On Re-establishing Surgically the Interrupted Portal Circulation in Cirrhosis of the Liver.—WEIR (*Medical Record*, February 4, 1899) reviews the experimental and clinical work which has been done in this direction, and details a case of his own in which the attempt was made to unite the peritoneal covering of the liver to the diaphragmatic peritoneum and that of the anterior parietes.

The peritoneal surfaces were scratched with the sharp point of a hat-pin, and after the oozing had ceased the omentum was stitched to the edges of the abdominal wound and the wound closed. Siphon drainage was secured by passing a double perforated tube into the pouch between the bladder and attaching a Cathcart apparatus. Compression of the abdomen was produced by overlapping straps of adhesive plaster.

The patient did well for a time, but died from a peritonitis which apparently entered through the drainage-tube, although every precaution had been taken to keep it aseptic. The peritonitis was apparently localized about the tube, and was most intense in that region. The autopsy showed that firm adhesions had taken place where the peritoneum had been irritated. Scolices of echinococci were found encysted on the liver; their presence so deep in the peritoneum may have predisposed to peritonitis. Many micrococci in chains were also found in the adhesions.

Of the seven cases that have been operated upon, two recovered; two recovered from the operative interference, but were not benefited by the operation, and three died. Of these latter, one died from shock, and two from infection through the drainage wound.

The author would hereafter prefer to resort to paracentesis if it became necessary, rather than employ permanent drainage, as the risk seems less. Furthermore, of necessity, in the early stages of any surgical measure such as this, one must and should operate only on those patients who are regarded as hopeless of cure by other measures. Finally, the intent of the operation is to afford relief to the obstructed portal circulation by an artificial anastomosis that will aid nature's efforts in the way of collateral venous circulation.

Traumatic Epiphyseal Separation of the Head of the Femur, with its Relation to Coxa Vara.—SPRENGEL (*Arch. f. klin. Chir.*, Band lxvii. Heft 4) reports two cases of epiphyseal separation of the head of the femur that closely simulated coxa vara. In both cases the epiphysis was displaced downward and had united in a false position that restricted function and produced symptoms so analogous to coxa vara that the true condition was not diagnosed until after the operation. This consisted in a resection of the head of the femur, leaving the great trochanter and part of the neck. The motion in the limb was increased, but neither patient could stand on the affected limb, and they were compelled to use crutches.

The author enters into a long discussion of the literature and finds that recent investigation has shown that the traumatic separation of the epiphysis is much more frequent in the head of the femur than was formerly supposed. Twenty-three cases have been reported, including the two noted in his paper. They should lead in all cases of traumatic injury in youths to the investigation of the condition found present in the epiphysis, and this condition should never be lost sight of.

This author believes that resection and removal of the head of the bone is preferable to any other method of treatment, as by osteotomy either of the neck of the femur or through the trochanter.

Surgical Intervention in Traumatisms of the Heart and Pericardium.—CESTAU (*Gaz. Heb. de Méd. et de Chir.*, 1898, No. 17) makes a careful and critical review of the clinical and experimental work that has been done in connection with this subject. He finds that the pericardium and heart are not regions where surgical intervention is always contraindicated. Surgical intervention with relief from conditions that threatened life has been followed in a number of instances by recovery. Foreign bodies that have entered the pericardium and wounded the heart itself have been removed, the pericardium has been emptied of clots, while suppurative pericarditis has been cured by pericardotomy and drainage.

Before intervention is attempted the condition of shock that is generally present must be overcome. This is accomplished by the intravenous injection of physiological serum and other fluids. The old method of venesection has been abandoned, and it has been found that there is no greater danger by the new method of producing fresh hemorrhage. Intervention should not take place while the heart is weak, and nothing should be done to enfeeble it. Anæsthetics should be avoided or used only in a very slight amount, without full anæsthesia.

The method of intervention is influenced by the form of injury that requires it. If the injury is of the nature of a puncture or prick as by a needle, the foreign body should be removed. If the volume of the foreign body is greater it is better to operate where everything is in sight rather than to trust to the closure of the wound by a contraction as the body is gradually withdrawn. The pericardium and, if necessary, the heart is laid bare, sutures are placed in position, the foreign body removed, and the wound closed immediately by drawing the sutures.

Where an incised wound of the heart is suspected the symptoms must be the guide. Secondary intervention has succeeded in a number of cases, and intervention must be postponed till the symptoms indicate the necessity. The complications to be watched for are hemorrhage and pericarditis. In suppurative pericarditis the universal opinion is that it should be treated as all other forms of abscess in serous cavities.

In hemorrhage the question is still *sub judice*. Immediate intervention is never indicated as spontaneous arrest often cures. Therefore, if the area of pericardial dulness remains stationary and does not increase, expectant treatment is indicated. When, however, there is an aggravation of the general condition, with pallor, weak pulse, syncope, an augmentation of precordial dulness, weakening of the sounds of the heart, and recurrent external hemorrhage, intervention is indicated. When possible the track of the wound should be examined before opening the pericardium.

Further Observations on Coxa Vara.—WHITMAN (*New York Medical Journal*, January 21, 1899) reports an additional series of twenty-two cases of this disease. He believes that it is much more common than is supposed and that many cases are treated as cases of tubercular disease. Coxa vara