saying that she was still free from the eruption.

From my experience in this case I would commend cacodylate of soda for trial in all cases of erythema, more especially of the angioneurotic type.

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OBSTETRIC EXPERIENCES AMONG THE AMERICAN INDIANS

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The generally accepted opinion that obstetrics among the American Indian women is always a simple matter is, I think, hardly a true conception of the subject, as shown by the several cases cited below. The majority of labors are, of course, conducted without trained medical care, but the women nearly always have the assistance of native midwives, and it is now growing daily more common for them to call on the nearest white physician for aid.

I have prepared brief notes on a few cases which have come under my observation during a residence of several years among the Indians of southwestern Oklahoma, and which may prove of interest.

CASE 1.—A primipara, aged 16, only a short time out of one of the government schools on the reservation, was attended by an old woman who enjoyed an enviable reputation among her people as a midwife. The patient came under my care a few days after she had been relieved of a dead fetus and presented a pitiable condition. The placenta remained within the uterus, a putrid, decomposing mass; there was a rise in temperature, a burn of the third degree covered almost the whole of the abdomen, an area 8 or 10 inches in diameter; this had been produced by a hot, flat stone placed there by the midwife in the hope of stimulating uterine contractions. The perineum was somewhat torn, though not badly, and there was also a urethrovaginal fistula, through which the urine constantly dribbled and kept up a foul, urinous odor. After the uterus had been emptied and washed out, the patient was removed to the hospital at the Fort Sill Military Post, where, with the assistance of Assistant Surgeon Cloud, she was operated on for the urethrovaginal fistula. The first operation not proving a complete success, a second one was performed at a later date. The patient remained under my care for several weeks, the incontinence and abdominal burn both proving to be very persistent and troublesome, but finally made a complete recovery and has since borne children.

CASE 2.—The patient was a young woman, the mother of three children, fairly well educated and the wife of one of the most prominent and enlightened of the younger members of the Kiowa tribe. Her case appeared to be progressing normally when, about the end of the seventh month, I was hurriedly sent for; she was about to be confined. Her labor lasted several hours, when she was delivered of a fetus that appeared to have been dead for some time. The most interesting feature of this case was the condition of the placenta, which was much atrophied, small, quite hard and on section

was found to be granular and of a whitish color. It had undoubtedly undergone calcareous degeneration, which, I find, on referring to the literature, is rather an uncommon condition. There were no evidences of either syphilis or tuberculosis.

CASE 3.—A full-blood Indian woman was brought to my office from a long distance in the country on the third day after her confinement. On arrival she had a temperature of 105 F. and appeared very ill. After a rest she was brought to my office and prepared for operation. The uterus was carefully and thoroughly evacuated of its contents by means of a rather large, dull curet, followed by a thorough irrigation with sterile normal salt solution. Her temperature came down promptly after this, showing it to be a case of localized infection only. She was kept under observation for several days, the case soon ending in complete recovery. This woman was confined without medical care and surrounded, no doubt, by the most insanitary conditions possible for such cases, which resulted in a severe infection. The case is somewhat unusual on account of the curettement, without accident, so early post partum.

CASE 4.—This case was one of multiple pregnancy. The patient, also a full-blood Indian woman, was quite well advanced in age and the mother of several children. I was not called until she had been in labor four days. When I arrived, which was early in the day, I found the patient kneeling on the floor of her tent (it having been erected for the occasion near her house) with her hands grasping an upright pole in front of her that had been driven securely into the ground and fastened to the top of the tent. On examination I found one of the heads presenting within reach of the examining finger. She was given several rather large doses of quinin sulphate at regular intervals, and strychnin hypodermically, and by afternoon she was delivered of two healthy though somewhat undersized babies. She passed through her puerperium successfully. This woman seemed to be unable to complete her labor without assistance.

I might mention other cases of a similar nature, but those above recorded will suffice to show that the Indian woman, like her white sister, is frequently subject to serious accidents and complications attending the function of parturition.

ANEURYSM OF THE PALMAR ARCH

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The following case may prove to be of interest because of its extreme rarity. In looking up the literature on the subject, as far as I have been able to find, there are no similar cases on record.

History.—T. D., a switchman, aged 35, entered the Swedish Hospital, Sept. 2, 1911, complaining of dull pain in the palm of the hand, which was increased by pressure and radiated toward the fingers. His past history was negative, with the exception of a possible history of syphilis fifteen years previously. He had always been in railroad employ since he was 14 years of age, but had trained for prize-fights on the side, and had been in several professional fights.

In May, 1911, he hit the angle cock of an air hose, while trying to shut it off, with the palm of his right hand. His hand pained him considerably at this time, and the pain continued off and on for several months. In June, one month later, he noticed that a small tumor had developed in the palm of the hand; it could be moved very easily and throbbed after extra exertion. This tumor continued to enlarge for the next few months, until it was the size of a hickory-nut. His hand would be swollen after a day's work and the pain steadily increased. An examination showed a small tumor lying deep in the palm of the hand. No pulsation was perceptible.

Operation.—Sept. 2, 1911, the patient was given ether and a tourniquet applied at the wrist. A curved linear incision was made in the palm of the hand and the small tumor was found at the center of the deep palmar arch. On loosening up the tourniquet the tumor could be seen to pulsate plainly, and to increase to more than twice its size in the collapsed state. It was an aneurysm with a small pedicle, which was easily ligated, and the whole sac removed.

The patient made an uneventful recovery, and now has no difficulty at all in using this hand.

A NEW TONSIL HOOK

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I have devised a new tonsil hook which seems to me an improvement over any that I have used. Its advantages are the following:

A snare can be slipped on or off the tonsil without changing the hold on the tonsil after the hook is once placed.

The hook, once placed, will stay in place and not drop out when pressure is relaxed, as the slight thickening on the lower two-thirds of the inner surface of the prongs holds it in place.

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KNEE-JOINT AMPUTATIONS

REPORT OF A NEW METHOD

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To overcome the disadvantages of the thigh amputation, and to combine the good points and disadvantages of disarticulation with those of the osteoplastic operation, I have devised the following operation:

An oval anterior and posterior flap are turned up, the former line of incision extending from the lower portion of the internal condyle downward, and anterior as far as the tuberosity of the tibia. The patella tendon is cut without dissecting the skin from the patella and also leaving a portion of the patella tendon attached to the patella. The posterior flap is cut off approximately equal length or a little longer, if possible. The hamstring muscles are cut long. Disarticulation is then completed by cutting the remaining structures. Vessels are ligated, nerves pulled down and cut short, and allowed to retract.

The anterior flap is next turned up and the posterior surface of the patella sawed off. This is easily done by grasping the patella tendon by a pair of strong holding forceps when the patella can be sawed without difficulty, care being taken to remove as small a part of the patella as possible, so as to preserve nearly its original thickness.

Next, a small piece is sawed off each side (Fig. 1 A A) in such a manner as will leave the patella narrower toward the upper end, or quadriceps attachment, and also narrowed toward the anterior surface.

If it has been possible to preserve sufficient skin flaps to cover the stump, the next step is to saw into each side of the intercondyloid notch (Fig. 2 A A) in such

a manner that, when the piece of bone has been removed by means of a mallet and chisel (Fig. 2 B), there is left a depression, or modified intercondyloid notch, which is broader at the bottom and also toward the popliteal space, or, in other words, narrower at the end of the bone and also toward the anterior surface. The bevel of the notch is made to conform as nearly as possible to the bevel of the patella, but as there is of necessity a slight error, our aim should be to make the bevel of the patella greater, or that of the notch less, so as to insure good apposition when the patella is fitted into position.

The patella is next grasped by a pair of strong bone-holding forceps and drawn down forcibly until it slips into the place prepared for it and dovetails into it (Fig. 3). The greater the muscular pull, the more firmly it holds its place.

Next, the hamstring muscles are sutured to the patella tendon. The skin is sutured, a small drain inserted and the leg put up in dressing. It will be found that the forcible drawing down of the patella brings the line of skin suture well to the popliteal space and away from all pressure.

If, however, it is impossible or inexpedient to save enough skin to cover the stump without too great tension—and this can be determined by grasping and drawing

Figs. 1, 2 and 3.—Diagrams of patella and joint, illustrating new method of knee-joint amputation.

the patella down before anything has been done toward preparing the notch—equally good results may be obtained by sawing through the condyles and then cutting out a notch in the sawn condyles so that the patella will dovetail into it as before. Nearly 2 inches may be gained in this way without sacrificing any of the advantages of the operation.

In either case we get a stump that is very satisfactory. The patella forms the center of it, and laterally the two condyles share their portion of the weight in such a manner that the normal distribution of weight, as in the flexed knee, is preserved.

The large bearing surface formed by the tough skin taken from the anterior aspect of the knee is able to take the full weight of the body without abrasion or discomfort.

Another advantage, which it shares in common with disarticulation, or amputations below the knee, is the enlargement furnished by the condyles, or even portions of the condyles. With the enlargement, an artificial leg can be adjusted so that it will not slip up and down when walking or sitting.

Still another advantage which this operation possesses is the short flap which is sufficient to cover the stump