was drained. Contrary to the procedure of many operators, no attempt was made to perform immediate gastro-enterostomy, because it was thought the added shock would prove detrimental in many cases, and also because it was felt that many cases of gastric ulcer recover after perforation. It is noteworthy that the majority of the patients remained free from subsequent gastric disturbances after treatment.

The Interpretation of Functional Renal Tests with Special Reference to the Significance of Minimal Excretion of Phthalein and Indigo-Carmín.—Beer (Ann. Surg., 1916, lxiv, 434) says that the last word in functional renal tests is still far off. The practical value of these tests becomes more and more evident as one succeeds in improving the interpretation of the facts elicited. In research along these lines one encounters puzzling contradictions, and it will take much more work to explain many of them. Why a given kidney (e. g., a case of ureter stone) secretes more urea than its mate, but fails to excrete indigo- carmin while its mate does it normally, or why a patient dies of uremia while the phthalein output is normal or almost normal, illustrate some of the perplexities that one encounters. The important practical point in Beer's work is to arrive at an understanding of the significance of zero or minimal excretions. From a study of 17 cases, he concluded that: Extrinsic causes (usually obstructive in character) may lead to permanent symmetrical renal damage, evidenced by minimal or zero excretion of phthalein or indigo-carmin associated usually with high blood urea and high incoagulable nitrogen blood content. Operation in these cases will be of no permanent benefit, and even the slightest (in one case the passing of a cystoscope) may bring on a fatal uremia. Similar extrinsic causes may lead temporary renal damage evidenced by the same phenomena. Operation in these cases, particularly after adequate preliminary treatment, will be rarely followed by uremia. These two wholly different types of cases can be differentiated by removal of the usual causative factor, i. e., relief of the obstruction, either by use of indwelling catheter, of regular catheterization, or by preliminary cystostomy under local anesthesia or gas. If the case is of the first type, no marked change in the renal output will result, whereas if the case is of the second type, the renal output will regularly improve. A similar low combined output may be caused reflexly (inhibitive or toxic) by more or less extensive disease of one kidney, while the other kidney is adequate and improves in its function after removal of its diseased mate or after relief of the pathological condition in its mate. A low combined output may also be due to bilateral intrinsic causes and improvement in these cases is possible only after operative attack on the kidneys, or the kidney, if single, under an anesthetic which has no injurious effect on the diseased parenchyma and provided no severe wound infection or other septic complications, etc., which overtax this parenchyma, develop.

The Treatment of Genital Tuberculosis in the Male.—Cunningham (Surg., Gynce. and Obst., 1916, xxxiii, 3825) says that the material upon which his communication is based is from the postmortem and clinical data of the Boston City Hospital; the Long Island Hospital, where there is a large tuberculosis camp; private cases; and a survey of the