Clinical Notes, Suggestions, and New Instruments

A WATER-COOLED RETRACTOR FOR USE WITH A CAUTERY IN THE MOUTH*

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Adequate protection of the lips and cheeks is essential in the treatment of malignancy in the mouth with a cautery. Protection is especially needed when heat is applied for a long time. The water-cooled retractor herein illustrated

Fig. 1.—Water-cooled retractor in place; wooden spatula protecting tongue preparatory to cauterization of epithelioma, alveolar margin and cheek.

Fig. 2.—Water-cooled retractor, anterior view.

Fig. 3.—Water-cooled retractor, lateral view.

fulfills requirements, at the same time giving good exposure in the cauterization of growths on the alveolar margin.

The portion of the retractor coming in contact with lips and cheek consists of two layers of metal with a space

* From the Mayo Clinic.

between for the passage of water. The water passes in and out at the distal end of the handle of the retractor.

Soldering irons or an electric cautery may be used with this retractor, thus eliminating the necessity of a water-cooled jacket on the cautery handle. In this way a better view is obtained of the growth and the point of the cautery.

A wooden spatula is also used to protect the tongue in cauterizing growths of the jaws and cheeks.

A NEW SPINAL CURVATURE BRACE

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In attempting to carry the principles of the Abbott rotation method for the treatment of scoliosis beyond the plaster jacket wearing period, I have found it practically impossible to derive satisfaction either for the patient or for myself from celluloid jackets or the spine braces now in use. For nearly two years I have been using and gradually improving the brace illustrated herewith. This brace gives definite control of the shoulders and hips and rotation pressure on the ribs.

Fig. 1.—Patient without brace and with brace applied; this was one of the first braces made.

The brace offers several desirable features. It is infinitely adjustable for position or growth. Any part of the brace may be modified or even exchanged without sacrificing the brace as a whole. There is no constriction of the chest. Finally, with a firm grip on the shoulders and the pelvis, in the exact position desired, any degree of positive rotation pressure on the ribs may be obtained.

The brace is not offered as a substitute for plaster-of-Paris jackets applied as described (the Abbott method). I still use and shall continue to use the plaster jacket as the desirable treatment for most scoliosis patients before applying the brace. On the other hand, I believe that my brace is preferable in almost any case to a jacket applied in suspension. This is because this brace controls the pelvis and the shoulders in such a way that extension of the trunk with or without flexion of the spine and with true rotation pressure on the ribs may be obtained.

The brace is not recommended for advanced fixed scoliosis except when the plaster-of-Paris jacket is contraindicated or for any other reason cannot be used. Even in advanced cases, however, this brace will give a corrective tendency and a

degree of protection against further deformity which I believe it is impossible to obtain with any other brace.

I at first recommended that the brace be made on measurements of the girth of the pelvis, the length of the back and the width between the armpits only. It is my present conviction, however, that the most satisfactory control of the patient can be had only by making the pelvic portion or girdle fitted on a plaster torso of the patient. This can, of course, be made only by securing a plaster mold of the patient in the best position possible (in the Abbott frame if necessary), and then having the bracer pour the torso model into the mold so obtained. (It is still better to make and remodel the torso oneself.)

After the brace has been made, it is thus applied to the patient:

The nut from the top of the upright is unscrewed and the arm pieces, segments and rib-segments removed all the way down. The pelvic portion of the brace is laced (or buckled) on. Segments are now slipped on until the spine portion of

assistant cooperating, the position secured is maintained while the nut is screwed firmly down, locking all parts of the brace securely in place. If now on careful inspection slight modifications of position are desirable, they can be obtained by bending the ribs or shoulder pieces slightly.

Any degree of flexion or extension of the spine may be provided for by bending the vertical rod before construction of the brace on the patient is begun.

This method gives definite improvement in practically all cases. Not all can be made straight or cured. The length of time required for maximum benefit is sometimes much greater than we thought when we first began using the Abbott method. But it is much the best treatment we have ever had.

A considerable number of patients treated unsatisfactorily in the pre-Abbott period have been treated with satisfaction since. I believe it to be the method that we should all learn and use if we are to give our scoliotic patients a real opportunity for improvement or cure.

Figs. 2, 3 and 4.—Patient with pronounced paralytic scoliosis and with brace. This is the style of brace now being used. The pelvic portion is adapted from a sacro-iliac brace first kindly furnished to the author by Dr. R. B. Osgood. It grips the pelvis firmly without discomfort. The other portions of the brace have been reinforced and are stronger, but not materially changed otherwise.

the brace has been built up to a point at which it is desired to apply rotation (rib) pressure on one side or the other. A right or left hand rib is slipped on as desired, and then another segment without a rib. Next another rib segment designed to give additional pressure in the same direction or on the other side, as desired, is put on. To secure the desired amount of rotation, pressure on a rib convexity of any size requires a series of three or four rib segments (alternating with ordinary segments), all pressing in the same direction. An assistant standing in front of the patient holds these ribs in position as one puts them at the proper level and rotates them to the point desired. When the brace has been built up to about the shoulder level, the segment carrying the shoulder piece for the shoulder above the rib convexity is first put on and the shoulder (in the arm piece) rotated firmly backward. Then the shoulder piece for the shoulder above the rib concavity is put on and the shoulder well raised (this has been the low shoulder before) and carried forward. The final segment is now put on, and with the patient and

Whooping Cough.—An issue of the New York State *Health News* is devoted to the whooping cough situation in the state. Whooping cough, which is usually classed as one of the minor diseases of childhood, has carried off more lives in New York during the past five years than the much more dreaded scarlet fever. The total number of deaths from scarlet fever during the years 1911-1916 was 2,904, equivalent to an average rate of mortality of 5.9 per hundred thousand total population. During the same period 3,739 children died from whooping cough, which corresponds to an annual death rate almost 30 per cent. higher than that of scarlet fever—7.6 per hundred thousand. In the year 1916, whooping cough ranked next to measles as a cause of death in this state, taking almost as many lives as typhoid fever (593), and scarlet fever combined, 745. In the past ten years the death rate from whooping cough has fluctuated between seven and nine per hundred thousand, with only a slight downward tendency.