Question: That was in the hands of an expert, was it not? (Referring to Dr. Neale's case.)

Dr. Rowland—Yes.

Of course, one must be sure that there is no serious obstruction to the passage of the child before using pituitary extract. My opinion is that the one question now to be settled is the matter of pituitary extract vs. whether or not one may use it to induce labor in pre-eclamptic and nephritis cases.

AUTHORS' ABSTRACTS.

Surgery, Gynecology, Obstetrics, and Genito-urinary Diseases.

Final Plea for Inactive Medical Reserve Corps. By H. C. Coe, Washington, D. C. Military Surgeon, December, 1914.

The author announces that his plea is absolutely free from any personal interest. His constant effort has been for the benefit of the entire Medical Reserve Corps. He speaks of the flourishing condition of the organization in New York, which has 130 members enrolled, several of whom have been on active duty. He speaks of the disheartening indifference of Washington to the most earnest pleas for the encouragement and instruction of the Medical Reserve Corps. He tells what a prompt and general response the corps gave at the call to duty during the late Mexican crisis and the earnestness and devotion they displayed. His plea is for more chance for practice-work for the corps, placing them on the army register as is done with the Naval Medical Reserve Corps; change the objectionable title "Inactive" to "Unassigned," as in the Navy, and in every proper way make the position attractive. He warns that unless the corps has more encouragement good men will resign and no desirable successors will take their places.

In spite of his personal pleas to the Surgeon General and to the Chairman of the Congressional Committees on Military Affairs, practically nothing has been accomplished. He says the Surgeon General thinks that perhaps some of the corps may go to militia camps next summer, entirely at their own expense.

[There is no prospect of the Medical Reserve Corps of the United States Army being placed in the Army Register, or of having the obnoxious term, "Inactive," dropped. The Adjutant General gives no reason for this decision.]

Data Obtained Through Correspondence With Nine Hundred General Practitioners and Surgeons Relative to the Diagnosis, Treatment and Classification of Acute Appendicitis. By Frank D. Smythe, Memphis, Tenn. *Memphis Medical Monthly*, December, 1914, pp. 1108-1122.

First—Seventy per cent of the general practitioners in this territory regard acute appendicitis as a strictly surgical disease.

Second—Twenty-nine per cent regard the disease as surgical, but are opposed to operation for primary attack.

Third—One per cent only were opposed to operation under any and all circumstances, for appendicitis.

Fourth—One hundred per cent of the surgeons addressed regard the disease as strictly surgical and advise operation as early as possible after diagnosis.

Fifth—Cases of acute appendicitis operated upon within the first twenty-four hours after onset of symptoms by a competent surgeon, no mortality.

Sixth—The pain, nausea and discomfort incident to the affection may be modified by the use of medicine given internally and applied locally, we all agree. On the other hand, we all agree that the course of the disease is not influenced by such remedies and that 24 per cent plus die when subjected to the so-called medical treatment, while practically no mortality results in cases treated surgically during the early stage of the affection. Correct diagnosis can be made in the great majority of cases within twelve hours after onset of symptoms.

Remedy offered by the essayist for a no-death rate in acute appendicitis:

The subject should be taught in medical colleges to medical students by those teaching in the surgical department only.

A Rare Type of Bladder Ulcer in Women: Report of Cases. By Guy L. Hunner, Baltimore, Md. *Transactions Southern Surgical and Gynecological Association*, December, 1914.

The author contrasts eight cases of simple chronic ulcer of the bladder with those of the Fenwick type.

These ulcers are classified as simple because of an absence of a demonstrable source of origin and because of the histologic picture of the excised ulcer.

They have all been located in the vertex of the bladder wall as contrasted with the Fenwick ulcer on the base.

On cystoscopy they are easily overlooked. Noticed by seeing one or two extra pale white scar areas. Beside the scar area is seen a slightly hyperemic spot. On touching this it readily oozes blood. At times the stretching of the granulating area incident to the ballooning of the bladder in the knee breast posture causes a slight ooze and makes the area more easily found.

These ulcers at times extend through all the coats of the wall and involve the peritoneum by thickening and adhesions.

Clinically they are characterized by pain, discomfort, frequency, stranguary, and loss of rest at night, together with their resistance to treatment.

The urine in all was macroscopically clear. Centrifuged specimen revealed in each case a few leucocytes and a few red blood corpuscles. In no case was there bacteriuria. The ulcer may temporarily heal on the surface, when the urine becomes free of pathological elements until the surface is again broken. But one patient of the series had ever noticed blood in the urine as contrasted with the Fenwick ulcer, in which the most important feature is hemorrhage.

The diagnosis is fully established only after a failure to heal under ordinary forms of treatment, when excision of the inflammatory area with the entire subtending bladder wall results in a prompt recovery.