the stomach tube for rather more than a month, but by firmly plugging the external opening into the pharynx he could swallow three weeks after operation.

Cholecystitis and Infectious Angiocholitis due to Coli Bacillus—Cholecystotomy—Recovery.—LEJARS (*Gaz. Heb. de Med. et de la Chir.*, March 25, 1897) reports an interesting case of infection of the biliary passages by the coli bacillus.

He says we have to do in this case with a coli bacillus infection, without lithiasis of the gall-bladder and of the larger subhepatic ducts, and this infection has made itself manifest for two years by painful and febrile crises, which have latterly become more and more frequent. In addition the intervention took place during an acute attack, more acute and more severe than any of those previous, and had for its purpose the relief of symptoms typhoidal in nature and menacing a general septic nature.

The immediate relief produced by the cholecystotomy and drainage of the bladder was shown in the evening fall of temperature.

The case admirably demonstrated the results which such an intervention, so simple in its nature, affords. It also provided a method not only for the relief, but also for the cure of a chronic condition which had resisted all other forms of treatment.

A Case of Subphrenic Abscess followed by Empyema Successfully Treated.—MCNAUGHT (*British Medical Journal*, May 22, 1897) reports the following interesting case:

A well-nourished man, aged thirty-three years, was seized with severe epigastric pain and vomiting. His previous history showed dyspepsia, but no hæmatemesis. Morphine relieved the pain, and no further vomiting occurred.

Ten days later he had a severe, catching pain at the lower angle of the scapula. Coarse friction-sounds were audible at that point. There was a short cough, but no expectoration. Temperature 101° F., pulse 114. As there had been no exposure, the author suspected a rupture of the stomach and the formation of a subdiaphragmatic abscess. There were no signs of general peritonitis. Two days later a displacement of the lower border of the diaphragm was noted throughout its entire extent. The usual liver-dulness was replaced by tympanites, which extended from the lower costal margin as far upward as the nipple and as far back as the anterior axillary line. At the right base there was marked dulness extending from the inferior angle of the scapula, and this dulness was bounded anteriorly by a curved line running steeply down from the posterior axillary line to the costal margin. Breath-sounds were entirely absent over this area. Above the tympanitic area in front, and extending in a band two inches wide transversely along the nipple line from the sternum along the ribs to the back, there was also marked dulness. Above this the lung was resonant, and auscultation discovered moist râles. Dyspnoea was considerable, but there was very little expectoration or cough.

Forty-eight hours later the tympanitic area had increased, and splashing sounds could be heard entirely distinct from the stomach, whose tympanitic

area was also easily differentiated. A hypodermic needle drew fetid pus between the ninth and tenth ribs in the posterior axillary line, and an incision drew off a large amount of pus and gas. Serum was found in the pleura. The abscess-cavity was washed daily and drained. Pus was evacuated by aspiration after a fortnight from the pleural sac. It was, however, sweet. Resection of a rib was finally necessary, and after drainage and packing it healed.

The previous history leads the author to believe that the abscess was due to a small rupture of the stomach or duodenum, as the abscess-formation was slow. The amount of gas and the distention made the diagnosis easier.

In another case he would open the subphrenic cavity between the eighth and ninth ribs, and use siphon drainage earlier in the pleural cavity.

Chronic Prostatitis and Sexual Neurasthenia.—In discussing the relation of these diseases HOTTINOER (*Correspondenzblatt für Sch. Artz.*, 1896, No. 6) says that many functional derangements of the genito-urinary system, which have been called purely nervous or symptoms of neurasthenia, have as their pathological and anatomical basis a chronic or other form of prostatitis, and that the so-called neurasthenia disappears as soon as this pathological condition has been cured. If these cases were only recognized early and treated properly, there would be a great diminution in the number of neurasthenic patients. A greater decrease, however, the author believes would follow the stamping out of gonorrhœa and the education of the public in the physiology of the sexual organs.

As a case in point, the author details the history of a patient who had had loss of power for four years and had detected the presence of semen in the urine for two years and a half. At the same time he had decreasing strength and loss of appetite and digestion. He had been treated for various diagnoses without avail. The microscopical examination of the urine disclosed the fact that there existed a prostatitis. The prostate was but slightly enlarged, was somewhat harder, but not especially tender; the expressed secretion showed a large number of leucocytes, some red blood-corpuscles, and spermatozoa.

Treatment *per urethram* and by drugs *per rectum* produced no results, and the patient did not begin to improve until massage of the prostate was carefully and systematically carried out. The patient improved rapidly and was cured, and was seen in perfect health two years after the time of his discharge.

Foci of Suppuration at a Distance from the Appendix in Cases of Appendicitis.—PIARD (*Arch. gén. de Méd.*, November, 1896), after considering the etiology, pathology, and symptomatology of these abscesses, considers their treatment and the indications for operation.

In considering the question of the removal of the appendix, he says that to insist upon the removal of the appendix in these cases at all hazards would be to increase markedly the gravity of the intervention. The indications are in some cases absolute, in others relative. In the presence of suppuration situated at a distance from the appendix, he says the indication for removal is only absolute in the following cases:

1. When a perforating appendicitis has produced a cystic peritonitis of multiple foci.

2. When the inflamed appendix threatens to become the origin of a general septicæmia.

3. When the appendix keeps up and renews the infection in the foci at a distance.

In all other cases the resection of the appendix is less urgent.

The author makes the following *résumé* of his study of this subject:

1. Abscesses are observed at a distance from the primary focus of infection in cases of appendicitis.

2. They are situated in various regions, some of which are the iliac cellular tissue, the peritoneal cavity, in the anterior abdominal parietes, in the liver, in the pleura, in the lung, and in various organs situated at greater distances, as the brain, parotid glands, kidney, and spleen.

3. These abscesses are peculiar in that they do not infect surrounding tissues even when at a distance from the appendix, and are thus readily differentiated from periappendicular abscesses in abnormal situations, due to a vicious situation of the appendix.

4. These abscesses are the expression of a diffuse appendicular infection produced by means of a peritoneal contamination, sometimes through the channel of the vascular system of the appendix by its connections, physiological or pathological.

5. They present in their variety all the transitional stages between a local inflammatory process and general septicæmia. They permit us to conceive of a new chapter to add to the autoinfections of internal origin.

6. These abscesses are rare. Their recognition will result in a more precise knowledge of the indications for operation in the surgical treatment of appendicitis.

Silver Salts as Antiseptics.—CREDE (*Cent. für Chir.*, October 24, 1896) published a monograph upon this subject in May. The results he obtained have been confirmed by his own and his assistants' observations since that time, and by over one hundred of his surgical colleagues who have used these antiseptics since then. He believes that, though the antiseptic method may not be as near the ideal as the aseptic, it is more practical in the majority of cases. This is not because he believes the results that can be obtained by strict asepsis are not so good, but because as good results may be obtained in a simpler manner, in less time, with less labor, and at less cost.

The ordinary preparation of the hands and the employment of dressings, aprons, dishes, etc., that are not sterilized, but are made antiseptic, save time and labor. Only the instruments are boiled. Thus much labor is saved, as also in the changing of dressings, as these are smaller and simpler than the aseptic. The small amount of dressing is very marked, and makes a material difference in the total expenses of the year. The security of the silver salts as antiseptics lies in the fact that they are mild but energetic antiseptics. Germs are destroyed by them of which asepsis cannot take note, and they are more efficient than other forms of antiseptics.

The method which he has employed for nearly a year is the following: wounds which the surgeon makes are covered, whether they are sutured or

not, with a dressing of silver gauze; occasionally the line of incision is strewn once with a powder, itrol (arg. citric.), to prevent more surely a secondary infection of the wound; over this is placed silver gauze, which contains, in fine powder, metallic silver; it is absolutely non-irritant, and can be sterilized, although this is unnecessary; it becomes antiseptic just as soon as pathogenic micro-organisms develop in the wound, since the lactic acid which they produce forms with the silver a combination which is an energetic germicide.

In old wounds, after a thorough cleansing of the surrounding skin, the wound and surroundings are washed with a 1 to 2000 bichloride or a 1 to 5000 silver solution. Dependent tissue is removed and large undermined areas are laid open; smaller crevasses and joint-surfaces are left alone, and the surface of the wound is powdered over lightly with itrol. If inflammatory processes have resulted, he applies a wet antiseptic dressing for a few days; and when no reaction is visible he applies silver gauze, then cotton, and places the part at rest by a bandage and fixation. When the dressing becomes partly soaked with blood and serum he attempts to dry the dressing or reinforces it with cotton. When the secretion is very great he changes the entire dressing. The contact of the secretion with the air is of no moment, as the wound is securely protected from infection. If pathogenic micro-organisms had already found entrance into the deeper tissues, they can but produce an abscess, which is treated as such. The dressing, when it remains dry, is changed for the first time on the fifth to the tenth day. No eczema or argyria has ever been observed from the use of this antiseptic dressing.

Actol (arg. lactic.) and itrol (arg. citric.) are the two forms of this silver antiseptic which can be obtained in powder or tablet form suitably prepared for making standard solutions. Silver gauze can also be had, and the author warns the profession that there are certain preparations which are not of proper strength or stability, while those which he employs are stable in any climate and for any length of time. They should be kept, however, away from the light, or their efficiency will be slightly affected after a lapse of some time.

The stains produced by the silver may be removed by placing them for a few minutes in the following solution: 1 part sublimate, 2000 parts of water, 25 parts of salt.

Resection of the Superior Maxilla.—WILDT (*Centralblatt für Chirurgie*, 1897, No. 18) describes a new osteoplastic method, by Bardenheuer, for the closure of the palate defect after excision of the superior maxilla. The flap is made from the nasal septum in the following manner: The ordinary incision is made, except that it is directly in the median line, through the upper lip, and then up through the median line of the nose, with a lateral incision carried beneath the eye in the ordinary manner. After the formal resection of the maxilla has been performed, the osteo-mucoid flap is formed by cutting through the nasal septum, just above the osteo-cartilaginous junction, with cutting-forceps, the incision being carried in a curve backward and downward to the hard palate. An incision is then made parallel to the bridge of the nose from the anterior end of the upper cut down to the hard palate, an eighth of an inch from the anterior border of the septum. The flap is now free on all but its inferior margin, where it is attached to the