The prognosis is affected by sepsis, the site of suture, the prognosis being more favorable the nearer the suture is to the spinal cord. Bad shunting [efferent fibers passing down to afferent terminals or vice versa], which frequently occurs even with the most perfect surgical technique, is probably a common cause of imperfect recovery in such nerves as the ulnar. Incomplete recovery may also be caused by destruction of branches of the nerve, in addition to injury to the trunk. Ununited fractures especially of the humerus in injuries to the musculospiral are serious complications. Primary fixation of the bone seems advisable.

The intrinsic muscle of the hand and the muscles in the distal part of a limb recover less frequently than the larger muscles in the proximal part. Several factors in explanation of this are probably the distance which the young nerve fibrils have to travel away from their trophic center in the spinal cord to reach the muscle; the size of the nerve of supply; the phylogenetic history of the muscles.

The through and through suture should be avoided. The construction of a new bed for the nerve after suture is preferable to the use of any autogenous or heterogenous protective material. Displacement of the ulnar nerve in front of the internal condyle or widespread freeing to procure apposition of the ends does not appear to retard recovery. Liberal resection of the injured ends is essentially, especially if there is sepsis. No recovery after secondary suture could be regarded as perfect. The intraneural anatomy must necessarily be disturbed in resected cases. The nerve is making a second effort to regenerate, the first attempt being represented by a neuroma or outgrowths along fascial plants. [Stragnell.]

Souttar. PLACE OF ELECTRICITY IN DIAGNOSIS AND TREATMENT OF NERVE INJURIES. [Br. Med. J], September 11, 1920. J. A. M. A.]

In the case of an injury of a peripheral nerve Souttar says the use of electrical methods, merely to discover whether the nerve is divided or not, is of no great interest. It is when approaching the period of recovery that the importance of refined methods becomes pronounced; but even here the eye and hand of the expert rather than the actual method which he employs counts. After all the work that has been done, and all that has been written on the subject, it still remains true that the subtle change from slow to pick response, with all that it means of recovered nerve and awakening muscle, is as evident to the trained eye, whether it be produced by a simple galvanic set or by some elaborate electrical device. This change in Souttar's opinion is by far the most important index of recovery. It precedes the return of voluntary power and of faradic response by a period which may vary from two or three weeks to several months; it invariably appears if recovery

of function is ultimately to occur, and is a sure indication that a certain degree of recovery has already taken place. The actual response may be observed either in the muscle itself or in its tendon. If the presence of a quickened response is an encouragement to be eagerly looked for, its absence should be a check to the undue optimism which has done so much to darken knowledge of the results of nerve suture. The primary object of the application of electricity to a paralyzed limb should be the production of contractions in the paralyzed muscles, and the surest direction of progress lies in the development of special forms of current for this purpose. The faradic current can be used to exercise the normal muscles, to free them from adhesions, and to restore them to their full vigor.

Walshe, F. M. R. LOCAL PARALYSIS FOLLOWING SUPERFICIAL INJURIES.
[Brain, Vol. XLII, Part IV.]

This author here comments on a small group of cases of local paralysis after injury to a limb, in which no nerve trunk has been involved. The injury may be trivial and may produce marked paresis or paralysis, with wasting of muscles and diminution of their faradic excitability, impairment of the corresponding tendon jerk, subjective and objective sensory and vasomotor disturbances. These signs have a definite localization corresponding to a peripheral innervation. In every instance the injury was within the territory innervated by the affected nerve and cutaneous nerve endings were either directly injured or overlaid or in some way involved, while the trunk escaped. Sepsis was not an essential factor. They approximate the condition known as ascending neuritis. It is probable that a small proportion of Babinski's physiopathic disorders may have been of the same nature.

Thorburn, W. END RESULTS OF INJURIES TO PERIPHERAL NERVES
TREATED BY OPERATION. [Br. Med. J., September 25, 1920.]

The impression is conveyed to Thorburn by a review of reported cases that secondary nerve suture gives very good results in somewhere between one-third and two-thirds of all cases, but the most careful study of original articles, as well as personal experience, leads him to believe that a perfect neurologic recovery is rarely if ever obtained. Permanent disability may be masked in various ways, but is almost invariably to be detected if carefully searched for. Complete failures are by no means uncommon, and must be looked for in a very definite percentage of even the best operations. Such appear to be the general results in the case of secondary suture. In the case of grafting, much less is to be hoped for. Thorburn believes that it will be found that the greater the experience of end-to-end suture, the less often the need for grafting will be found to arise. So much can be done by bold operating, by extensive