

you get a case that goes all to pieces, and then you have not got it. It has got you.

I have been doing this work now for the last twenty-five years, I suppose, and I have gone through all the phases of this particular operation of cleft palate, and I shall confine myself to the palate in this talk before you now. In the year 1896, until about 1900, I was a great defender and advocate of the Lane operation. I used to perform it in almost every case under circumstances where the clefts were very wide, and I would succeed in rare instances in getting a complete closure in one portion by means of this operation. But I came to the conclusion that the Lane operation could not give me the proper results. Regarding the Brophy method I have always thought, and I still think, that the Brophy is not so simple and not so easy as Brophy would have the average man believe.

AUTHORS' ABSTRACTS.

Surgery, Gynecology, Obstetrics, and Genito-Urinary Diseases.

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Acute and Sub-Acute Metastases. By A. L. Blesh, Oklahoma City, Okla., *Southwest Journal of Medicine and Surgery*, May, 1916, p. 129.

Modern conception of metastasis is not to be found in the text-books. The work of Rosenow under Frank Billings in showing the transmutability of bacterial strains and their tissue predilections constitutes the great modern medical drive which has placed internal medicine abreast of surgery.

Malignant metastases have long been known. In pyemia also the phenomenon of extension is by "jumping."

Old definitions of metastasis do not now hold. Blood stream dissemination in accordance with special tissue predilection and the law of reduced local resistance from traumatism, etc., is now rising to greater prominence.

Acuteness or chronicity depend more on virulence and quantity of infection in relation to tissue resistance than upon the route of distribution. Secondary lesions are often called "idiopathic." Pathologic changes are true to form, no matter where they occur.

Mouth infections furnish 60% of primary foci. Gall bladder and appendix are frequently infected from the same source.

Active factors of disease metastasis are, of course, always pathogenic bacteria.

Passive are—

1. The nidus or focus.
 2. Tissue predilection.
 3. Traumatism.
 4. Result is the pathology or morbid anatomy.
- Factors to be considered are—
1. Infecting agent.
 2. Focus or portal of entry.
 3. Route metastases.
 4. Selective action of germs.

Focus is of utmost importance and here is to be concentrated our diagnostic drive.

Case reports for illustrative purposes.

Above all it must not be forgotten that surgery is for the benefit of the patient and not the surgeon.

Again, getting well of an operation does not necessarily mean recovery from a disease.

Chronic Trigonitis. By H. W. E. Walther, New Orleans, La., *Medical Record*, May 13, 1916, p. 853.

Walther points out that trigonitis *per se* has been a neglected malady among urological workers. Some of the most careful clinicians in this field of medicine have long recognized that there is such a condition as inflammation of the trigone of the urinary bladder, but few even today in this country have taken enough interest in the subject to tabulate their personal opinions or experiences with this form of cystitis.

Garceau, Furniss and Bierhoff have been the most prolific contributors to this subject in American medical literature.

Trigonitis is most common in women. The causes are: (a) primary infection, or (b) secondary infection engrafted upon a simple hyperemia of the trigone due to eurgorgement of these parts accompanying some pelvic disorder.

The chief symptoms are, frequency of urination, pain during the act, urgency and tenesmus.

The diagnosis can only be made with the cystoscope. The writer fully describes the cystoscopic pictures which characterize this condition.

Under the treatment Walther takes up the dietary treatment, the instituting of free catharsis, rest (physiologic), and medicinal. Of all the urinary antiseptics he believes urotropin of the greatest value. Locally irrigations are mentioned, but not recommended. Instillations of silver nitrate solutions in strengths of from 0.25 to 2% are of extreme value in some cases. The writer uses alupin as a local anesthetic in bladder before instilling the silver. In cases of the worst types which do not respond to the usual line of treatment he recommends suprapubic cystostomy with curettage or otherwise treat trigone through surgical incision and drain viscus with Pezzet catheter.

Canadian 606. By Wm. S. Robertson, Charleston, W. Va., *W. Va. Medical Journal*, May, 1916, p. 372.

In spite of adverse criticism it is evident from the use of thirty-four injections of Diarsenol that this preparation is identical with Ehrlich's Salvarsan.

Primary, secondary and late syphilis yield as well and as promptly to the Canadian as to the German product. The ill effects following the use of the former have been reported after the administration of the latter and are attributable to idiosyncrasy, faulty technique, administration in unsuitable cases, etc. The author has experienced no difficulties in his series. (Injections to date number 57, June 24th.) The usual dose employed is 0.3 G. This is apparently as effective and is undoubtedly safer. It is repeated in from three to five days as indicated. A simple apparatus is used consisting of a 20 cc. Luer syringe, two-way stop-cock to fit syringe, and two pieces of small rubber tubing about six inches in length. The needle is inserted into the vein, one tube to it and the other in the beaker containing the solution of Diarsenol. By alternate suction and pumping with stop-cock valve properly turned, the beaker is emptied into the circulation.