which the prostatic tissue was removed. Hemorrhage can be controlled only if this inflated bag is held securely in position.

One of the difficulties encountered has been fixation of the bag in position. Usually this has been done by clamping the tube where it emerged from the penis, or the outer end of the tube was drawn down on the thigh and fastened by means of adhesive straps. Both of these methods are insecure, and if much tension is made on the tube following the former method, a great deal of soreness of the urethra follows, because of constant pressure on the meatus. I am indebted to Dr. Carl Lewis Wheeler of Lexington, Ky., for the suggestion of the need of some mechanical device which would maintain direct pressure over the area of operation after prostatectomy, and for his description of the device of Dr. Townsend of Rutland, Vt. He and I agreed to try to develop some method of exerting pressure for control of hemorrhage. The device presented is the result of the efforts which I have made in that direction, and its practical application has demonstrated its value.

In October, 1916, I devised the wire anchor here presented for the purpose of accurately fixing the pressure bag after the latter has been properly placed and dilated with air. Immediately after the operation, the Hagner bag is drawn through the bladder in the usual manner. The tube from the bag is brought through the hole in the summit of the wire anchor. The bag is then distended by injecting air from a large syringe. Tension is made on the tube, bringing the bag down into the neck of the bladder, with as much

pressure as desired, and held in this position by the little screw clamp just outside the hole in the summit of the wire anchor. The anchor is made of soft copper wire of sufficient size to have some rigidity and sufficient strength to hold any tension that might be made on it for this purpose. The flexibility of the wire anchor allows it to be molded to fit the individual patient. It is not in the way of the dressings which may

Fig. 2.—Wire anchor in position before application of outer dressings.

need to be changed before the removal of the Hagner bag, which is usually allowed to remain from twenty-four to forty-eight hours in order that any recurrent hemorrhage may be immediately controlled. The apparatus was described by Dr. W. N. Wishard at the Evansville meeting of the Ohio Valley Medical Association last November.

A CASE OF BROMODERMA, OR BROMO-IODODERMA

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Bromid and iodid eruptions are among the most frequently seen drug eruptions. The case reported herewith belongs to the rarer though perfectly well recognized type of bromid eruption. It is unusual on account of its severity, and the fact that part of the development of the lesions was probably due to the simultaneous use of iodids for a short time previous to its appearance. As bromid and iodid eruptions of this type resemble each other, it is impossible to define the part played by each drug in this case, and so it would seem best to classify the eruption as a bromo-iododerma tuberosum fungoides.

S. L., a girl, aged 5 months, of Polish parents, was referred to me, March 18, 1917, by Drs. D. M. Lewis and C. S. de Forest. The child had had convulsions since birth, frequently as many as twenty in a day. When about a month

old, mercurial treatment had been given for a few weeks. No definite information in regard to the treatment given from this time up to three weeks before my visit could be obtained.

For three weeks previous to the time at which I saw the child, she had been given 8 grains of potassium bromid daily, and for a week or ten days also 4 grains of potassium iodid. Both of these drugs had been stopped once or twice when

Fig. 1.—Appearance of eruption when patient was first seen.

there were not more than eight convulsions in twenty-four hours. The present eruption had developed very rapidly, had been present about a week, and at its beginning had been diagnosed as chickenpox.

The child was well developed and well nourished. The appearance of the eruption is shown in Figure 1. On the face there were about twenty vegetating, somewhat condylomatous growths, circular or polycyclic in outline. The larger ones were evidently formed by smaller ones having grown together as they extended. They varied from 0.5 to more than 6 cm. in diameter. The largest ones were elevated about 2 cm. above the surface of the skin. Their color varied from nearly that of arterial to that of venous blood. During convulsions the larger growths frequently bled. On the buttocks was a discrete, apparently vesicular eruption of the more usual type of bromid eruption. There was little fluid in the vesicles at this time, as vegetating growths had begun to appear under the unbroken epidermis.

Fig. 2.—Appearance of eruption about one week later.

The child was immediately referred to Dr. J. I. Linde, who admitted her to his service in the New Haven Hospital. For about ten days the growths increased somewhat in size, after which they gradually began to grow smaller. The second illustration, taken about a week after the child was admitted to the hospital, shows the elevation of the growths and also a vesicular eruption of two days' standing which, if seen by itself, might easily have been mistaken for chickenpox.

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