CHLORALAMID. S. V. Clevenger (Medical News, December 8, 1900).

The author holds that chloralamid or chloralamid-formamidatum is superior as a "nutrient hypnotic," as it sustains the heart, causes no irritation of the mucous membrane, and leaves no stupefying after-effects as is so often seen in the use of bromides, chloral hydrate and other hypnotics and analgesics. Nocturnal epilepsy, especially if associated with somnambulism, is markedly benefited by this drug. Chloralamid has proven efficacious as a hypnotic in melancholia, toxemia, neuroses and psychoses, and traumatic neurasthenia. The pain of locomotor ataxia and inveterate neuralgia has also been mitigated; in these cases as an analgesic, chloralamid is superior to morphine.

During its employment in the Hamburg asylum for the insane, for the period of forty months, the mortality fell from 6 in 160 to 5 in 519 in uncomplicated delirium tremens cases. Owing to its stimulating influence, chloralamid has failed in the excitement of mania and parietic dementia. Its after-effects of stupor, headache, exhilaration and epistaxis that have been reported as attending its use, are coincidences rather than results. The dose of chloralamid is 15-60 grains one-half hour before retiring. Sleep in those suffering from insomnia, has been secured on the subsequent night after one dose. As there is no liability of addiction, and no serious consequences, the blandness and efficiency of chloralamid should replace the danger of chloral hydrate, especially in insane asylum practice.

TREMAINE.

OPERATION FOR EXTIRPATION OF GASSERIAN GANGLION. H. Cushing (Journ. American Medical Association, Vol. 35, 1900, p. 1,100).

The author publishes an operation for removing this ganglion which necessitates less manipulation, causes less hemorrhage, and removes the entire ganglion more easily than other methods.

A horseshoe incision is made with a base of 4 cm., on the zygomatic arch, convexity slightly higher than the pinna of the ear. This skin-flap is first turned down exposing the temporal fascia well down to its attachments to the malar bone and zygoma. An incision is made, through the periosteum, along the outer surface of the zygomatic arch, which is raised from the upper portion, leaving intact the masseteric attachments. The ends of the zygomatic arch are then cut by bone forceps. An incision through the temporal fascia and muscle is then made concentric with the skin edge, and the soft structures retracted well down from the temporal fossa which is exposed. A small opening is made with a gouge through the most prominent part of the great wing of the sphenoid and is enlarged by the rongeur to 3 cm. The middle meningeal runs on the dura across the opening, and both may be lifted from the middle fossa as far as the foramen ovale. Between the firm attachments of the dura to the foramen ovale and rotundum the envelope of the ganglion may be split, and by careful dissection its entire upper surface exposed, care being used not to disturb the ganglion itself since its blood-supply comes mainly from below. The ganglion is then liberated by blunt dissection from the base of the skull, the second and third branches, and, finally, the sensory root and first division are freed, when the ganglion may be removed entire by cutting the three branches and evulsing the sensory root. By clinging close to the sensory root the operator is less liable to damage the cavernous sinus or the sixth nerve. The brain is allowed to fall back into place, and the muscle, fascia and skin sutured.

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