

appendix was passed through the abdominal wall and the end removed. At the second sitting a few weeks later, after frequent irrigation of the "new bladder," the normal bladder was extirpated, the closed end of the ileum brought down, and the ureters implanted into this portion of the intestine. There was at first a marked constipation, followed by a severe diarrhea. The urine was at first very cloudy with mucus and pus, notwithstanding the frequent irrigations. After some weeks the urine showed only some flakes of mucus. The new bladder contained 500 c.c., but the patient preferred the frequent introduction of a catheter, and was much pleased with the results. Among the advantages claimed for the operation were the following: Small danger of infection because of the absence of feces from the isolated piece of intestine. The ileocecal valve and peristalsis in the ileum offer a certain protection against backflow. The implantation of the ureters can be performed with much less tension into the movable end of the ileum than into the less movable cecum, as in Makkas' operation. The urine unmixed with feces does not cause dangerous absorption, and does not irritate the mucus membrane of the lower colon and rectum, as when the ureters are implanted into the sigmoid flexure. The new bladder contains easily 500 c.c. and is continent.

Stasis Hemorrhages Due to Traumatic Compression of the Trunk,—LANG (*Deutsch. Zeitschr. f. Chir.*, 1912, cxx, 76) presents an extensive study of this subject, and reports 7 cases, the first with much detail. In a traumatic compression of the trunk, from the increased intrathoracic and intra-abdominal pressure, a backward pressure in the vessels is produced, most markedly in the large veins, which is transmitted in greatest part to the upper parts of the body and to a less extent to the lower parts. The chief effect is to be seen in stasis hemorrhages in various parts of the body. The increased blood pressure is due substantially to the passive compression of the body cavities, and therefore of the lumina of their contained vessels. If reflex "active factors" (closure of the glottis, body exertion) play a part, they only favor the extravasation of the blood from the vessels, but are not necessary factors. The almost constant skin ecchymoses in the region of the tributaries of the common facial vein, is due to valve insufficiency and impaired function of the intima duplicatures in these veins. The corresponding mucus membrane hemorrhages are due to similar causes. With a very high venous blood stream, in the presence of a decreasing blood pressure, the functionally competent valves may be insufficient against the impact. The relatively rare occurrence of intraocular hemorrhages and the complete absence of brain hemorrhages, is explained by a normal intraocular and intracerebral pressure, which, with the aid of the clothing (shirt collar, folds in the clothing) can prevent the occurrence of the extravasations. The brain veins are especially protected by a valve-like arrangement at the point of emergence of the sigmoid sinuses into the jugular veins.

The End Results of Double Fractures.—MOLINEUS (*Deutsch. Zeitschr. f. Chir.*, 1912, cxx, 137), under this title, discusses fracture from pronation of the foot, or the Dupuytren fracture. The clinical symptoms of this fracture are given as follows: (1) Marked swelling

of the region of the ankle, due to hemorrhage into the joint and surrounding tissues. (2) Displacement of the foot outward and at the same time backward, the axis of the leg passing out of the inner side of the foot. (3) Severe pain. (4) Abnormal mobility of the foot at the ankle-joint. (5) Indirect pressure pain from the calcaneus outward. It is absolutely necessary to give close attention to the reposition of the fractured ends of the bones, and much care to the fracture for a long time afterward. Good reposition is possible only by an overcorrection in supination, according to the severity of the case, and by preservation of this position by the dressing. This fracture should not be treated at home or by an ambulatory dressing, because without adequate assistance and sometimes deep narcosis, a proper dressing cannot be applied. The injury is of such a nature that it can be treated properly only in a hospital. At home the patient often leaves the bed too early and develops very serious secondary results. For a long time the callus is in a so-called rachitic condition, that is, it is soft and yielding. Even if in the beginning or after supposed union with the foot in good position, too early use of the foot allows it to turn outward, so that the troublesome traumatic flat foot develops. After fourteen weeks it is usually necessary to correct the condition by operation.

Hypertrophic Arthritis.—JACOBSON (Mitt. a. d. Grenzgeb. d. Med. u. Chir., 1912, xxv, 589) says that almost all authors handle chronic joint diseases differently. They have their own conceptions, classifications, and nomenclature. He concerns himself with the study of hypertrophic arthritis, and regards it as a well characterized disease. Its separation from other chronic joint diseases, especially those with atrophic degenerative processes, the progressive so-called chronic rheumatic affections, should not be difficult. Unlike them it is mono- or oligo-articular and is non-progressive. It affects males by preference. There are often palpable prominences and foreign bodies, and often joint creptitation. There is no ankylosis, and muscle atrophy is not very pronounced. There are rarely other trophic disturbances or marked constitutional disturbances. The x-rays show little bone atrophy, but always protuberances, and often cartilaginous or bony loose bodies in the joint without ankylosis formation. Often when the disease has existed only a short time, the x-rays show striking changes. The atrophic joint diseases often show only slight changes after they have existed a long time. The pathological anatomy shows that the hypertrophic alterations begin in the cartilage, the atrophic in the synovial membrane. The name "arthritis deformans" should not be employed. The adjective "hypertrophic," brings into prominence its most characteristic sign. In all other joint diseases the hypertrophic symptoms are absent and only to this disease can the name be applied with justice. In the treatment rest should be avoided and motion encouraged. While rest will relieve the pain, it leads to muscle atrophy, the avoidance of which is the most important indication. Even with the existence of a joint effusion, rest in bed or a fixation dressing should be employed as little as possible. In a remarkably short time muscle atrophy with all its unpleasant consequences, develop. These are impaired function, weakness, edema, etc., and