protect the peritoneum from the heat of the cautery or from contamination with the contents of the appendix as can these shields.

After the separation of the appendix the shields may be very easily removed. No jerking is required. The slightest traction releases them. After they have been displaced the base of the appendix is held in a simple light clamp. It is now readily possible to introduce the purse-string suture, after Dawbarn's method, or the Lembert sutures, after the method of Joseph Eastman, the forceps remaining in place and preventing escape of infectious material until the purse-string suture is ready for tightening, or the Lembert stitches, all in place, are ready for tying, according to the choice of the operator and the shape of the stump. The purse-string suture, if used, should be drawn tight as the forceps are removed. On the release of the stump by the removal of the forceps the canal may be explored and the stump invaginated. All of these manipulations may, if it be desired, take place simultaneously.

If the method described be used there is hardly any time at which there is a possibility of pus or any infectious matter from the lumen of the appendix or cecum escaping into the peritoneal cavity. The jaws of the forceps are so light as to cause very little contusion or devitalization of the tissues of the stump.

The use of the forceps minimizes hemorrhage and will in most cases shorten the time of operation. As to the use of the cautery for the separation of the appendix there can hardly be a valid argument against its use. McBurney and many others cauterize the stump after removal of the appendix. Why, therefore, not secure the additional safeguard against infection by making an igni-amputation of the appendix with the cautery? In most cases a separation may be accomplished with the cautery almost as quickly as with the knife, and certainly with greater safety. The forceps should have slender jaws beveled on the under side to avoid cutting the serosa of the cecum where they compress.

The forceps as represented in the illustration appear somewhat heavier than they should be. The grooves in the jaws should not run transversely, but parallel to the jaws of the forceps. The jaws with longitudinal grooves may be more readily withdrawn from the appendix.

THE SUCCESSFUL TREATMENT OF GONORRHEA AND ALL INFLAMMATORY DISEASES OF THE URETHRA

BY PACKING IT WITH AN ANTISEPTIC OILED DRESSING.

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Neisser declares gonorrhea to be the most prevalent contagious disease, except measles, in all Europe, and that more than three-fourths of the urban population have had the disease. I believe reliable statistics would show the same condition to exist in America. So widespread is this disease that few practitioners are ever without one or more cases. The consequences and sequelæ of gonorrhea are so often hurtful and its treatment by the profession generally has been so uncertain and unsatisfactory that it really is to be considered a woeful disease.

The injection treatment, perhaps the most universally used, and, by the way, the most abused, can never be depended on to yield definite results. The irrigation treatment, now popular with a large number of physicians, is so often disappointing that it is scarcely more

commendable than the injection treatment. Internal medication is not to be considered a treatment *per se*, and should only be used as an auxiliary to local treatment. Certainly nothing approaching a specific has ever heretofore been proposed to treat this most common affliction of mankind. Hence it is with peculiar pleasure that I announce to the profession a new method of treating this intractable malady by packing the urethra with an antiseptic oiled dressing.

When a patient presents himself for treatment he is examined carefully to ascertain the real condition to be dealt with: whether the case be acute or chronic, anterior or posterior gonorrhea, and what complications, if any, exist. I believe in giving only the most important directions and require them to be carried out. When too many directions are given the patient he is not careful to follow any of them. I advise bodily rest only when convenient for the patient. A regular non-stimulating diet is allowed. Coffee, tea and tobacco are to be used sparingly. It is better if they are discontinued entirely. Alcoholic drinks and sexual indulgence are absolutely prohibited while under treatment. Salines are directed to keep the bowels open. The treatment proper is given in the following manner: After the patient empties his bladder completely the urethra is irrigated with a hot solution of potassic permanganate, about 1 to 3000. For this purpose I use the Valentine irrigator; though, if nothing better is at hand, the urethra may be flushed out several times with the ordinary rubber-tipped hand syringe. The packer

Fig. 1.—A. Groove for index and second finger. B. Slide. C. End slightly tapered and curved. D. Edge rounded and smooth.

is then dipped in a bottle of the solution used on the dressing, or glycerin may be used instead; after which the penis is grasped with the fingers of one hand and the packer introduced slowly and carefully into the urethra with the other hand. It is passed back about four inches in anterior gonorrhea and back to the neck of the bladder in posterior gonorrhea and prostatic troubles. Force is never used in introducing the packer. The urethra is then lightly packed with one inch continuous gauze strips, or better, a loosely spun cotton cord, which I now use, saturated with one of the following solutions:

R. Iodoform gr. xcv
Balsam of Peru ʒiv
Castor oil q. s. ad ʒiv

Rub iodoform in castor oil, then add balsam of Peru. You will notice that the odor of iodoform is practically masked in this solution. Or:

R. Ichthyol
Resorcin, aa gr. xl
Balsam of Peru ʒiv
Castor oil q. s. ad ʒiv
M. Ft. sol.

The instrument is gradually withdrawn as the dressing is pushed through, and when it emerges from the meatus the cord dressing is clipped with scissors, leaving about one-eighth inch of the cord outside of the meatus, which can be taken between the fingers when the cord is to be removed. A small piece of cotton is placed over the head of the penis and treatment is complete. The patient is now instructed to go as long as he possibly can before urinating, when the cord is slowly removed. The average patient will go from five to eight hours before urinating without much discom-

fort. I have packed the urethra at 8 or 9 o'clock p. m. and the patient has retained the packing all night. Ordinarily I pack the urethra once a day until after the discharge ceases, then every other day for ten days or two weeks. In some cases it is necessary to pack twice a day, morning and evening, till the discharge ceases. When the patient reports once a day for treatment he is given a solution to inject himself two or three times a day: a 2 per cent. solution of protargol in acute cases and a 1 per cent. solution of zinc sulpho-carbolate in chronic cases. While this may not be necessary, it is my practice to do it, unless the patient can report twice a day for treatment. The accompanying illustration shows an instrument I have designed to pack the urethra. While the instrument is intended primarily for a urethral packer, it can be used to pack any cavity equally as well. It is made on the order of a urethral sound, with the distal end slightly curved and tapered. The edge of

Fig. 2. The method of packing, patient standing, physician sitting.

the distal end is rounded and smooth. This facilitates introduction into the urethra and prevents injury to the urethral mucosa, which is an important consideration in the treatment of the inflamed urethra.

I submit below a record of some of the cases treated:

CASE 1.—C. B. C., clerk, unmarried, health good. Acute gonorrhea of one week's standing. Treatment was begun by having patient empty bladder completely. Then the urethra was irrigated with a hot solution of potassic permanganate about 1 to 3000, after which it was packed four inches back with gauze strips saturated with the solution. The patient was then instructed to go as long as he could before urinating, then to remove the packing slowly by catching it between the fingers and making gentle traction. He was irrigated and packed once a day for a week, then every other day for ten days, when he was dismissed. The discharge ceased after the second packing.

CASE 2.—M. R., engineer, unmarried, health good. Had treated himself by injections for about two months, yet there was a free yellowish discharge. Urethra was very tender about two inches back from the meatus. He was packed every

day for six days, then very other day for ten days, when he was dismissed. The discharge ceased after the third day.

CASE 3.—H. G. N., clerk, married, health good. Chronic gonorrhea for ten weeks. Had been treated by irrigation since attack first began. There was a scant thin discharge during the day, with the morning drop. There was also a very tender spot about an inch back from the meatus. I first passed a sound, then irrigated and packed urethra for four inches. He was packed every day for four days, then every other day for a week, when he was dismissed. The discharge ceased the third day.

CASE 4.—M. W., superintendent, married, health good. Said he had gonorrhea three years previous and supposed he was cured. He had been treated for stricture. He came to be treated for an enlarged and painful testicle, also a like affection of the right inguinal glands. On examination of penis a drop of creamy pus could be expressed from the meatus. Said he had noticed this every morning for three weeks previous. He was packed every day for four days, then packed every other day for ten days, when he was dismissed.

This method of treatment is at once simple and rational and can easily be carried out by any physician who can pass a sound. All cases of gonorrhea, whether acute or chronic, yield promptly to this treatment. The discharge ceases in two to five days, and in ten days or two weeks more the patient is dismissed cured. The antiseptic oiled dressing renders the field unfavorable for germ development and promotes healing of the inflamed mucous membrane. There will be no foul discharge to soil the patient's linen. In all cases I have treated no complications like prostatitis, epididymitis, orchitis or cystitis have occurred, nor have any strictures followed.

EXCISION OF THE GASSERIAN GANGLION.

WITH REPORTS OF TEN CASES OPERATED UPON BY THE
HARTLEY-KRAUSE METHOD.

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AND

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So many excellent articles on all phases of this subject have appeared during the past few years that it seems superfluous for us to consider it exhaustively at this time, especially as little has been added to our knowledge since their publication. We will, therefore, take up only the principal points in the anatomy and pathology of the Gasserian ganglion, the etiology and symptomatology of tic douloureux, the history of the development of the operation for excision of the ganglion, and the modern methods of performing the operation itself.

ANATOMY.

The Gasserian ganglion lies in a depression at the apex of the petrous portion of the temporal bone. It is a small crescentic mass of nerve substance, which appears, after careful dissection, simply as an expansion on the sensory root of the fifth nerve, which enters it at its postero-superior border. Its two chief surfaces are the antero-external and postero-internal; the former intimately connected with the overlying dura mater, and the latter separated from the bone by a thin layer of dura with which it is loosely connected.

Cushing describes, in addition to the thick dural layer covering the ganglion, a thinner fibrous tissue, firmly adherent to its upper surface and binding it and the sensory root to the underlying tissues. If the separation is begun from the front, the dural layer is easily lifted from the ganglion, this thinner layer remaining intact.