frequent fluid stools, any fecal drainage through the incision. Naturally it would be supposed that the worms made their way into the abscess cavity from some portion of the intestinal tract, but why, if ten worms of the size of most of these made their way through the intestinal wall, had there been no escape of any other intestinal contents? This remains a mystery. The worms were most of them full-sized individuals varying from 5 to 9 inches in length and were all alive at the time of removal.

There seems to have been some relation between the doses of santonin and the appearance of the worms, the majority of them having appeared soon after administration of the drug. It would be interesting to know whether, if the santonin had never been given, the worms would have appeared or not.

Whether the worms were responsible for the exceeding sluggishness of the wound or whether that was due to other causes is also a question. The pus was always more abundant on the days that the worms appeared and for several days afterward. Unfortunately, in Central Persia, there is no means of access to the literature on the subject, so I am unable to find out whether the case is a unique one or not.

It may be interesting to note, in connection with this case, an instance related by the father of this patient, who is a native physician. He tells of a patient of his whom he had tapped repeatedly for dropsy. On one such occasion, greatly to his surprise, when he inserted the trocar a roundworm came forth. Cases in which worms have been vomited, have appeared at the nose or gone through the eustachian tube into the ear are not uncommon in this country; and cases have been reported in which a worm has perforated the intestinal wall, causing peritonitis.

ADHESIVE SUPPORT FOR TENSION SUTURES

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When placed under tension sutures are apt to cut their way through the tissues, thus diminishing their support of the wound.

Parallel glass tubes, covered with adhesive plaster, placed over incision to relieve suture tension.

In closing wounds in which there is likely to be much tension, as from tympanites, vomiting or when the patient is to be got up early after operation, I have used the following simple method with satisfaction:

Two pieces of $\frac{1}{4}$ -inch glass tubing are filed and broken off the length of the wound. Two pieces of zinc oxid adhesive plaster are cut as wide as the length of the rods, and as long as necessary to give firm support. One end of each piece of adhesive plaster is rolled once around a glass rod, adhesive surface in, and overlapped on itself $\frac{1}{4}$ inch.

After the wound has been closed with sutures in the usual way, with silkworm-gut tension sutures inserted but not tied, the adhesives are applied, the rods coming just within the line of tension sutures on each side of the wound. Close

to the rods, with knife or scissors, are cut small slits, through which the ends of the sutures are passed, drawn taut, and tied over a strip of gauze laid on the wound. Additional support may be obtained by passing tapes through other slits and around the rods, tying the ends together over the gauze. The usual dressings are then applied.

The sides of the wound are firmly and evenly supported, and the wound is placed at rest, a condition favoring prompt healing with minimum scar formation and liability of hernia.

THE RADICAL CURE OF AN UNUSUAL TYPE OF HEADACHE

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The following clinical record is presented as an example of a rarely diagnosed disease-form and its cure:

History.—Mrs. L. L., aged 35 years, referred by Dr. William Duffield, Los Angeles, is the fifth in a family of nine children. Her parents are alive and healthy. There is no history of headaches or nervous disease in the family. Up to her seventeenth year the patient was in rugged health. Her menstrual history began at the age of 15, and is the dominant feature of the case. Menstruation has been very irregular. During the last five years it has appeared normally but twice, and not at all in the last thirteen months. Some of her headaches seem to have been due to cerebral hyperemia caused by suppressed menstruation, inasmuch as at every period when menses should show and failed to do so she suffered with terrific hyperemic headache. She was married five years previous to her first examination and has never been pregnant. Apart from her headaches and attendant symptoms the patient does not complain, except that she has had pain at times in the region of the appendix. She complains of terrific, prostrating headaches, and has suffered with them since her seventeenth year. They have been growing worse, and have become so intolerable that she has contemplated suicide.

Onset and Progress.—The headache begins as a sharp, cutting pain in both temporal regions. Thence it moves backward, and seems to go through the brain deeply. It is not noted in the frontal or occipital regions. There is the subjective symptom of excessive pressure from within outward and never the reverse. When it is at its worst she must jump to a sitting or standing posture; she has at times sat up in a chair all night because of it. When she lies down or stoops forward it is made worse. During the headache she vomits often. The duration of severe pain is generally from one afternoon through the night and until about 10 o'clock the next morning. There are no visual phenomena and no aural symptoms, except a dull throbbing. During the throbbing she feels as if there was pressure back of both eyes pushing them forward. The pain is generally one-sided, and is most often on the left. When it is at its height the face is cadaveric and she becomes very anxious. There seem to be two symptom-complexes: (1) intense encephalic hyperemia, especially when the menses are due (vicarious); and, grafted on this (2) migraine.

Examination.—Muscular condition is excellent, though there is evidence of underweight. Heart sounds and blood-pressure do not vary from the normal. There is no abnormality of the bony spine. Pupils are equal and react normally. There is spasm of the orbicularis palpebrarum on the left side. Pelvic examination demonstrates a small, undeveloped uterus but no ovarian disturbance (both ovaries seem normal as to size and position).

The patellar and biceps tendon reflexes are equal and somewhat exaggerated. Painful zones are noted below the left external ear and along the left side of the cervical and upper dorsal vertebrae, and over the trapezius muscle on the left side. There is some tenderness over the region of the appendix. Examination of the eyes (by Dr. Mansur) shows normal fundi, vision and muscle balance. There is no papillo-edema. The urine is normal.