whole, the left leg was the longer; the right in 16 per cent. The arms were equal only in 17+ per cent., and unequal in 83 per cent.³ In 75 per cent. of the whole the right arm was the longer, the left in nine per cent. Only one man in one hundred was left-handed and only a single man of this class had the right arm the longer.

THE FORAMEN CÆCUM.⁴

Professor Holl points out that the statements in anatomies concerning this little hole are not all the same. The general impression concerning it is that it is sometimes merely a blind pit, in other cases a communication between the cranial and nasal cavities transmitting a vein. The last impression, according to Holl, is quite a mistake. In the adult it is a closed canal completely filled by a process of dura mater. In the macerated skull of a young person it is truly a canal, but it transmits no vein, for skulls which have not been macerated show that it is closed below by cartilage; the process of the dura mater which passes through it runs for a short distance between the cartilage and the nasal bones. In an embryo of a new-born child this band runs as a small thread to the tip of the nose. The bone which grows round the upper part of this is the nasal spine of the adult frontal bone. This spine is very important; it runs as a pin between the ethmoid, the nasal bones and the median prominence of the frontal. This has, moreover, a pathological interest. If the nasal spine does not develop, this place is closed only by membrane, so that an encephalocele may occur.

THE TRANSVERSE PALATINE FISSURE.⁵

This is the fissure formed by the junction of the horizontal plates of the palate bones with those of the superior maxillæ. It has received no great attention as its variations are of no practical consequence. Professor Stieda has classified the kinds of suture with his well-known accuracy. It is possible that the matter may have some ethnological value. Besides irregular forms which defy classification, he finds three chief dispositions of this fissure. The most usual is when it bends forward with a convexity which is completed at the median line by the opposite suture. It may instead run straight across, or finally it may bend backward. Stieda examined 1,382 skulls which were suited to the purpose, that is to say, in which the hard palate was not injured nor the suture obliterated. More than 1,000 of these were in two collections at Königsberg, but the remaining 300 were in the anthropological institute of Rome. About 200 of the last were skulls of Melanesians and the rest of Italians. Of the Melanesians about 48 per cent. had the anterior convexity and about 40 per cent. had a straight suture. This is very different from the results obtained with the German collections which showed the anterior convexity in from 65 to 68 per cent., and the straight line in from 14 to 19 per cent. The Italian skulls had the forward convexity in 72 per cent., the straight line in 40 per cent. In all races the posterior convexity was less common and irregular forms rarest of all.

THE LYMPHATICS OF THE ANUS.⁶

Dr. Quénu finds that the lymphatics of the anus

³ In the original these figures are respectively 18 and 82, but this does not tally with what follows. We have corrected two evident mistakes but an error of one per cent. remained.

⁴ Verhandlungen der Anatomischen Gesellschaft, 1893.

⁵ Archiv. für Anthropol., Band xxii, 1893.

⁶ Jour. de l'Anat. et de la Physiol., No. 4, 1893.

empty into the glands near the termination of the long saphenous vein, most often somewhat above that level, but not rarely below it. The lymphatics of the anus are connected with those of the rectum along the columns of Morgagni. The course of the rectal lymphatics was studied only on children, which seems unfortunate. The author wished to ascertain whether they emptied only into the glands of the meso-rectum, or whether they had any connection with glands at the sides of the pelvis. He found that the lymphatics of these parts may be divided into three sets: those of the anus already mentioned inferior to the *levator ani*, those just above that muscle running to the lateral glands in the neighborhood of the internal iliac or of its chief branches, and finally, superior ones running to the glands along the superior hæmorrhoidal artery.

New Instruments.

A MODIFICATION OF THE LONG TRACTION SPLINT FOR HIP DISEASE, DESIGNED TO PROVIDE A LIGHT APPARATUS FOR LITTLE CHILDREN.

BY AUGUSTUS THORNDIKE, M.D., BOSTON.

It not infrequently happens in orthopedic practice that a child three or four years old has to wear a Taylor hip-splint, a high-soled boot, and use crutches. It is almost invariably very slow work teaching such small children to walk thus encumbered. In the out-patient clinic the parent becomes first discouraged,

then firmly convinced that it is impossible for such a small baby to walk on crutches; and in some instances the child is taken away from the clinic, and all treatment for a while is abandoned. If not, then after several months of encouragement and advice on the part of the orthopedist, the child gets to use crutches in spite of the parent's unbelief. In the hospital-ward instruction in the use of crutches is more easily and quickly given; but a little child always monopolizes a great deal of the nurse's time before it finally learns to walk. Taking both of these factors into consideration, it seemed to me that much time and trouble might be saved

by making the splint out of a lighter material than the square bar of iron or steel generally employed, at least in this city. For this purpose, I have used for the upright of the splint a piece of steel tubing, which is both lighter than iron gas-pipe and stiffer than brass tubing.

Into the upper end of the tube is brazed a forged

piece, flattened out and shaped like the forging on top of the upright of a Taylor splint, which serves to connect it by three iron rivets to the waist-band of the splint. To insure strength, the lower part of the forging should nearly fill the tube for the upper two inches. The waist-band is not different from that of the ordinary traction hip-splint, and provides buckles for the completing belt and two perineal bands. Into the lower end of the steel tube, slides an iron rod; the lower part of this is forged into a light foot-piece, while upon the upper portion, for about six inches, a thread is turned of twelve turns to the inch, which carries two nuts. This rod should slide easily within the tube and at the same time almost fill it. By cutting a slot in the tube of one inch (the lower end of which should be at least two inches from the bottom of the tube) and inserting a small pin through the slot into the rod, the foot-piece is kept from twisting. Two straps riveted to the sides of the foot-piece serve to attach it to buckles on the leg extensions. The thigh-pad and calf-band are secured to the splint by simply wrapping the end of the arm once around the tube and tightening it with a screw. This holds the arm firmly enough for a small child, and enables one to alter the position of the bands with great ease. The upper part of the tube may be made to fit the natural curves of the body, but the lower six inches should be straight to allow the rod to slide within it.

In applying the splint the belt and perineal straps should first be tightened. The straps from the foot-piece should then be buckled firmly into the buckles on the leg extensions, and the webbing strap from the calf-band fastened. When the splint is put on, the pin should be at the top of the slot. By turning the upper of the two nuts with the wrench, any desired amount of extension may be applied; then holding the first nut steady with the wrench, the second nut is screwed firmly down on the first. This locks the two and prevents slipping. Two wrenches are provided for the purpose.

I have only had occasion to apply this form of splint twice during the past eighteen months; but the rapidity with which those little children have learned to get about has led me to think that I have been using too heavy apparatus. My limited experience has already disclosed two facts about this splint: first, that any rivet-hole or screw-hole in the steel tube renders it liable to break; and, secondly, that the "locked" nuts do not hold, but gradually loosen, if the little patient attempts to discard crutches and walk about on the foot-piece and high sole only.

Now that steel tubing is manufactured in this country, the cost of this appliance should not exceed that of other long traction-splints which provide for the adjustment of the amount of extension by the ratchet and windlass.

THE VALUE OF BUGS.—A curious case has recently come to trial in Brooklyn. A professional bug-exterminator sued a saloon-keeper for \$25 for clearing his premises of insects. The plaintiff declares that he killed 8,000,000 bugs, which is at the rate of 3,200 bugs for a cent. The defendant asserts that the sum agreed upon was \$12.50, that the plaintiff previously owed him \$11.40, and that in the course of the work of extermination he (the plaintiff) drank up more than the balance.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

J. T. BOWEN, M.D., SECRETARY.

REGULAR meeting, Monday, October 9, 1893, the President, Dr. C. F. FOLSOM, in the chair.

Dr. GEORGE HAVEN read a paper on

SOME CASES OF LAPAROTOMY.

Dr. J. G. BLAKE: I have nothing to say about the appendicitis cases. I only desire to congratulate the reader upon getting the malignant disease of the uterus at such an early stage. Usually, when these cases come under treatment the disease has really got beyond control, that is, the glandular tissues and the uterine appendages are so diseased that removal of the uterus itself does not seem to accomplish a great deal. I should like to ask if the surrounding parts were quite free.

Dr. HAVEN: They were entirely free. The trouble was entirely in the body of the uterus.

Dr. BLAKE: I think this is the class of cases that justifies a grave operation like removal of the uterus. I have long thought after studying the statistics of radical methods and comparing as far as possible the results with those of milder methods, that the preponderance of evidence was in favor of not incurring the risk of grave operations, but of treating symptoms and keeping the disease in subjection by constant supervision. In considering the results of vaginal hysterectomy for malignant disease, Dr. Chadwick makes the statement that all his cases died within a year; and in the "System of Gynecology," edited by Mann, the statement is made that none of the patients who had undergone the operation of removal of the uterus were living at the end of five years. From my own knowledge, I feel safe in saying that where as much of the disease as can be reached is removed by curettes and caustics and the patient kept under supervision, life is rendered tolerable, free from pain, and prolonged on an average about two years. Unless the doctor is fortunate enough to get the disease in an early stage of development my own opinion is that the milder methods accomplish as much, taking into consideration the risks that follow the radical operation. Most of the cases of malignant disease of the uterus which have come to the City Hospital have come at a late stage, and looking back over a number of years I have never been quite satisfied that the conditions present when the patient came under observation were such as to justify resort to the graver operation.

Dr. J. B. AYER: The second case I think was extremely interesting. The little girl of six years when I first saw her did not have pain exclusively localized in the region of the appendix. The pain was general. I felt suspicious of this trouble, but could not then make a positive diagnosis. On the second day in consultation with Drs. Haven and Putnam we concluded that there could be no doubt about the diagnosis. The case seemed a desperate one from the outset. The result I think was most brilliant.

I have recently seen another patient who died of appendicitis on the second day, in whom pain did not begin near the appendix, but in the epigastric region. In a few hours, however, it was over the appendix.

Dr. E. H. BRADFORD: I am glad Dr. Haven has