through the perineal wound and left in position to act as a drain. The gaping wound is then packed with more gauze, and may be reduced in size by a few sutures. The writers placed a permanent catheter in the bladder, but think it would perhaps be better to avoid its use, since the bladder rarely escapes infection from it in spite of all precautions.

In conclusion, the writers consider that, if the sacrifice of the sphincter be admitted to be advisable, the abdominoperineal operation offers a free and safe removal of the cancer in the early stages, and permits the removal of some that are inoperable by other methods. It marks a notable progress in the treatment of cancers of the rectum.

Report of the Results of Non-traumatic Surgery of the Brain and Spinal Cord at the Massachusetts General Hospital.—CODMAN (*Boston Medical and Surgical Journal*, July 20, 1905) says that of the 36 operations performed, in 28 an attempt at a radical removal of the tumor was made, but that none was successful. In those who lived after the operation, relief of pressure was followed by improvement in a considerable number. The failures were probably due to strangulation of the motor cortex through the trephine opening, or to damage to the brain tissue. Therefore, in the hands of most surgeons, a simple, palliative operation for relief of pressure will be the best in the long run. In but three cases was a radical removal of a tumor actually done. Two of these died almost at once and the third recurred later.

Putnam says that the cleaning up of the results of old injuries to the cerebral membranes and skull undoubtedly results favorably in a fair number of cases, although they are strangely variable. The most important point, as regards the treatment of epilepsy by operation, is as to the value of excision of the motor areas of the cortex in cases with localized aura. Although there is much to say of a practical character in its favor, it is still in doubt.

A Case of Sacculated Aneurysm of the Abdominal Aorta Treated by the Introduction of Silver Wire and the Passage of a Continuous Current.—GRIFFITHS (*Lancet*, August 12, 1905) reports an interesting case, in which the illness had its origin about three months before the operation. He experienced a strain in lifting a rather heavy camera and other impedimenta, and swinging them over his shoulder. There was no history of syphilis or rheumatism. He had gonorrhœa about twenty years before. The tumor in the abdomen occupied mainly the epigastrium, and was entirely on the left side of the median line. It was about the size of a cocoanut, and was distinctly pulsating, with a well-marked systolic bruit. The patient said that there had been no increase in the size of the tumor lately, but he thought it had become harder, and although at one time he was able to "squeeze it away," he was now unable to do so.

An incision a little to the left of the median line was made over the tumor, opening the abdomen. The placing of a temporary ligature around the aorta above the tumor was not practicable, on account of insufficient room. A spot devoid of vessels was selected on the surface of the tumor, and a small circle was enclosed in a purse-string suture, through the centre of which a fine, long, metal trocar and cannula were thrust well into the sac. Through the cannula a vulcanite cannula

was introduced for insulating purposes. Next some fine silver wire was introduced into the sac through the double cannula. While putting in the wire the writer tried to avoid the communication between the sac and aorta by keeping the end of the cannula to one or other side of the sac. After some wire was introduced, it was connected with the negative terminal of a constant-current battery, the current being completed through the patient by means of an electrode placed on the thorax. A current of from 15 to 25 milliampères was given and continued for fifteen minutes, when the aneurysm felt harder and the expansile pulsation had grown less, if it had not quite disappeared. The wire (about six feet) was then pushed in, the cannula withdrawn, the purse-string suture tied, and the abdomen closed. The patient suffered greatly from shock, and died five and a half hours after the operation. The postmortem showed that the aneurysmal sac communicated with the aorta by means of a narrow, elongated mouth, about one and a half inches long. The sac was filled with a dark clot and coiled wire, a double loop of which had entered the aorta and passed, for about two and a half inches, up into the thoracic aorta. The rapidly fatal termination was undoubtedly favored by the interference with the functions of the stomach, which was stretched around the left and lower border of the aneurysm. The patient failed rapidly before the operation, and became increasingly anxious that something should be tried to relieve him, even if it were not successful.

The Pathology of Prolapse of the Rectum and its Operative Treatment by a Plastic Operation on the Pelvic Floor.—HOFMANN (*Zentralblatt f. Chirurgie*, September 2, 1905) thinks that our present methods of treatment, including operations, leaves much to be desired. Recurrences have probably been more frequent than positive successes in the hands of all. Those operative measures aiming at a cicatricial contraction of the anal orifice are insecure and disappointing, except, perhaps, the method of Thiersch, by the introduction of a wire ring around the anus, that not only contracts the anal orifice, but may be compared to a well-fitting truss, which, while it does not cure, prevents dangerous complications. The striking results sometimes obtained from the Thure-Brandt massage is explained by the increased strength given to the muscles of the pelvic floor.

Hofmann believes that prolapse is not caused by a prolapse of the mucous membrane first, and then a dragging out of the rectum, but, as Waldeyer thinks, it is like a hernia, the result of intra-abdominal pressure and weakness of the retaining wall; in this case the pelvic floor. An impaired pelvic floor is necessary to its production, the anal opening furnishing what corresponds to the hernial orifice.

The uterus prolapses only when it is deprived of a supporting pelvic floor. The role played by this support explains the well-known fact that the prolapse of the rectum occurs usually in children and weak women. In children the straight sacrum, the weakness of the muscles, and the strong intra-abdominal pressure exerted by children in defecation favor prolapse. Spontaneous cure results from gradual increase of strength in this region with the development of the child. To the same explanation may be attributed the favorable results following the Thure-Brandt method of massage. The failure after colopexy is due to the continuance of the weak pelvic floor. There is even a tendency