during the night as he had been doing for the past five years, he has to get up only two or three times, and this is due to habit.

The profession and humanity are greatly indebted to Dr. J. Bentley Squier for elaborating the technique of this simple and effective prostatectomy.

I thank Dr. Frank Hodges for his attention to the patient's general condition during convalescence.

REFERENCE TO AN UNUSUAL CASE OCCURRING TWENTY YEARS AGO.*

BY SAMUEL R. BENEDICT, M.D.,
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Gentlemen, I feel that I am due you an apology for reporting a case which is not my own, but one which occurred in the practice of my father some twenty years or more ago. However, you may feel that I am justified when you hear the report of the case, as the condition is one which is very rare and the operation performed was the first of its kind on record at the time to be attended by success. I might further add that the author, who is no more, after reporting this case, was the recipient of many letters of congratulations from prominent surgeons, not only in this country, but abroad. The paper deals with an operation on a child fifty-three hours old, and I have here a picture of the patient before the operation and also a small one showing the boy as he is today. He has just graduated from one of our largest Southern universities, and is a fine specimen of manhood, 6 feet tall and weighs between 165 and 170 pounds, and from all appearance is a perfectly normal man. The title of the paper which I am to read to you tonight is:

AN ENORMOUS CONGENITAL UMBILICAL HERNIA WITHOUT CUTANEOUS COVERING, OPERATION AND RECOVERY.

At 6 a. m. Saturday morning, January 9, 1892, I

*Read before the Jefferson County (Alabama) Medical Society, January 18, 1915.

delivered instrumentally Mrs. B. C. E. primipara, age thirty-three, of a large male child, approximately 10 pounds in weight, well formed and rounded and perfectly developed with the exception of the anterior walls of the abdomen around the umbilical cord as described below. Presentation normal. Upon raising the bed clothes to tie the cord, I found a protrusion of the abdominal viscera through a circular opening in the abdominal wall four inches in diameter, the tension upon the cord assisting in pulling out the contents considerably. Instantly tying the cord and dividing, I handed the child to the nurse with directions to say nothing, but to keep her hand firmly pressed down upon the protruding mass. After giving the mother proper attention, I had the child moved to an adjoining room for dressing, and there upon further examination found the following condition: There was an entire arrest of development in the skin and muscles of the umbilical region of the abdomen, the edges of the skin forming a perfect circle with radius of two inches, adherent by a rounded edge to the peritoneum and covering of the cord, which spread over the whole peritoneum, covering the mass. The umbilical cord passed out from the lower edge of the hernia about one and one-half inches above the pubis.

The color of the mass at birth was a dark, bluish-black, and the covering so thin that the movements of the viscera below could be seen. Realizing that I had a desperate case to deal with and undecided just then what to do, I covered the whole mass with dry bichloride gauze, bandaged firmly with a flannel bandage an inch and a half wide, and had child dressed with directions given as explicitly as possibly to handle carefully and prevent crying as much as possible. The same day I began to hunt up authorities upon umbilical hernia and failed absolutely to find in any work on surgery any report upon or instruction for dealing with such a case. Wyeth, Erickson and a number of other books were searched, but in vain. In Gross Surgery, Vol. II, page 712, issue of 1859, is a very accurate description of the condition, and the only thing of the kind I could find. He says, "When umbilical hernia is large, death usually takes place a few days after birth from the effects, apparently, of peritoneal irritation. If the child survives an attempt may be made, etc." Seeing no chance for this child to survive with the large area of peritoneum to be exposed when the cord covering should slough off, I decided that there was nothing to do but to attempt the operation. Accordingly, on Monday, January 11, at 11 a. m., 53 hours after birth, the operation was made. I

began by attempting to dissect up the now dead and yellowish white membrane covering the peritoneum.

This was a very difficult part of the operation, as it was firmly bound down to the external surface of the mural peritoneum, and the dissection had to be carefully done. The peritoneum was as thin as a cobweb and tore upon the slightest tension, exposing more than once the cavity. After dissecting off as best I could to the skin circumference, I divided closely down the umbilical cord and vessels, now a dried and shrivelled mass, and giving no blood upon section. I had hoped that I could pare the rounded edges of the skin, invaginate by tension upon skin the peritoneum, and so approximate in a perpendicular line the skin from sides of abdomen. This was found impossible, as besides the firm union of the skin to the peritoneum, the liver and spleen occupied a large portion of the wound, intestines being only in the lower portion. I then penetrated the edge of the skin with a fine pair of curved, sharp pointed, conjunctival scissors and cut closely to the peritoneum the skin all the way around, leaving a circumference of skin still attached to the peritoneum. The skin was then dissected up sufficiently to make close approximation of subcutaneous surface and not the edge of the skin. This was held together by three silver pins wound with silk in figure eight way, and intermediate approximation done by black silk sutures. The line of approximating about four inches long and perpendicular was dusted with iodoform, covered with rubber tissue in narrow strips, bichloride gauze cotton and a firm bandage.

The operation lasted fifty minutes, the child, two days old, taking in all $\frac{1}{2}$ ounce of chloroform, rallying promptly and in good condition. Directions were given for one drop of paregoric every hour or two if necessary to quiet the child, and we left not expecting the little one to be living 48 hours hence. We were disappointed. There was never any elevation of temperature or abnormal rapidity of heart's action, the child resting nicely, with but very little paregoric, not averaging a drop in five hours. The wound was not examined until the third day, then it was found that the skin had become adherent over the peritoneal surface and all along the line of approximation. There was considerable cutaneous redness an inch around the wound for a few days, but this gradually subsided. Upon the fifth day it was found that the tension had caused the silver pins to loosen, and they with sutures were removed and their place supplied by adhesion strips. On the 10th day it was found that the great intra-abdominal pressure

had separated the cutaneous edge for about an inch in length, exposing a granular surface over peritoneum 1-4 inch in its widest part. This was strapped more firmly, and a laced adhesion bandage passed around the body, the lacing being over the wound and dressing. This answered admirably and has kept the parts so well at rest that today, January 30, there is complete union. The child has never acted other than any child of its age. It has nursed regularly with avidity, his bowels and bladder acting normally. Paregoric has been used occasionally, chiefly at night, but never over six drops during the night.

Before operation.

There is now nothing to show for the hernia but the line of cicatrization four inches long, which is a finer truss than anything else could be. When he cries or strains there is a slight rounded bulging at the umbilical opening, but not enough to give cause for further uneasiness, and this is kept down by a silk elastic bandage four inches wide and 13 inches long, made by Williams & Co. of Baltimore. The child of course has no navel and never will have. If he lives he may be the envy some day, on the Tom Sawyer plan, of his fellows in bathing.

If he lives he will be a strong argument in favor of a strictly aseptic operation, and of the cure of a condition which I doubt if ever has be-

fore been made by an operation. Have any of my readers known of such a case?

AUTHORS' ABSTRACTS.

Surgery, Gynecology, Obstetrics and Genito-Urinary Diseases.

Syphilis of the Oral Cavity. By W. Pettus Dey, Jacksonville, Fla. *Journal of the Florida Medical Association*, February, 1915, pp. 230-232.

The manifestations of the different stages of syphilis of the oral cavity as differentiated from the various forms of stomatitis, and cancer as well as some rare conditions as burns, hydroea, Vincent's angina, etc., is brought to the attention of the dental surgeon not only from a diagnostic standpoint but for his personal protection as well.

In view of the fact that not a few are infected who are not themselves cognizant of the fact, a large number of syphilitics deny the infection to any but their medical adviser.

The dentist is advised to exercise extreme caution when dealing with any mouth which presents an ulceration (especially a perforating ulcer of the soft palate) no matter how small or innocent it may appear, and summarizes as follows:

1. It is practically impossible by inspection alone to differentiate syphilitic from nonsyphilitic sores and is only possible by means of laboratory methods.

2. Syphilitic ulcers of the mucous membranes of the mouth are highly contagious, in fact the most contagious of all specific ulcers.

3. It is a safe rule to look with suspicion upon every ulcer of the mouth, throat and tonsil.

4. In view of these facts it should be the duty of every physician who has knowledge of this condition in a patient to confer with the dentist regarding the infection when referring him for dental work.

Treatment of Fractures. By B. F. Zimmermann, Louisville, Ky. *American Journal of Surgery*, March, 1915, pp. 90-96.

The author presents a resume of the subject of fractures and their treatment. Nearly all the varieties of fracture are adequately described, and the most suitable method of treating each type fully outlined. The views of many authors are carefully abstracted and presented.

In comparing the work of abdominal surgeons with that of "bone surgeons," he remarks that the treatment of bone lesions is today the most difficult of all surgery, requiring a technical fineness scarcely known to abdominal surgeons of twenty years ago, and possessed by comparatively few of the present.

The two recently developed greatest factors contributing to the more successful management of fractures are: (1) radiography, and (2) the open method of treatment. While Lane may plate successfully all his simple fractures, and Murphy may secure union in ununited fractures by bone transplants, such radical procedures will always represent a small portion of the fracture work required of physicians and surgeons.

The primary object in treatment is to secure

good functional results. Experience has shown that nearly all cases of "non-union" are merely "delayed union." In the majority of fractures physiological use is the best agent to assist in making union solid, but protection by artificial support is required even after the fragments appear firmly united.

Open treatment is indicated only in aseptic surroundings with the most rigid adherence to aseptic technical details; otherwise the closed method is safest in the best interest of the patient. Operative treatment may be undertaken at any time within ten days after the injury.

Some Mistakes in Obstetrics. By J. H. Graves, Waco, Texas. *Texas State Journal of Medicine*, March, 1915, pp. 466-468.

(1) Mistakes of Omission: Failure to overhaul obstetrical case. Failure to have on hand perineum needle and holder; sterile forceps; five yards boiled and dried cheese cloth; kitchen table strong and clean in room to operate upon if necessary; reinforce bed with more slats, if no table is available. Failure to have your patient ready. In primipara make external measurements as soon as consulted. Administer a little anaesthetic just as head is born. Retract foreskin of male babies at birth, and instruct nurse to retract it daily for several days, anointing with sterile vaseline. Crede's method of instilling 2 drops 2 per cent Sol. Arg. Nit. in each eye; follow immediately with sterile normal saline previously prepared. Determine position and presentation as soon as possible. Delay in use of forceps, when indicated, often destroys the child, but seldom ever hurts mother much.

(2) Mistakes of Commission: Too frequent and too rough digital examination. Unnecessary haste in use of forceps, and unnecessary use of forceps. Resort to basiotribe, when patient manipulation, plus pituitrin, judiciously given, would deliver child. Unsterile hands, instruments and dressings is criminal. Leaving perineum lacerated and unattended to. Instructions given to women to lie on their backs too much after delivery cause retrodisplacements et al. Unnecessary use of pituitrin. Tie cord with sterile ligature, dust stump powder. Boric acid 1 part, talcum three parts. Leave off all dressings, no binder, no nothing. Thus the mother or nurse can see stump at all times, and no hemorrhage can occur and escape quick detection.

Thoracotomy in Unresolved Pneumonia. By Randolph Winslow, Baltimore, Md. *Surgery, Gynecology, and Obstetrics*. March, 1915, pp. 350.

The author reports two cases of pneumonia in which symptoms did not subside at the usual time and empyema was suspected.

The first case was that of a boy of sixteen years with a lobar pneumonia which failed to clear up, and an empyema was suspected. Aspiration failed to discover pus, but it was decided to do thoracotomy. This was done under nitrous oxide and oxygen anaesthesia. No pus found, but lung was hard, non-collapsible and adherent to chest wall.

The adhesions were released and a drainage