The Filling of Cranial Osseous Defects with Charred Bone-plates.—GREKOFF (*Centralblatt für Chir.*, October 1, 1898) has employed in actual practice the method which Barth found valuable in experiments. In the cases of two young children who had, as the result of operation after serious injury, defects in the cranial bones, he used the charred bone with success. In one instance all the plates were not sufficiently charred, and he was obliged to remove some fragments. This gave him the opportunity to observe the actual condition in the remaining plates. He found that the results were all that could be desired, and that the charred plates had been replaced by new, healthy bone.

The function of the charred bone, the author believes, is solely that of a skeleton over which the new bone develops from the adjacent margins of the skull. The cancellated bone is, therefore, most readily penetrated and absorbed, and makes the best plates. In his cases he employed the scapulæ of the calf.

Bier's New Osteoplastic Amputation.—PAYR (*Centralblatt für Chir.*, 1898, No. 19) reports three cases in which this new osteoplastic method of amputation was employed with success, as demonstrated by a skiagraph taken a year after the operation.

The purpose of the method is to unite the extremities of the tibia and fibula by an osteoperiosteal flap, which is derived from the tibia in the following manner:

A musculo-cutaneous flap is formed from either the anterior and external or the anterior and internal aspect of the leg in the ordinary manner. The tibia is freed to a considerable distance below the point at which it is desired to amputate. A transverse incision is then made at a distance below the line of amputation equal to the length of the desired bone-flap. This incision forms the base of a wedge-shaped portion of the tibia, that after removal permits the insertion of a flat saw-blade and the cutting of the osteo-periosteal flap up to the line of amputation. The periosteum is now raised over the line of amputation at the base of the osteoperiosteal flap. A grooved director is passed beneath the periosteum, and with a narrow saw the portion of the bone-flap is removed, which will permit it to bend over without interfering with the circulation on which it depends for its nutrition. When this has been accomplished the flap of bone is turned back and the tibia cut through. The fibula is cut at the same level, and the osteoperiosteal flap is fastened upon the resected ends of the two bones. The wound is closed in the usual manner. Asepsis or the use of only non-irritating antiseptics is essential to the success of this operation. The Röntgen ray picture showed that the osteoperiosteal flap had retained its original thickness throughout, and that it was firmly united to both the tibia and fibula. The functional result attained was all that could be desired.

The Diagnosis of Nephrolithiasis by Röntgen Ray Pictures.—RINGEL (*Centralblatt für Chir.*, December 10, 1898) has followed out the experiments of some of the earlier investigators and has found that the different forms of renal calculi vary in their opacity to the Röntgen rays.

Oxalic-acid calculi are the most opaque, uric-acid calculi are less opaque,