hard palate. This attachment is now divided for one-third of its breadth to make certain that the flap breaks at the desired level. The flap is now gradually bent down by first introducing one and then two fingers behind it; its posterior border is united to the soft palate, while its anterior and upper border is attached to the mucous membrane and muscles of the upper lip and cheek.

The advantages gained are manifest. There is a complete separation of the nasal from the oral cavity. Speech and swallowing are facilitated, and it is possible to remove much more of the diseased or suspected mucous membrane, and consequently recurrence is less liable to occur.

Catgut or silk sutures are employed. There is comparatively little bleeding more than in the ordinary operation, and the closure of the wound is the same in all other respects.

A Case of Brain-cyst with Jacksonian Epilepsy; Operation followed by Relief.—CABOT (*Boston Medical and Surgical Journal*, June 3, 1897) reports a very interesting case in which the gradual onset of the symptoms was well marked and carefully studied by an intelligent patient.

The history was that of a disturbance of nerve function beginning two years before, and at first only affecting the leg-centre at the upper part of the fissure of Rolando. Gradually the irritation extended down along the fissure of Rolando to the centres of the abdomen, shoulder, arm, and face. The degrees of functional interferences with these centres was also gradually increasing, until he had a temporary paresis of the muscles following each attack. As the irritation reached the shoulder-centre it had attained a sufficient degree of intensity to affect the sensorium, and led to a general convulsion.

It was necessary to consider the possibility of tumor, including cyst, tubercle, and gumma, and also of some degenerative changes in some way connected with the old injury to the cranium, which was a blow by a heavy stick twelve years previously, either through the irritation caused by a depressed spicula of bone, by an adhesion of the membranes, or by some change originating in an injury of the brain substance itself.

The absence of severe pain so characteristic of the invasion of the brain tissue by a tumor, and the slow development of the symptoms, led him to regard the gliomatous or sarcomatous tumor improbable. The history did not point to a gumma or tubercular tumor. On the other hand, the history of the injury to the head was so clear as to lead to it in seeking a cause for the symptoms. With so exact a location it was determined to operate.

The operation was done in two stages. An osteo-cutaneous flap was formed, and then, five days later, the dura was opened; the brain bulged, and did not have a normal pulsation. It was also noticed that the cortical portion of the brain had a yellowish color toward the upper part of the opening. Stimulation of this area produced no result, and it was only by stimulation anterior to this area that motion in the arm could be induced. The yellow area was punctured, and brownish serum escaped. The cyst was opened. It was the size of a pinhead's egg, with a very thin wall and no connection at any part with a tumor.

Total removal was impossible, so the cyst was drained with strands of silk.

The patient made a quick recovery, and the drain was removed on the third day. The patient went home sixteen days after the operation with everything solidly healed.

For one month and a half he remained free from symptoms, then the aura returned. By the use of bromide he so far recovered that three months after recovery from the operation he went West and began to work. Later he began to work harder, with the result of bringing on more severe attacks. They continued to grow worse, and he finally returned for further operation, which was performed fifteen months after the previous operation. The size of the cyst cavity was found to be much larger, but the wall had the same character. The attempt was made to remove the wall, but it was impossible; wick drainage was introduced of gauze until a suitable drainage-tube could be made. The tubes were made the shape of a shirt stud, the stem being 20 French in size, perforated sufficiently to give good drainage. One just small enough to have the smaller end enter the cavity was introduced, and the drainage was much more free than with the gauze. The patient was up on the seventeenth day, and went home on the twentieth, but the hinton was not removed till the forty-fourth day, when the cavity was obliterated. The patient has since—two years—been free from any further seizures, and has apparently been completely relieved from further trouble. The contents of the cyst fluid made it probable that it was of traumatic origin, although there was no pathological examination of its wall.

Lorenz's Non-cutting Method of Treating Congenital Dislocations of the Hip.—ELLIOT (*Medical Record*, May 29, 1897) describes this new method, with which he says he has had unqualified success, as follows:

The first step in the operation consists in the reduction or bringing the head of the dislocated thigh to the level of the acetabulum. The patient is anesthetized to a degree of extreme muscular relaxation. If manual extension is insufficient, which is frequently the case, a hand is passed around the perineum, protected by padding, and a foot hand is put about the ankle. This latter hand is attached to a screw-extension apparatus. The extension is now very carefully and evenly exerted. The operator grasps the muscles of the thigh with one hand, while the other is kept on the dislocated joint. As the extension gradually goes on the operator manipulates the thigh muscles, increasing their tension by intermittent pressure against the femur beneath, while with the hand upon the joint he appreciates the descent of the trochanter. The extension is stopped when the upper margin of the trochanter is at or just below Nélaton's line. While the extension goes on the pelvis on the diseased side is drawn down, causing some abduction of the thigh. This abduction is desirable to exert increased extension of the adductor muscles abnormally contracted. Fracture is to be avoided through care in having the extension uniformly exerted.

The next step is the reposition after the head has been reduced to the acetabulum.

Here is the chief difficulty of the operation, due in the main to changed anatomical findings.

The anterior fibrous wall of the capsule hugs closely to the surface of the acetabulum, and is rendered more taut by the extension. The acetabular