A SCLEROCORNEAL TREPHINE

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In my first use of the Stephenson trephine I felt the need of the shoulder attachment as a factor of safety. I used this attachment in several operations and in two of them found that the shoulder interfered with the application of the cutting surface at the sclerocorneal junction because of the fold of the turned-down conjunctival flap.

I then used the instrument without the shoulder attachment, but there is some danger in this.

To avoid these troubles (troubles at least for the beginner in this very promising operation), I have had made a trephine with a barrel of even diameter for 0.75 mm. from the cutting edge, then a slight flare, as shown in the accompanying pic-

A sclerocorneal trephine.

ture. This makes a very safe and very efficient instrument; indeed the instrument has proved so satisfactory that I venture to call attention to it.

7 West Madison Street.

SHELF FOR RECTAL AND VAGINAL OPERATIONS

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In many rectal and vaginal operations a shelf conveniently placed will save much time when the operator finds it necessary to lay down and pick up his needle-holder, scissors, thumb-forceps, etc., frequently.

This device weighs about 3½ pounds and hooks on the lower end of the operating-table after it has been dropped. Thumb-screws permit of adjustment near to the table or farther away.

Fig. 1.—Shelf for rectal and vaginal operations.

After this had been made, I learned that Dr. E. B. Cragin of New York had used a similar device. In a letter he informs me that he has been using a shelf for about two years but has never described it in the journals.

LONGITUDINAL FISSURED FRACTURE OF THE LOWER END OF THE RADIUS

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Few examples of longitudinal, or fissured, fracture of the lower end of the radius are on record. Cotton¹ speaks of only

three specimens as constituting the entire evidence. Stimson,² who refers to the lesion as an incomplete Colles' fracture, has seen only one skiagraph of the condition.

The condition was first described by Bigelow,³ and although there are sundry references in the literature, published radiographic findings seem to be limited to Parrish's recent article.⁴

The latter, so far as I know, is the only published report (except this one) with roentgenographic illustration of the lesion.

REPORT OF CASE

W. R., aged 31, truck-driver, Sept. 19, 1912, fell from the seat of his truck, striking his right wrist against the pavement. At the time of the accident he paid but slight attention to the injury, although he suffered some pain in the wrist, and

Roentgenogram of longitudinal fissured fracture of lower end of radius.

there was a moderate degree of limitation of motion. Shortly following, he was conscious of the fact that the wrist was swollen. A few days later, still suffering from the above-described symptoms, he decided to consult a physician. The latter, suspecting a fracture, applied a temporary dressing.

One week following the accident, the patient came under my care. The wrist at this time presented a moderate degree of edema, was sensitive to pressure, and manipulation caused pain. Deformity was, however, entirely absent.

Having in mind the possibility of a Colles' fracture without the presence of the characteristic deformity, I advised the use of the x-ray. A longitudinal fracture of the lower end of the radius of the fissured type, was revealed, as here shown.

3. Bigelow: Boston Med. and Surg. Jour., 1858.

4. Parrish, Robert C.: Longitudinal Fracture of the Lower Extremity of the Radius, THE JOURNAL A. M. A., Jan 11, 1913, p 123.

1. Cotton: Dislocations and Joint Fractures.
2. Stimson: Fractures and Dislocations.