the abdomen. He first applied a hand compress, like a button-hole—(plano-convex)—to cover the opening. This should be large enough to extend three-eighths of an inch beyond the margin of the opening, and should be covered with one or two thicknesses of fine soft muslin. After returning the protruded substance *perfectly*, the compress should be fixed in position by short adhesive strips, then apply the elastic webbing around the body of the child tolerably tight, and let each turn of the bandage lap the previous one half its width, making a sufficient number of turns to cover six or eight inches of the abdominal surface vertically. He would leave this on, undisturbed, unless the child became restless, or exhibited some indication of injury, for a month or longer before removing it. He had never found that the skin suffered from the confinement of the perspiration.

Another advantage was that the elastic webbing being rough and the lips of the bandage holding each other, it always stayed in place, and held the button firmly and so secured the opening against any possibility of protrusion. He had used this method successfully for about thirty years. He had a case at Waukegan, which occurred twenty-four hours after birth; did not attend the mother at the birth, but was called to treat the hernia which was reducible, and would gurgle in and out at almost every respiration, bulging out as large as an English walnut. He visited the child only once, and told the parents to remove the bandage at the end of four weeks, when the opening was found entirely closed. The child is now 9 or 10 years old, perfectly healthy and always has been.

DR. CHARLES CALDWELL: The Fellows of the Society have evidently misunderstood the nature of the case described in the paper. I am sorry that such obscure and confused conceptions have been conveyed. The case was one of hernia of the umbilical cord, consisting in "the escape from the abdomen, at the point of insertion of the cord," of some of the foetal abdominal viscera, and was due either "to arrested embryonic development, preventing the complete closure of the abdominal cavity, or failure of the foetal intestines, originally situated outside the abdomen to enter the same" (Task). The remarks of most of the Fellows are accordingly irrelevant.

As no one who witnessed the operation was present at the discussion of my paper, several questions were unanswered.

Dr. Sawyer wished to know why we decided so quickly that surgical interference was necessary to save the child's life?

The consultation was held about twenty hours after the birth of the child, and at that time the outer layer of the sac, the amnion, was dark and gangrenous in several spots. Its nutrition was cut off when the cord with its umbilical vessels was ligatured, and it would have sloughed off in a few days, leaving the viscera covered by the peritoneum only. We were of the opinion that such a condition as then existed would be followed by general peritonitis and death without some surgical operation.

Dr. Byford wished to know the literature of the subject. He had been able to find but one case

similar to his. Thomas Bryant, in the last edition of his "Surgery," mentions the only case he ever saw and his treatment. In June, 1876, a child, one day old, was brought to him with hernia of the cord. The sac was translucent, the size of a small egg, and contained the cæcum and vermiform appendix. He pressed back the bowel with the thumb and forefinger, stitched up the cord at the umbilical orifice with deep sutures and ligatured the cord itself at the apex of the congenital hernial sac.

Recovery was complete without a single bad symptom. He recommends his operation in all similar cases, evidently considering it the only treatment indicated. So we were supported by the best of authority, in operating instead of trying to apply a compress. Should I ever meet with a similar case, I would perform an operation different from either Bryant's or mine.

I would first remove the amniotic layer of the sac, if it could be separated from the peritoneum, excising or amputating it at its junction with the skin, return the viscera and peritoneal sac to the abdominal cavity and close the abdominal opening as in a case of exploratory incision, or simple laparotomy. Either incising the peritoneal sac to better protect the bowels from needle points, or stitch to the bottom of the wound by deep sutures, and support the sutures by adhesive strips around the abdomen. I would recommend this operation after observing how quickly the amnion sloughed away. It might just as well be removed at once if it can be easily separated from the peritoneum.

(To be concluded.)

FOREIGN CORRESPONDENCE

LETTER FROM PARIS.

[We are permitted to publish, for the information of those intending to visit Europe, the following translation of a letter addressed by Dr. Cornil, of Paris, France, to Dr. E. W. Cushing, Hotel Pelham, Boston, Mass.—EDITOR.]

Dear Doctor:—Last year, in the month of July, you did me the honor of visiting me in my laboratory, Rue Lohmond. We discussed very earnestly the organization of private courses, rapidly made practicable and demonstrative, in which physicians, and especially American physicians, could learn in some months the technique of scientific specialties, such as normal histology, pathological histology, bacteriology, accouchements, ophthalmology, skin and syphilitic diseases, diagnosis, nervous diseases, autopsies. Now, I can tell you that we will organize these courses in union with some of my colleagues in the Faculty of Medicine, and that we will accomplish them with the Assistants and Fellows of the Faculty. For my own part I shall be happy to have them succeed, and that your compatriots may find in Paris, where we have so many resources, all the facilities of instruction that they receive at Vienna.

I am persuaded also that the American physicians and students will receive here a better welcome,

founded on all the sympathies which bind us to the American Nation, and on the desire to sustain the most friendly relations with your medical fraternity. My medical laboratory will contain, besides the necessary rooms for the practical work of the scholars, a hall for private courses in bacteriology, which will be presided over by M. Chaumesse. The courses in bacteriology will last six weeks, and sixteen scholars may pursue the course at a time, having at their disposition all the room and material necessary. This course will be very well organized. I have, besides, a hall for a practical course in pathological histology, which will receive about fifteen scholars, each one having his table at a window. This course will be given by M. Dr. Brault, and will also last six weeks. You probably know Dr. Brault, who has written, with me, a volume on the pathology of the kidneys. M. Brault is an excellent pathologist. M. Chaumesse is well informed on bacteriological technique, and has recently passed a month and a half at the Gesundheitsamt, in Berlin. In accouchements, we have the course of M. Bar and M. Auvar, which is well given. M. Bar will give, besides, a more practical instruction in his hospital service, where he will admit some physicians and repeat operations. For nervous diseases M. Babruski, chief of the clinic of M. Charcot, will give some repetitions in the Hôpital de la Salpêtrière. For ophthalmology, one has yet only the puzzle of choosing. It is the same case with skin diseases and medical diagnosis. For this it will be very easy to have the lessons by series, with M. Capitan, chief of the clinique at Hôtel Dieu, or with another chief of medical clinic. For normal histology, there are just now demonstrative courses already prepared by M. Lattery. It will be possible to organize an analogous course if this does not suffice, either in the Collège de France or in my laboratory. As concerns autopsies, I make public autopsies at Hôtel Dieu, and I will let autopsies be made under my direction by persons who are registered. I will do this for all scholars, as the course is public.

You see that we are ready, and I assure you that your compatriots will find here all the means of instruction. To obtain information, they may address to my laboratory, which will be Rue de l'École de Médecine, en Face de la Faculté (fronting the University) or to M. Chaumesse, or to another of my assistants.

Yours truly, DR. CORNILL,
19 Rue St. Guillaume.

Paris, March 6, 1886.

DOMESTIC CORRESPONDENCE

LETTER FROM NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

The Fifth District Branch Meeting—Intussusception—Large Calculi; Operations for Stone—Epicystotomy for Sarcoma and Papilloma.

After Dr. Van Hoevenberg's paper, spoken of in my last letter, at the evening meeting of the Fifth District Branch of the New York State Medical Society at the Hotel Kaaterskill, the President, Dr. J. G.

Porteous, of Poughkeepsie, read the history of an interesting case of intussusception in which about seven inches of the intestines were discharged *per rectum*, and recovery followed without an operation.

Dr. C. R. Wood, of New York, said that it was the fashion now to operate in these cases, and the medical attendant who did not operate or send for a surgeon for that purpose was apt to be looked upon as actually criminal. At the Poughkeepsie meeting of the Fifth Branch he had read a case similar to that of Dr. Porteous, in which recovery also took place, although there was no operation; and such cases ought all to be published. Many lives, he thought, might be saved if this course was more frequently adopted. Laparotomy was very apt to prove fatal, and yet it was frequently resorted to even before other measures had been tried.

Dr. J. W. S. Gouley, of New York, said that he was fully in accord with Dr. Wood, if he rightly understood his views. "Belly cutting" had become such a mania among doctors that one was tempted to suggest that some of its advocates ought properly to be shut up in a lunatic asylum. More lives were lost than saved by laparotomy. While it was a perfectly legitimate operation, and of great service in its proper place, its scope and limitations were not as clearly understood as they ought to be. These limitations were, however, sufficiently well defined; and it was an undoubted fact that many cases recover spontaneously. Some years since he had collected quite a large number of these, and he remembered that in one instance six feet of intestine, and in another a still larger piece, were discharged.

So long as the intestinal canal remained pervious, operative interference was entirely uncalled for; but the moment that complete obstruction and commencing fecal intoxication occurred, laparotomy should be performed. He believed that the operation was often performed after symptoms of peritonitis had set in, and that under these circumstances it was worse than useless. If the operation had any value at all in cases of this kind, it was when the symptoms of complete intestinal obstruction first showed themselves. Then, and then only should it be resorted to. Afterwards it would be too late.

Dr. John Shady, of New York, related the case of a lady who was kicked in the abdomen and died three weeks afterward. The autopsy showed the presence of peritonitis, with six inches of invaginated intestine. He mentioned the case, he said, to show the length of time that the condition might last.

Dr. Gouley exhibited a series of specimens of large calculi which had been removed by himself, and which he said he wished to serve as a text for some remarks upon what he conceived to be a safe method of ridding the bladder of these dangerous foreign bodies. There were fourteen or fifteen of these specimens, most of which had been removed by lithoclastic cystotomy; and Dr. Gouley gave a short history of each case; after which he went on to say that surgeons, like women, have their fashions. Too often the sentiment entertained was, "Perish the patient, but let me operate." The operation of lithotripsy and evacuation at a single sitting, the old pro-