That these organisms are present in 80 per cent of *normal* mouths, as is claimed by Wingrave, I can hardly believe, but that they are very frequently present in mouths containing decayed teeth and soft, spongy gums, I feel sure. However, these I do not consider as normal mouths. That they are always associated with some of the other pathogenic microorganisms commonly present in the mouth is also undoubtedly true, for these latter organisms are nearly always to be found, but to prove Wingrave's contention true one needs to find the pathologic conditions known as Vincent's Angina and either not find Vincent's organisms or else find them in moderate numbers as might be done from a case of gingivitis or from a spongy soft gum showing hardly any inflammation, instead of finding them as will usually be the case in Vincent's Angina in enormous numbers and in almost pure cultures early in the case.

If these organisms are not the cause of this condition they at least increase most decidedly during its development.

If Vincent's Angina and noma are not the same thing, there are at least several very

striking points of similarity between them, and to me the assumption seems plausible that the latter is a case of the former, in a weak and debilitated subject, plus an invasion by one of the more virulent pyogenic organisms a gangrene resulting under these conditions. While these organisms may perhaps be considered as saprophytes under ordinary circumstances, in symbiosis with other and more virulent organisms they appear to become pathogenic and to aid in the production of very serious conditions.

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PISTOL BALL PENETRATION OF THE LEFT VENTRICULAR CAVITY, WITHOUT HEMORRHAGE, WITH REMARKS ON TREATMENT OF HEART WOUNDS.*

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Henry R., colored, male, 24 years of age, laborer by occupation, was wounded with a 32-calibre revolver on the morning of December 7, 1910. The bullet came from a distance of about five feet and entered the left side of the chest between the fourth and fifth ribs, at a point about one inch to the left of the nipple; there was no wound of exit.

On the following day, December 8, the

wounded man was brought to the Charity Hospital, where he was admitted to my service in ward 25.

Examination by the interne, Mr. H. E. Nelson (to whom I am indebted for notes of the case), showed the above-mentioned wound, which was cleansed and sealed with collodion. The chest presented on the left side dullness on percussion, diminished expansion, in-

*Read before the Section on Surgery of the Southern Medical Association, Hattiesburg, Miss., Nov. 10-12, 1911.

creased voice sounds and bronchial breathing, especially over the lower areas. The treatment was by the usual stimulating means, together with morphine for pain.

When I first saw the patient on December 12, five days after the injury, his condition was very grave. In addition to the physical signs noted above, which we took to denote hemothorax and pneumonia, he had a pulse of 150, respirations, 60, and temperature varying between 103 and 105 degrees F. His history and the situation of the wound suggesting the likelihood of heart injury, I exam-

a. Site of Bullet. ab-ab Divided Track of Bullet.

ined this organ and found, both on palpation and on auscultation, a feeble action, with remote beat and sounds. Suspecting the presence of blood in the pericardium, I introduced a fine trochar and cannula between the fifth and six costal cartilages on the left, less than one-half an inch from the sternum, to the depth of about one inch. No fluid came through the cannula.

Nothing further was done for the patient, who died at 9 p. m. of that day. At 6 p. m.

of the following day an autopsy was held by Mr. Nelson in the presence of Dr. A. A. Aucoin, coroner of Assumption Parish. It was found that the ball had perforated the lower lobe of the left lung, grazed the dome of the diaphragm, entered the pericardium and penetrated the heart, passing obliquely through the lower portion of the left ventricle from the lateral aspect, and lodging in the apex, at which point it was found encapsulated. There was no blood in the pericardium. The heart wound had healed. Lobar pneumonia and hemothorax were found. The trochar puncture in the pericardium was identified; the heart was intact opposite this point. The obliquity of the bullet track, paralleling many of the ventricular fibres, explains the absence of hemorrhage.

Dr. Irving Hardesty, Professor of Anatomy in Tulane University, upon request, gave me the following references on the musculature of the heart, in which is well described and clearly illustrated the course of the fibres in the ventricles whose interlacing in whorls explains the closure of the tract behind the bullet:

McCallum, J. B.—On the Muscular Architecture and Growth of the Ventricles of the Heart. (Welch Festschrift, 1900.)

Mall, F. P.—On the Muscular Architecture of the Ventricles of the Heart. (Am. Jl. of Anatomy, March, 1911, p. 211.)

The technique of treatment of suspected heart wounds may be stated as follows: Rehn resects the sixth left costal cartilage, through this wound explores the pericardium without injury to the pleura, and establishes or excludes the fact of cardiac injury. If injury has been found, the Spangaro incision is employed, laying wide open the fifth left interspace, including the pleura. Respiration is kept up by means of an intratracheal catheter, through which an air-ether mixture is pumped (Meltzer-Auer).

The venae cavae are grasped for short periods, while fine silk sutures are introduced

short of the endocardium and tied in diastole. Drainage is usually employed.

COMMENT.

I have reported this case for the purpose of encouraging operative interference in suspected heart

wounds. Between the case of heart injury that dies at once and that in which the injury does not threaten life lie a long range of cases of moderate injury, calling for operative help and affording ample time for rendering it. The study of the favorable cases must stimulate surgeons to attempt to give relief where indicated.

SUPRAPUBIC VERSUS PERINEAL PROSTATECTOMY.

By JOHN M. WILSON, M.D.,
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In reviewing a number of prostatectomies, both suprapubic and perineal, performed by myself in the past four years, and comparing the results, I have been convinced that the suprapubic route is by far the most practical. It has been my experience that better results are in the majority of cases obtained by this method of procedure.

I believe that this is the safer operation of the two for several reasons. It affords much better drainage, and then, too, the operator is enabled to bring the gland better into view before clipping its capsule.

The operation I usually employ is as follows: The symphysis is shaved and prepared as for laparotomy. An incision about three inches long is made in the median line just above the symphysis down to the prevesical space, which is readily recognized by a plexus of veins which should be pushed aside. The peritoneum, of course, is to be pushed back and not injured. The bladder is then opened and washed out with hot boric solution.

A piece of sterile gauze is placed in the fundus of the bladder by means of a large retractor placed against it, and the bladder pulled upwards. The capsule of the prostate gland can then be brought into view. It is

incised with a sharp pair of scissors sufficient to introduce the finger and is then enucleated.

In some cases I find it of advantage to have an assistant insert a finger in the rectum and push the gland upward. Of course, where infection is present, suprapubic drainage of the bladder is advisable, together with urinary antiseptics for several days previous to the radical operation.

In those cases where hemorrhage into the bladder occurs with threatening symptoms due to great hypertrophy of the gland, I do not hesitate to perform the radical operation without delay, but, of course, all patients should have the proper preparatory treatment when possible.

A drainage tube is inserted into the bladder, which is closed with fine sterile catgut.

In cases where post-operative hemorrhage is threatening I pack the prostate bed with a strip of sterile gauze, to be removed in twenty-four to forty-eight hours.

I have, with few exceptions, used ether as an anaesthetic, and feel that it is preferable to chloroform when no kidney complications exist.

BOOKS RECEIVED FROM LEA & FEBIGER,
New York and Philadelphia.

Archinard's Bacteriology, Second Edition.
Guenther's Physiology, Second Edition.

Browning & McKenzie on Syphilis.
Thornton's Formulary.

The above mentioned books will be examined and reviewed for the convenience of our readers