true examples of ambulatory epilepsy or somnambulism, and not, properly speaking, cases of localized amnesia. In my case the length of the period of amnesia, namely, seventeen years, is remarkable, as well as the sudden onset from a severe psychic shock with the sudden return of his original conscious memory. This seventeen years' lapse was in my mind not epileptic. Suggestion was tried upon him in all different ways, with no result in bringing out any details. In answer to Dr. Crothers, I would say that all memory of his previous occupations had been entirely lost.

THE TREATMENT OF FRACTURES OF THE FEMUR WITH THE AMBULATORY PNEUMATIC SPLINT.*

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The treatment of fractures of the femur has from time immemorial been an ungovernable condition, never fully under the control of the surgeon. The condition has been a source of anxiety to the surgeon and not an infrequent source of deformity to the patient. The injury has invariably resulted in shortening, which varied in amount from three-fourths of an inch to three and one-half inches, and in rare cases even more, with an average disability of twelve weeks' being the time offered by the Standard Accident Insurance Company as a cash settlement at the time of the accident. Heilfrich, in his book on fractures published in 1900, gives an average time for healing as thirteen and one-half months, with 34 per cent. able to work and 66 per cent. unable to work. In view of these facts I report the following case:

April 6, 1901, Mr. A. G. B., age 34, married, weight 205 pounds, height 6 feet and 1 inch, sustained a fracture of the left femur while bowling, caused by muscular contraction in the effort to throw the ball. The fracture was complete, there being free mobility at the point of injury. Little care was used in moving him to his home, and as a result the tissues surrounding the fracture were very much mutilated. The ecchymosis and extravasation that followed involved the limb from below the knee to the crest of the ilium. Forty-eight hours after the accident the circumference of the injured limb at the junction of the middle and upper third was fourteen inches more than the right one at the same point. The amount of fluid at this time about the knee joint was enormous. In fact, the whole picture of the injured limb at this time was of as severe an injury as I have ever seen of a thigh, barring one requiring an amputation. Dr. Buford, who examined the limb at this time, confirmed the severity of the injury. On the third day after the accident, with the assistance of Dr. J. G. Hughes, a pneumatic splint was applied. the limb was measured and showed one and one-half inches of shortening. It was impossible at this time to get complete extension because of the great swelling. A gentle massage of the limb was kept up at frequent intervals; which was easily done while the splint was on. By the fifth day the swelling had subsided enough so that the foot was brought down in perfect position.

Twenty-four hours after the application of the splint, the patient was free from pain, and could move himself about in bed with perfect ease. Two weeks after the application of the splint he was about the house. The next week he was going about the street, and in less

than four weeks after the application of the splint he was at his office; he was sleeping without his splint, and was able to get into a bath-tub unassisted. Measurements made by Dr. W. H. Vary, Dr. J. G. Hughes, Dr. Ochsner and the author, show that there is no shortening in the injured limb.

The following advantages are gained from experience with the pneumatic splint: 1. It can be applied without assistance. 2. Fractures can be reduced without an anesthetic. 3. Patient can move about freely in bed, after its application. 4. Gives free access to compound fractures without removal of splint. 5. Reduces the time of disability over one-half by American report. 6. Prevents shortening. 7. Prevents angular deformity. 8. Changes our pathology. 9. No complete circular constriction to impair the blood supply to the limb. 10. Massage can be given to the entire limb without removing the splint.

REMARKS ON THE TRAUMATIC NEUROSES.

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I think we are agreed in understanding traumatic neuroses to mean functional disturbance of the nervous system caused by traumatism. In the present state of society this traumatism is generally accidental. We are doubtless also agreed that in the symptomatology of the traumatic neuroses there is nothing pathognomonic of injury by violence and that a case of traumatic neurosis generally presents a picture of hysteria, neurasthenia or hypochondria, or, what is more frequent, a combination of two or all three of these neuroses. A certain admixture of melancholia is far from rare.

In the diagnosis of any neurosis the most essential step is not the recognition of a neurosis, but the exclusion of organic disease. For this a single examination will not always suffice, as a combination of the two is very common, and the former may so obscure the latter as to make its prompt and positive recognition impossible. Sometimes it is exceedingly easy. When organic change is undeniably present, it is still important to determine the presence of functional trouble, as this must necessarily have great influence on prognosis and treatment.

In my experience incorrect diagnoses are ordinarily made because of failure to recognize: 1, that pain, tenderness, paresis or paralysis, hyperesthesia, anesthesia, incoördination, tremor, dizziness, tachycardia, syncopal attacks, vomiting, loss of weight even to emaciation, impaired speech, convulsions and poor vision, are not necessarily indications of organic disease, no matter how continuous or how long continued the symptoms may be; or 2, that atrophy, reaction of degeneration, incontinence of urine or feces, retention of urine (generally), loss of deep reflexes, bedsores, Babinski's sign, ocular or facial paralysis, optic atrophy or neuritis, hemianopia, glossy skin, rapid (five or six per second) and uniform ankle clonus, impaired pupillary reaction, semi-erection of penis, and anesthesia corresponding exactly to a peripheral nerve or spinal segment, indicate organic disease.

In addition, it may be remarked that the nature and general extent of an accident, presence, absence or location of external lesions and even the duration of unconsciousness are most unreliable data upon which to base a diagnosis.

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