McBURNEY, M. D. (New York). A man had slipped while lifting a heavy packing box from a truck ; the edge of the box struck him just above the patella, causing a rupture of the quadriceps tendon near its insertion, but no external wound. A transverse incision across the joint above the patella showed that the capsule was extensively lacerated on either side of the bone, while there was a quantity of coagulated blood within the joint cavity. The fibrous fringes and the torn ends of the muscle were turned inward. The latter were excised, the rent in the capsule was closed with catgut and the ends of the tendon were kept in close apposition by quill sutures which were secured by doubled silver wire passed through the edge of the patella. A plaster dressing was applied and the wound healed quickly, the recovery of motion being slow, but eventually complete, although the patient had refused the use of passive motion, so that there was apparently no difference between the two limbs.—*N. Y. Surgical Society*, April 13.

JAMES E. PILCHER (U. S. A.)

III. Synovial Cysts in Connection with the Knee-Joint ; Synovial Cyst of the Wrist ; Operations ; Recovery. Mr. CHAUNCEY PUZEY. Case I. Synovial cyst in calf of leg, communicating with knee-joint ; synovial cyst of wrist. Patient, aged 26, had rheumatic fever four years before, when wrist joint and knee joint were most affected. A month before admission a slight contusion of wrist caused a swelling of the wrist, which had never quite recovered after the rheumatic fever. This swelling was situated over the radial side of the back of the wrist, extending from the base of the first metatarsal bone to two inches above the wrist. No heat or redness. Swelling divided into two by annular ligament. Fluctuation existed between these two portions, and a sort of crepitus could be felt within the sac on pressure. The right knee joint was considerably distended with fluid, and there was a large fluid swelling at the upper part of the calf, obviously communicating with the knee joint. Under Listerian precautions the swelling over the wrist was laid freely open by two incisions above and below the annular ligament, a few melon-seed bodies squeezed out and the sac stitched to the skin. The wound healed by granulations and the power of the wrist was afterwards greatly im-

proved. A few months later the man returned to have the knee operated on, as its condition prevented him from working. The swelling in the calf was laid freely open under antiseptic precautions and the sac was found to be very thin everywhere, except at its upper part, where it was constricted and communicated by a narrow channel with the upper and more deeply seated swelling. The communication with the joint could not be found. As much as possible of the sac was dissected out and a drainage tube left in. Made a good recovery.

Case II. Synovial Cyst in Popliteal Space. Patient, aged 51 years, commercial traveller. Complained of weakness in left knee. There was a swelling the size of a small Tangerine orange in lower part of popliteal space, slightly to inner side of median line. No pulsation, redness or tenderness. When the knee was flexed it disappeared, but became more prominent and very tense on extension. Palliative treatment failing, the swelling was laid open antiseptically. Sac very thin, but no communication with joint was found. As much as possible of cyst wall was scraped away. drainage tube inserted and leg fixed on a splint. Made a complete recovery.

Mr. Puzey considers that if the cases are seen early palliative measures should certainly be tried, but unfortunately usually fail. He thinks that subcutaneous rupture, either by force or a tenotomy knife might be successful; but prefers free incision and drainage if strict Listerian principles can be employed.—*Lancet*, Dec. 4, 1886.

H. H. TAYLOR (London).

IV. Further Cases of Plastic by Fresh Pedicled Flaps from Distant Parts of the Body. By Prof. H. MAAS (! Würzburg). As an addition to like cases previously reported by M. [v. ANNALES, 1885, June, p. 572] three new ones are here given in which success was attained by the above method.

In the first case there was extensive ulceration on the outer side of the left leg, which had withstood all other attempts at cure. The trouble originated in a large phlegmon from a contusion over a year previously. The depressed atonic sore was surrounded by a wide cicatricial zone. The ulcerated surface was cut around and prepared off, leaving a 12 x 4 ctm. defect. To avoid oozing into the dressing as