erin tampons applied directly against the drum membrane.

4. Cleanse the nasal and pharyngeal mucous membrane with a saline antiseptic spray or douche. Remove any existing hypertrophied lymphoid tissue.

5. Advise cautious blowing of the nose to limit introduction of infection to the tympanic cavity.

6. Apply dry heat to aid in control of pain.

7. Incision of the drum membrane under strict aseptic precautions on the appearance of pronounced redness of any portion of that organ when accompanied by pain, impairment of hearing and other evidences of acute inflammation.

8. Following perforation of the drum membrane the use of aseptic dry gauze packing for the purpose of excluding infection from without and also to withdraw the discharge from the tympanic cavity by capillary attraction.

9. Syringing, under aseptic precautions, only when the discharge is purulent and profuse, to be followed by as thorough drying as possible with sterile absorbent cotton.

10. Judicious inflation by Politzer's method only after the acute symptoms have subsided or after the drum membrane has been opened, to facilitate removal of discharge from the tympanic cavity and to prevent adhesive changes in the sound conducting apparatus.

11. Appropriate treatment of any associated systemic disease.

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TURNING IN ORGANIC HEMIPLEGIA.

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Dr. Leonard J. Kidd recently discussed the mode of turning in walking of organic hemiplegics and spastic paraplegics and referred to a paper by von Schüller in which the latter says that an organic hemiplegic cannot walk toward the sound side, as he must drag the paralyzed leg after him. It is also pointed out that the functional hemiplegic does not walk toward the palsied side but only toward the sound side, and Kidd concludes that the direction in which the hemiplegic turns is of equal diagnostic value, and that this test causes less inconvenience to the patient. To prove the correctness of this opinion, he examined hemiplegias and spastic paraplegics who were more spastic on one side or the other, and found that fully 99 per cent. spontaneously turned to the spastic or more spastic side. From this he draws the following conclusions:

1. If such a patient in walking turns round to the affected side or more affected side, an organic lesion is present.

2. If he turns to the sound or less affected side the case may be one of either functional or organic affection; a cursory examination will determine which.

As he urges clinicians to observe the direction in which a patient turns who is weak or spastic on one side, and as no one else has attempted to confirm his conclusions, I examined 36 cases of organic hemiplegia in order to determine the value of his observations. The patients were made to walk in some open place, to turn round of their own accord and to come back to the starting point. This was repeated and when the strength and facility of walking permitted, 10 turns were made.

In some cases, the mentality was such that the patients could not be made to walk away and to return merely on being told to do so, and it was necessary in these cases to call to them to come back.

It was found that the direction from which came the sound of the voice, and the presence of persons or objects, were sufficient to determine the turning in some particular way. As far as possible, crutches, canes and all outside influences were removed. It was found that only 67 per cent. of the whole number turned to the affected side, 16 per cent. turned to the sound side, and 16 per cent. turned indifferently to either side; a difference of over 30 per cent. from Kidd's figures.

While most hemiplegics seem to turn by preference to the more affected side, they do so in such numbers as hardly to make it a rule. Moreover the less the paresis and the greater the difficulty of determining between organic and functional complaint, the more indifferently the patient turns to either side, as shown by the fact that half of those examined who turned to either side walked excellently. The factors which determine the direction in which a hemiplegic patient turns seem to be many, but it may be said that when the paralyzed limb has marked foot-drop and contraction in that position, it becomes necessary to sweep the foot around in a large circle to bring it forward, and the turning is done on the other foot as a pivot. If the palsied leg be not so deformed, and it is not necessary or perhaps is difficult to swing the leg around, the turning is done on the affected leg as a pivot. If this is so, it is plain that there may be intermediate positions of deformity in which the patient turns to either side. One patient examined said that he turned according to which foot was foremost at the time, his position determining the direction, but most of those who were asked after being examined did not confess to its being any easier to turn one way than the other. Several hemiplegics moreover who turned consistently to one side were examined and told to turn in walking at such times as one or the other foot was advanced, but they nevertheless turned toward the same side as formerly, so that at most the patient's position explains but a part of the phenomenon.

If it can be shown that a functional hemiplegic ever turns to the affected side, and observations are perhaps needed to that end, the value of Kidd's deductions is much lessened. While the above findings do not disprove his conclusions, that a man who turns to the affected side is organically diseased, they make that fact applicable as a test to fewer cases, and consequently leave a larger proportion open to other means of diagnosis.

I am indebted to Dr. William G. Spiller for the use of his wards at the Philadelphia General Hospital, where about half of the cases examined were obtained, and also for his corroboration of part of the work done.

Management of Labor.—1. Absolute asepsis as regards the puerperal woman, lying-in room, and the person of the accoucheur. 2. A careful diagnosis of the position of the child should be made before the completion of the first stage of labor. 3. Watch expectantly the progress of the labor. 4. Non-interference during the labor except for cause. 5. A clean delivery of the placenta. 6. Be assured that there is a good contraction of the uterus before leaving the patient. 7. After the delivery, examine carefully by ocular inspection, and see if there is any laceration of the perineum. 8. If a laceration be discovered, repair at once.—*Medical Visitor*.