

sequent course of most of these, and there was but one fatality—this patient did not follow the explicit instructions given and failed to report at the hospital when ordered. Small pelvic measurements, indicated by external measurements and confirmed by subsequent internal examination in 23 cases. Of this number 4 cases came to Caesarian Section, 4 cases to a difficult forceps operation with damaged soft parts, 6 cases were normal deliveries with small babies. These occurred in the hospital where they were carefully watched in the early stages of labor, and where the conditions were such that we were prepared to interfere under the most favorable conditions, if necessary. The remainder of this group were later applicants whose labors have not as yet come off. Cases of this type to be delivered at their homes receive at the time of examination a card marked in red ink and at the commencement of labor are at once seen by the Out-Patient House Officer on duty at the time. The more marked cases of pelvic deformitory are admitted to the hospital before the onset of labor. Four cases of heart lesions; 7 cases of syphilis and other skin affections; 7 cases of extensive varicosities of the extremities; 4 cases of breast abnormalities; 5 cases of cystitis, 2 of which were gonorrheal in origin; 5 cases of poor general condition; 1 case of prolapsed uterus; 1 case of hydramnios; 3 cases of tuberculosis; 3 cases of antepartum hemorrhage; 2 cases of early rupture of the membranes; 1 case of vulval abscess; 2 cases of multiple pregnancy; 3 cases of breech presentation; 1 case of early intra-uterine death. This clinic fills a much-needed want in the community, its possibilities are unlimited. Of late it is being used with much success for teaching purposes.

To continue with the card, the results of the examination made before the onset of labor may be compared with those found at the antepartum examination. The results are often most instructive.

Prognosis is important in the final outcome of the case, and if operative interference is indicated the cause of such interference is put down at the time. Attention is called to the placenta and membranes, the mode of delivery, and especially as to the complete removal of both. They should be carefully inspected, and if there is a question as to their entire removal this should be noted on the record, and whatever treatment decided upon should be instituted at once. Vaginal lacerations should be carefully noted, with their treatment and the type of suture material used. We do not inspect cervical lacerations unless at the end of a manual dilatation or in case of cervical hemorrhage.

The condition of the uterus is carefully watched, and given a case where there have occurred nine uterine contractions after the expulsion of the placenta, the placenta and membranes entirely removed, we have as yet to see post-partum hemorrhage. The uterus is always examined by the attend-

ant before leaving the case, together with the maternal pulse; this is recorded in the chart. The infant's condition is looked into, cord for hemorrhage, general condition as evidenced by its activity.

The puerperal record may be looked after by the nurse, if desired, and easily abbreviated notes on the various functions are recorded. If the condition of the infant demands more space an extra card, which is of the standard size, may be used and filed with the record.

The final examination of the patient is important, and many trivial ailments can be corrected at this time, which if allowed to go on, will in a number of cases cause the patient discomfort, if not actual harm. The nurse fills in the clinical chart for the three weeks or more, and this is of frequent value in subsequent pregnancies. A short resumé of the infant is appended.

The cards may be obtained of F. H. Thomas Co., Boston, Mass.

Medical Progress.

PROGRESS IN OBSTETRICS.

BY ROBERT L. DE NORMANDIE, M.D., BOSTON.

TREATMENT OF ACUTE INVERSION OF THE UTERUS.

PHILLIPS¹ feels that the treatment advised by almost all writers, that is, immediate replacement of the inverted uterus, in all cases is not the best advice. From his analysis of the cases, he feels that the mere displacement of the uterus should be ignored until the shock, which is so frequently present, has been satisfactorily treated. The shock, he says, is the most important symptom. It is present in the majority of cases, and in some cases it is very profound, and in not a few does it cause death within an hour or two of the onset. On the other hand in a considerable number of cases, there was no shock at all. Pain and hemorrhage are the other symptoms. The shock is produced during the actual process of inversion. It is well marked immediately after the accident, but unless severe enough to have caused death, it gradually disappears even though the uterus is left in an inverted state. During the process of reduction of the inversion, shock is also caused, even when the patient is anesthetized. The shock so produced may be sufficient to kill the already collapsed patient. Phillips has collected from English literature 184 cases of acute puerperal inversion, and of these 43 died, 23.4 per cent. The mortality given by various authors varies from 40-50 per cent. In 79 cases in which the uterus was immediately replaced, in the presence of marked shock, over 30 per cent. died. In 23 cases where there was no shock, immediate replacement was followed by recovery. In 11 cases there is no note as to the presence or absence of shock. Immediate replacement was possible in

these cases. In 17 cases death occurred with the uterus unreduced. In 47 cases the uterus was not reduced at once, but was allowed to become a chronic inversion, and treated later in various ways with the recovery of the patient. In two other cases death was due to septic infection. In two cases the body of the uterus was twisted off by the attendant and yet the patient recovered. Of the 43 deaths, 41 took place within a few hours. Immediate replacement of the uterus is followed by fatal results in 21 per cent. of the cases. On the other hand, in the cases which were allowed to become chronic, only two died less the five per cent. Phillips advocates an intermediate course. He advises that the shock, if present, should be treated by saline infusion, injection of pituitary extract and morphia. Then when the patient has rallied she should be anæsthetized and the uterus replaced. At the same time he advises repeating the saline infusion, and any other stimulating measures which may be considered necessary. Phillips says the earlier the reduction the greater the ease with which it is effected, but the delay of a few hours does not increase the difficulty materially, whereas time is required to revive the collapsed patient. If there is no shock the uterus can be replaced immediately, but even then the patient should be anæsthetized and a precautionary saline infusion given.

The first case he reports he saw four hours after delivery. She was then very white and cold, with a small feeble pulse of 130. She was given a saline infusion, a quarter grain of morphia, wrapped in hot blankets and sent to the hospital. A few hours later, having recovered, she was anæsthetized. The inverted uterus was pulled outside the vagina, thoroughly washed, and then reinverted without any difficulty. The patient made an excellent recovery. The second patient had also marked shock, but no bleeding. No attempt was made to replace the uterus, which lay in the vagina. She was given a hypodermic injection of morphia. She soon became drowsy and the pulse improved markedly. She was sent to the hospital where, five hours later, she was anæsthetized and the uterus replaced with more difficulty than was experienced in the first case. Manipulation for ten minutes produced a great deal of shock. She gradually recovered and made a good convalescence. The third case occurred after an expulsion of the child unassisted by the doctor. The adherent placenta and the whole half of the uterus lay outside the vagina. The doctor found the patient very collapsed, just as if she had had a severe hemorrhage, and yet there was only a little bleeding from the torn perineum. The uterus was pushed back into the vagina without any anæsthesia. This caused the patient great distress, and the doctor desisted, and the patient appeared to be dying, with no pulse at the wrist. Phillips came to the case forty minutes after the inversion and found the pa-

tient very collapsed, with a feeble pulse of over 150. Her condition was much more serious than the other two cases. She was infused and a quarter grain of morphia added. At the end of forty minutes the patient's condition was greatly improved. She was much warmer and had a fair pulse of 104. A short while later she was taken into the hospital, but even then the condition did not warrant operation. The next morning she was considerably better, and some twenty hours after inversion had occurred she was anæsthetized, infused with saline, pituitary extract, and the uterus replaced. This required a good deal of pressure from twelve to fifteen minutes. Then she made an excellent recovery and had slight bleeding, but her condition never gave cause for anxiety.

PYOSALPINX REMOVED BY ABDOMINAL SECTION DURING PUERPERIUM.

Ferguson² distinguishes two kinds of cases in this division. First, those originating before labor, and becoming exacerbated in the puerperium, and second, those commencing in the puerperium from direct infection. He regards the first class of cases undoubtedly as most amenable to operative interference, for then the condition is more local. In the second class of cases, the complication is generally a mere incidence in a more general infection. As to the question of operating on these cases, Ferguson says it is better to avoid operating during the acute symptoms if it can be avoided. Assuming that there is pus in the tube, Ferguson says that he would not wait indefinitely in the hope of the pus becoming sterile in a puerperal case. He waits, if possible, until the more acute symptoms have abated, and then operates, if the physical signs and symptoms still call for interference. The case he records is a multiplara who had a premature labor and who in her fifth month of pregnancy complained of a dull, aching pain on her left side. The puerperium for the first five days was normal, when on the sixth day she began to complain of severe pain over the left iliac fossa. Temperature, 102. From the sixth to the ninth day she varied from 100 to 102 and her pulse stayed about 104. From the ninth to the seventeenth day she began to improve, and gradually the more acute symptoms subsided. On the nineteenth day when the acute symptoms had subsided, Ferguson opened the abdomen and found the left Fallopian tube distended to the size of a thumb, with dense adhesions around it. Separating these adhesions, thick yellow pus escaped. The tube and ovary on that side were removed, and because of the escape of pus was drained through the vagina. The abdominal wound was completely closed in the usual way. The wound became infected, but Ferguson says she made a satisfactory recovery.

SIZE OF THE UTERUS IN HYDATID MOLE.

Briggs³ reports the analysis of twenty-three cases of hydatid mole founded upon eighteen years of clinical observation on cases occurring in his own practice. From this study he comes to the conclusion that undersize, not oversize, of the uterus is the more prevalent disproportion in cases of hydatid mole. Of the twenty-three cases, one corresponded in size with the size of the patient's pregnancy. In fifteen cases the uterus was below the normal size. In four the uterus was larger than normal, and in two there was a choreo-epithelioma, one of which was undersized and one oversized. Briggs gives the clinical history of these cases. In these histories the irregular loss of blood after the pregnancy was supposed to have begun is a characteristic symptom, as is also the increased tension of the uterus. In only a few cases was it necessary to do a manual extraction. Briggs treatment was conservative in the great majority of cases, that is, either he put in a bougie, shortened according to the size of the uterus, or allowed nature to expel the mass. Briggs has followed up his cases remarkably well, and the number of well, healthy children that have been born to these patients after hydatid mole is large, and greatly upsets the previous conception of the tendency that hydatid mole has to become malignant. He summarizes his article by saying that it is unlikely that a series of twenty-three cases in which the features and associations of hydatid mole are otherwise so extensively embodied and confirmed, will prove to have been exceptional in the prevalence of the one clinical feature of undersize of the uterus. Undersize of the uterus in sixteen cases, with frequent quiescence and occasional recedence of the mole in a series of twenty-three, widens the differential diagnosis in cases of abortion and intrauterine death of the foetus and modifies the current and contrary statements. In the oversize of the uterus, the part played of a concealed intrauterine hemorrhage is apparently higher in frequency and greater in effect than has been generally stated. The tendency of cases of hydatid mole to malignancy comes out in the series with a diminished ratio. The article has several illustrations which are most interesting.

PUBIOTOMY IN A FACE PRESENTATION.

Morse⁴ reports a case of pubiotomy which he did in a generally contracted rachitic pelvis, with the chin posterior. He attempted to change the chin from a posterior to an anterior position but was unable to, and he then had recourse to pubiotomy. The pubiotomy was done in the usual subcutaneous method. A living child was obtained, and the puerperium was normal, except for the fact that the patient persisted in having incontinence of urine. Examination of the vagina showed a vesico-vaginal fistula, which healed spontaneously in two weeks. The

patient, except for this complication, made a normal convalescence. Morse has been able to find reported only four other cases of pubiotomy with face presentations. He sums up his article in the following conclusions:

First, in cases of face presentations where the chin is directed anteriorly, and the pelvis is normal, spontaneous delivery may be expected. When indications for terminating labor present themselves, the question of a pubiotomy will arise. He advises that the saw be ready for pubiotomy, the forceps then applied, and if extraction is not possible, he advises the performance of pubiotomy.

Second, if the chin is directed obliquely posterior conversion should be attempted as soon as the condition of the cervix permits. The usual procedures should first be carried out in order to try to attempt to correct the position. If all attempts fail, then he advises pubiotomy, and he says that pubiotomy should replace craniotomy in all face presentations, except where the child is already dead or in so serious a condition as to exclude a radical operation. Pubiotomy is contra-indicated in face presentations, where the conjugate vera measures seven and a half centimeters or less, or when the woman presents signs of infection or attempts at delivery have been attempted by those whose technic is open to question. Finally, pubiotomy must be regarded as an operation to save the child, and should be limited to those cases where there is a reasonable probability of obtaining a living offspring. He considers pubiotomy an absolutely unjustifiable operation, even though there has been no maternal mortality in the Johns Hopkins clinic, if the child is in such bad condition at the beginning that it will not survive extraction.

FIFTY FATAL CASES OF PUERPERAL FEVER.

Stowe⁵ analyzes the fifty fatal cases of puerperal sepsis, occurring at the Cook County Hospital within twenty-nine months. Many of these cases were treated indifferently or neglected, and were finally sent into the hospital in a hopeless condition. Although it is commonly supposed that the majority of fatal cases of sepsis can be traced to midwives, in this series, in twenty-one of the cases a physician was in charge, and the midwife was in charge of twenty, and in six the patient had attempted an abortion upon herself. While in the hospital all patients were placed upon energetic stimulation, the treatment consisting of strychnia, digalen, alcohol. Access to sunbaths were possible in only a limited per cent. Salines by rectum and hypodermoclysis, adrenalin, anti-streptococcic serum and collargol were used in several cases. Stowe calls attention to three general fundamentals which have a decided influence in the treatment of puerperal sepsis. All local forms of infection are self-limited. They tend to spontaneous recovery and require no

intrauterine therapy except in the presence of hemorrhage. The treatment is decidedly watchful expectancy. Second, by the employment of many common methods of treatment, a local type of sepsis may be converted into a virulent and fatal condition. A curette, septic fingers and intrauterine douche are directly responsible for many deaths. Third, our methods of diagnosing septicæmia in the early stages are uncertain. Before we are able to diagnose the condition, the invading process has reached a stage not amenable to local treatment, and the patient frequently succumbs to the toxæmia. Stowe insists that abortion and labor at term are necessarily surgical procedures and are to be treated upon strict surgical principles.

A septicæmia associated with good drainage and uterine retraction is not to be feared, and these conditions are treated best by ergot and Fowler's position. Instrumental dilatation of the cervix in septic abortion is conducted with great harm. If it is desirable to dilate, packing is by far the best treatment. If the septic process has extended to the parametrium or peritoneum the emptying of the uterus by the curette is a calamity. The instrument has no place in puerperal sepsis. Stowe feels that if the infection has spread to the parametrium or peritoneum it is best to leave the uterus alone, whether it is empty or not. The use of a curette after a full term delivery is never to be sanctioned. The danger from retained membranes has been overestimated, and he says that attempts to remove retained membranes from the uterus are often attended with more danger than their retention. If hemorrhage is present, while the membranes are completely retained, and the patient's aseptic environment is satisfactory, the attempt may be made to remove them. Otherwise, with these two exceptions, it is preferable to give ergot and rely upon the natural powers. He comes to the conclusion that uterine irrigations more frequently used by the general practitioner are useless and dangerous. They increase the number and virulence of the bacteria, inflict traumatism on the uterine musculature, and cause an extension of the infection. In selective cases, posterior colpotomy is of great value. If there are collections of pus in the pelvis high up, it is best to leave such conditions alone for weeks or months until after the acute process has terminated. Hysterectomy, he says, is associated with a heavy primary and secondary mortality. If the virulent process is confined to this organ its removal is indicated, but its early diagnosis is exceedingly difficult. In general, hysterectomy is indicated where there is uterine traumatism with infection, probable or already commencing. Second, in inflamed or gangrenous myomata. Third, mortification of the fetus in utero. Fourth, severe inflammations of the uterus when purulent processes are found in the walls from which pyæmia may originate.

Serum therapy has been of little value in puerperal sepsis. Collargol is not specific but is used in certain cases. Stowe used intravenous injection of bichloride of mercury in undoubted cases of septicæmia and lost five patients. In the cases that recovered the beneficial effect of the mercury was noticeable. The general treatment in all cases of septicæmia is of the greatest importance. The feeding should consist of eggs, milk, beef juice, and alcohol. Rectal feedings may be necessary. The relief from pain is often brought about by keeping ice on the abdomen. Otherwise give opiates. The patient should have from six to eight hours' sleep daily. Salines by rectum or under the skin are of value, especially when the kidney function is weak. The drop method of Murphy is of great value in certain cases. Strychnine, digalen, camphorated oil are indicated as cardiac tonics. Fresh air and sunlight are of great importance, especially during the period of convalescence. His article ends by a brief analysis of the fifty fatal cases.

PITUITRIN IN OBSTETRICS.

Hahl⁶ briefly reviews the early works on the use of pituitrin in obstetrics, and then goes on to report forty-two cases of his own where pituitrin has been used. At the first pituitrin was given in .4 and .5-.6 of a gram and later, towards the end of his cases, he gave one gram repeated in two or three cases in about three hours. In all cases was the pituitrin given subcutaneously, except in one case where it was given directly into the uterine musculature in a Cæsarean section. In the majority of cases the pains started within a short period after the injection of pituitrin and became considerably stronger with shorter intervals. The effect of the pituitrin lets up in about eighty minutes. Hahl feels that at the present time not too great hope must be put in it. It is by no means an infallible measure of starting up uterine contractions, and the danger lies in the fact that as the pains become stronger, the intervals become shorter, and from his experiments on several cases, intra-uterine pressure becomes greater. After the liquor has gone from the uterus there is a greater tendency for the uterus to come into a state of tetanic contraction. Each individual woman may react differently. It is better to try a small dose first and then to repeat the dose rather than to give one large dose, but in a case of hemorrhage the effect cannot be too quick, and therefore, a large dose should be given at once. That was shown in one case of his where there was a twin pregnancy and there was severe bleeding. The uterus did not contract well, and immediately after one gram of pituitrin was given good contractions were obtained and the bleeding ceased. In two cases he records that its use brought about the death of the child. Hahl's conclusions at the present time about the use

of pituitrin are that it is a valuable aid, though not infallible means of making the uterus contract more forcibly. He does not feel that the contractions become continuous unless too large doses be given.

INFANT MORTALITY.

Jacobi⁷ in his presidential address before the American Medical Association took for his subject, "The Best Means of Combating Infant Mortality." The first part of his paper is taken up almost entirely with an appeal for maternal nursing. The second part on what he has to say about midwives is most interesting. He takes a definite stand that a system of teaching midwives should be developed in the United States. The standard that he puts for the midwives is a high one. He says she must have as moral a character as you expect in a male or female student of medicine. She must have a good common school education, without Latin or Greek. She must have fair health so as to endure the hard work she must undergo in the future, a reputation for love of work and conscientiousness and must have such knowledge of popular physiology and anatomy as the program of our future midwifery schools will designate. The schools must teach the care of expectant women, the conduct of normal labor, care of babies immediately after birth, the simple principles in urgent cases of artificial feeding and the diagnosis of abnormalities so as to advise the calling of medical skill. He calls attention to the fact that the Bellevue and allied hospitals have established a small school of midwifery. He says that it is useless to attempt to compare the midwife with the medical man. They must be considered individually. An ignorant doctor in obstetric work is the inferior of a well-informed midwife, and vice versa. The whole paper is one that should arouse the interest of all medical men who come in contact with infants.

MEDICAL EDUCATION IN THE MIDWIFE PROBLEM.

Williams⁸ made up a questionnaire of some fifty questions and sent them to the professors of the one hundred and twenty medical schools giving a full four year course in the United States, and from these one hundred and twenty medical schools, forty-three professors answered his questions. His paper, which he read before the American Association for the Study and Prevention of Infant Mortality, is based on these questions and answers. The article is too long to abstract fully and one can only show the mere outline of his findings, but it behooves all medical practitioners who are interested in the welfare of their profession to read it thoroughly and intelligently. His questions cover the ground of teaching obstetrics splendidly, and the answers that he obtained are an absolute disgrace to medical education in the United

States. The answers that he has obtained show that the teaching of obstetrics is absolutely inadequate and that each year the medical schools are turning loose on the community (what many of the more conscientious men have known for years) hundreds of young men whom they have failed to prepare properly for the practice of obstetrics and whose lack of training is responsible for many deaths of women and infants. These admissions that the poor training of the medical men is responsible for many unnecessary deaths in childbirth, forces Williams to say that the improvement in the status of the midwife alone will not materially aid in solving this problem. His conclusions are as follows:

(1) Generally speaking, the medical schools are inadequately equipped for teaching obstetrics properly, only one having an ideal clinic. (Professor Williams has carefully omitted all names in his paper, and what clinic this is is not stated.)

(2) Many of the professors are poorly prepared for their duties and have little conception of the obligations of a professorship.

(3) Many of them admit that their students are not prepared to practice obstetrics on graduation.

(4) Half of the answers state that ordinary practitioners lose proportionately as many women from puerperal infection as do midwives and over three-quarters admit that more deaths occur each year from operations improperly performed by practitioners than from infection in the hands of midwives.

(5) Reform is urgently needed and can be accomplished more speedily by radical improvement in medical education than by attempting the almost impossible task of improving midwives. The reforms Williams suggests are as follows: (a) Reduction in the number of medical schools. (b) Insistence that the head of the department of obstetrics be a real professor and not a prosperous practitioner. (c) Recognition by the medical schools and hospitals that obstetrics is one of the fundamental parts of medicine. (d) Education of the general practitioner to realize that he is competent only to conduct normal cases of labor and that major obstetrics is major surgery and should be undertaken only by especially trained men. (e) The requirement by State examining boards that every applicant for a license to practice medicine submit a statement saying he has seen delivered and has personally examined, under appropriate clinical conditions, at least ten women. (f) Education of the laity that poorly trained doctors are dangerous and that most of the ills of women result from poor obstetrics. (g) Extension of obstetric charities and free hospital and out-patient service for the poor, and proper semi-charitable hospitals for those in moderate circumstances. Williams wishes to see the greater development of the visiting obstetric nurse and the gradual abolition of midwives in

large cities, and he says that if midwives are to be educated it should be done in a broad sense and not in a makeshift way.

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Book Reviews.

Case Histories in Neurology. A Selection of Histories Setting Forth the Diagnosis, Treatment and Post Mortem Findings in Nervous Disease. By E. W. TAYLOR, A.M., M.D. 8vo, pp. 305, with 37 illustrations. Boston: W. M. Leonard. 1911.

This volume of the Case History series presents brief descriptions of 117 cases of various forms of disease of the nervous system, under the conventional divisions of diseases of the peripheral nerves, spinal cord and brain, diseases with a vague pathological basis and psychoneuroses. An introductory chapter gives a brief but excellent description of the principles of diagnosis, based on anatomical and physiological considerations and illustrated by a few simple and instructive diagrams, and each division is preceded by a brief explanatory section on the principles of diagnosis and treatment. The object of the book is "to set forth in practical form, on the basis of the Case System, certain fundamental facts regarding the symptomatology, diagnosis, treatment and pathological findings in the more frequent disorders of the nervous system." As the discussion of the individual case rarely extends beyond two pages it is evident that little space is available for the discussion of the details of treatment or of clinical examination. Within the limitations of such a work, however, the cases are well presented and the selection has been such as to present most of the important forms of nervous disorder. It is curious, however, that none of the half dozen cases of tabes described should have presented the tabetic cuirass, which is so often of help in diagnosis. The work as a whole may be recommended to all those who find benefit from the Case History system as an excellent presentation of that system in its neurological aspects.

The Treatment of Short-sight. By DR. J. HIRSECHBERG, Berlin. Translated by G. Lindsay Johnson, M.D. New York: Rebman Company.

The subject matter of this little book (123 pages) is interesting and will be useful to any practicing ophthalmologist as giving the views of an eminent authority on the subject. The author does not believe in the full and constant correction of myopia except in the lower degrees. Not all oculists will agree with the statement, "Nobody can endure wearing -16, 18 or -20 D. continuously." However, the book is full of keen comment based on long experience. The work of the translator could not well be worse done.

Principles and Practice of Physical Diagnosis.

By JOHN C. DACOSTA, JR., M.D., Assistant Professor of Clinical Medicine, Jefferson Medical College; Assistant Visiting Physician, Jefferson Hospital, etc., Philadelphia. Second edition, revised. Octavo of 557 pages, with 225 original illustrations. Philadelphia and London: W. B. Saunders Company. 1911.

DaCosta's Physical Diagnosis in this new edition is a work which can be highly recommended as a text-book of its subject. In the first section the technic and methods of physical examination are fully and clearly described, and in subsequent sections the different anatomical regions and physiological systems of the body are discussed in turn. In each the clinical anatomy and the general phenomena of physical examination are first described, and then each individual disease is given separate consideration with reference to its clinical pathology, physical signs, and in most instances the methods of differential diagnosis from other diseases. The descriptions are clearly stated, and are ably supplemented by excellent illustrations and diagrams. Recent advances have as a rule been closely followed, although in the rapidly changing field of cardiac arrhythmias the generally discarded nodal rhythm is described, and the teachings of the electrocardiograph are not mentioned.

Transactions of the Seventeenth Annual Meeting of the American Laryngological, Rhinological and Otological Society. Published by the Society. 1911.

This volume contains not only the papers and discussions of the annual meeting, but also those of the midwinter meetings of the four sections, making in all fifty-eight titles. Most, if not all, of these papers have been published in different medical journals, and are here collected as additional means of reference. These transactions as they appear annually are an excellent means of furnishing a library with a collection of articles, many of them important, in a compact and available form.