unsuccessfully. The fistula, however, healed, but an absolute stricture remained. With a set of Bowman's probes, I decided to dilate the stricture. The patient was of such a nervous temperament that nothing could be accomplished unless under an anæsthetic, which was always employed when the probes were used. The lachrymal canal was thoroughly laid open to its junction with the duct, and a No. 1 probe inserted. This was arrested at a point a little below the junction, but by gentle perseverance this point of resistance was passed. Other slight obstructions were overcome, until, when estimated to be within one-twelfth of an inch of the final termination, an obstinate obstruction was encountered, which conveyed the impression it was an obstruction of bone, and which successfully resisted the further passage of the instrument. A No. 2 probe was easily passed to this point and then arrested. A few days later, again placing the patient under an anæsthetic, beginning with a No. 2 probe, Nos. 3 and 4 were successively passed to and arrested at this same point.

Then, after passing all the set of probes, including No. 8, and being unable to get beyond this obstruction, an instrument was ordered and made by Chas. Truax & Co., of Chicago, of the form and diameter of a No. 8 Bowman probe, but armed with a steel drill at the distal extremity. A regular No. 8 probe was passed to the obstruction and withdrawn, in order to open as well as could be the tract, and the armed probe entered. There was a little difficulty experienced in passing it, owing to the disposition of the sharpened edges of the drill to catch in the membrane, but patience and perseverance overcame this, and the obstruction reached, several rotary motions of the drill were made, and there was no difficulty in detecting when the bone was perforated. The drill was withdrawn, a No. 8 probe passed the entire length without difficulty. The patient experiences great relief, and is in a large measure free from the troublesome symptoms attending a lachrymal stricture.

Albion, Mich., April 16, 1887.

A NOTE ON TANNIC ACID AS A SURGICAL DRESSING.

BY T. J. HUTTON, M.D.,

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Tannic acid forms an excellent dressing in three classes of wounds, viz.:

1. Incised wounds—applied after the sutures are inserted, or adhesive plaster is on—if the wound does not require stitching.

2. Small wounds of irregular form and recent occurrence.

3. Wounds of moderate size in compound fractures. Wherever applicable it excels all other dressings in the following respects:

1. Convenience.
2. Cheapness.
3. Cleanliness.
4. Efficiency.

It is always ready. It costs but a trifle. It requires no greasy mixing, measuring or muddling and

has neither smut nor smell. While of its efficiency I can only say after sixteen years use that I am satisfied: I ask nothing better. I first called attention to this neat, choice dressing in an article entitled "Fifty Fractures in Mining Surgery," which appeared in the *Medical and Surgical Reporter* for September, 1878.

The method of application is simply to keep the wound covered with the powder. Wounds thus treated heal on the average in about one-third of the time required for similar ones treated by liquid, oily or salve dressings. In converting compound fractures into simple fractures by this method, the flesh wound is often healed in one-twelfth of the time required to heal it by wet dressings or salves that are frequently removed and re-applied. Illustrations are unnecessary if I have clearly defined the classes of wounds in which this dressing is applicable. Although hundreds of cases thus treated could be adduced that would prove interesting reading, I will describe the last case only in which this dressing was employed:

F. J., aged 16, German, on January 26, 1887, was struck by a falling tree. Next day he was brought to my office. There was a semi-circular scalp wound six inches in length over left parietal bone, and a fragment of this bone almost the size of a silver quarter dollar, stuck up trap-door fashion. The flaps had shrunk wide apart and were swollen and angry, as the injury had occurred twenty hours previously. The whole wound looked bad, being full of hair, dirt, serous effusion, chips, leaves and brush-wood. The patient was very feeble, but conscious. A dose of whisky and hot water was administered and the wound douched for one hour with warm carbolyzed water. When the bony fragment had been gently depressed almost to normal position, (I could not succeed in reducing it to the normal level) the scalp-wound was sutured with horse hair. Tannic acid was then applied, and directions given that it be dusted on freely every few hours, more especially if moisture should appear over any part of the wound. A laxative was administered, also small doses of aconite and bromide of potassium.

The flesh wound healed by first intention. No fever ensued; the pulse never exceeded 92. The patient went home on the 31st—the fourth day of treatment, and two weeks later his father reported that he was "all right."

April 9, 1887.

MEDICAL PROGRESS.

INFLUENCE OF ALTITUDE ON PHTHISIS.—SURGEON MAJOR NATHANIEL ALCOCK says: The explanations hitherto offered of the action of altitude upon phthisis amount to three: greater expansion of the chest from aerial rarefaction; absence of bacterial organisms from the air and general tonic effect.¹ Were the first of these effective, some improvement would be expected to follow the use of gymnastics at lower levels; of the second it may be said that every consumptive carries his own microbes with

¹The Lancet, Jan. 8, 1887.