AN IDEAL ARRANGEMENT FOR THE TREATMENT OF FEMORAL FRACTURES

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The accompanying illustration shows a practical and exceedingly satisfactory arrangement for the treatment of fractures of the femur. Hammerstein's extension table is made use of to fix the patient's body and limbs; an x-ray tube suspended on an adjustable cross-bar of the table is connected with the coil. An assistant can increase or decrease the amount of extension by a turn of the screw attachment, as can he also control the amount of abduction or adduction.

The operator thus equipped can make frequent use of the fluoroscope during his manipulations and all guess-work is positively eliminated. When perfect position is secured there is no hindrance to the application of splints. Should plaster-of-paris casings be used we have the same unobstructed freedom as when applying spicas for tubercular hips. I use internal plaster splints and external splints of the same material, reaching from the axilla to the external malleolus with a steel rod incorporated for extension on the foot. When the splint is properly applied and secures muscular immobilization there is no reason why the bony fragments should be displaced.

The last three femoral fractures that have been referred to me were difficult cases, all of the patients

Extension table with x-ray attachment for the treatment of femoral fractures by the illuminated method. Note the unobstructed field for application of immobilizing splints; also mode of applying extension and abduction, and case of positive reduction.

having suffered breaks in the region of the surgical neck. The three after this method of illuminated reduction and immobilization were taken from my operating room to their homes in conveyances. Later radiographs show splendid results.

NEW APPARATUS FOR COMPLETE DRAINAGE OF THE BLADDER FOLLOWING EITHER SUPRAPUBIC OR PERINEAL CYSTOTOMY

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Having had considerable difficulty in draining the bladder after cystotomy with the ordinary apparatus, I devised the apparatus shown by the accompanying cut, which fulfills perfectly the purpose for which it was constructed, that of perfect drainage of the bladder.

After the patient is placed in bed the tubing is connected with a drainage tube from the bladder. The Y-shaped tube F must be below the level of the patient lying in bed; the reservoir A filled with water, the stop-

Apparatus for complete drainage of cystotomy; A, reservoir for water; B, stopcock for regulating the flow; C, cup weighted in the rear to hold in place when empty; D, funnel to catch the water when the cup tips on being filled with water; E, long tube which connects the funnel with the Y-shaped glass tube; F, Y-shaped glass tube; G, tube connecting the drainage tube from the bladder with the Y-shaped tube.

cock B turned on so that the water will drop slowly into the cup C, which, on being filled, tilts and empties itself into the funnel D. The water running down the long tube E into the Y-shaped tube F forms behind it a suction which causes a siphonage of the fluid in the bladder. This siphonage may be regulated to occur at any given interval by arranging the flow of water from the stopcock B which flows into the cup.

Usually the first twelve hours following the operation I regulate the flow so that the cup will tilt every five minutes, which is sufficiently often to keep the bladder perfectly dry. During the second twelve hours I arrange the flow so that the cup tilts about every ten minutes; during the second twenty-four hours, about every fifteen minutes.

I find this apparatus of exceptional value, particularly after prostatectomies, in which perfect drainage is exceedingly essential. Complete drainage of the bladder causes the patient to be comfortable and free from pain,

whereas if the bladder is not drained completely and is allowed to fill, the distention is accompanied with considerable pain and discomfort to the patient.

I am sure that those who are doing much bladder work have met with the same difficulties in perfect drainage as I have met with in my work, and that if they will take the occasion to use the apparatus which I have devised they will be satisfied with the results.

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WOUND CLOSURE WITH A MINIMUM SCAR *

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This subject is ever interesting, as the scar which remains is a constant reminder to patient and surgeon of an important event in a human life. It is the one thing that remains uppermost in the mind of the patient long after the disease for which the operation was performed is forgotten. In exposed parts, especially neck and face, an unsightly scar is embarrassing.

There are two essential factors in the production of a minimum scar, viz.: asepsis and the proper coaptation of tissues. The former is impossible, the latter is rapidly being perfected. The older method of interrupted sutures which was devised with the thought in mind that if one suture gave way, owing to sloughing, the remainder might hold, has largely been replaced by the continuous. The right-angle subcuticular suture is an excellent one for closing the skin and is the one now in general use.

After experimenting on dogs, Dr. Ryfkogel and I have put into use, in the former's clinic and in our private work, the following method for closing wounds. For example, in the closure of a laparotomy wound, the peritoneum is closed with No. 00 iodized catgut, the serous surfaces being approximated by a right-angle suture. One, two or three silk-worm-gut tension sutures are placed through the remainder of the abdominal wall and left untied. The muscles are drawn together by No. 00 iodized catgut, and the fascia either overlapped according to Moynihan, or the raw edges approximated with No. 1 chromic catgut. The space between muscle and skin is obliterated, as the case requires, with No. 00 iodized catgut. A similar suture is run close to the skin, which is closed by a continuous suture of china-bead silk carried by a No. 16 embroidery needle. The stitches are placed nearly two-thirds of a centimeter apart and include nearly one millimeter of the edge of the skin in their grasp. A collodion strip is placed over the wound and the tension sutures are tied over a bolster of plain gauze.

The apposition of the skin is almost perfect, there being no spaces left in which blood clots may form. The wound is inspected within three days. When the sutures have served their purpose they can be wiped off with a dry sponge, leaving an almost invisible scar.

We have not attempted to keep any record of these cases, but so far there has not been one bad result.

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Syphilis of the Upper Air Passages.—W. A. Lieven (*Journal of Laryngology*, March) states that tertiary processes in the larynx require energetic general treatment as there is a marked tendency to cicatricial narrowing of the larynx in these cases.

Therapeutics

ACUTE CHOREA

Although there is nothing new in our knowledge of the best treatment of this disease, it may be well to rehearse our present understanding of chorea, as well presented by Charles H. Scribner, Patterson, N. J., in the *Journal of the Medical Society of New Jersey*, February, 1909.

The pathologic disturbance which causes the muscular movements which are termed chorea seems to be principally located in the brain, and the great variety of movements and their generalization in severe cases of chorea show that there are irritations in various parts of the cerebral cortex and basal ganglia. The symptoms referable to cerebral irritations are, besides the muscular movements, mental irritability, sleeplessness, troublesome dreams, night terrors, impaired memory, and various hallucinations of sight, taste, and smell. Besides anemia and disturbed menstruation in young girls, often amenorrhea, a most frequent complication is endocarditis.

It is probable that chorea is due to an infection, and this infection is doubtless closely associated with the micro-organisms that cause acute inflammatory rheumatism. There is no reason to believe that the disease of chorea is contagious, but neither is rheumatism. Still, it is wise to isolate a child, not only for its own sake, but on account of other children involuntarily mimicking the movements of the patient, and imitative chorea is an accepted condition.

The earlier the patient is taken from school and put to bed in good hygienic surroundings, or, if the case is very mild, taken where, with the least exertion, noise and confusion, he or she may have the most fresh air and sunlight, the less likely is the chorea to be severe.

The success of any medicinal treatment must be judged by the accepted fact that chorea is self-limited, and the intensity of the symptoms will abate in from two to four weeks. Arsenic, in the form of Fowler's solution, the dose being increased by one minim a day until the full physiologic effects are obtained, is the treatment that is most lauded and many times apparently the most successful. On the other hand, it often fails, and it is possible that in the many mild cases in which it apparently succeeds it is successful only because the disease is self-limited. Doubtless many cases of neuritis and blood deterioration have followed in the steps of chorea because too much arsenic has been used, and it certainly does not seem advisable, in a disease that is apparently self-limited, to give a poison in sufficient amount to produce poisoning to attempt to shorten the disease. Scribner says that as soon as the lids become puffy, or gastrointestinal symptoms develop, the dose should be decreased again to the starting point.

To reiterate, it does not seem advisable to use a drug so foreign to the system as arsenic to the point of serious symptoms (and it should be remembered that when puffing occurs under the eyes from arsenic there is also generally albumin in the urine). When, during its administration, choreic movements cease, it is by the self-limitation of the disease, or by the arsenic causing some debility of the nerves, if not an actual neuritis.

Scribner states that antipyrin is one of the most valuable of drugs in lessening muscular activity and easing the pains that may be present in the muscles and joints. This drug is valuable in relieving muscular contrac-