

of the nasal duct cut away, exposing the guide, with a curved chisel, gouge, or the author's bayonet-shaped curette, thus making the same open gutter. The guide protects two-thirds of the lumen of the duct and prevents injury to same or wounding the antrum or ethmoidal cells.

The gutter can be extended up into the sac if necessary, but should stop just beyond the stricture, as determined by the ease of re-introduction of the probe.

The operation is similar to a urethrotomy with a guide and can be done painlessly, bloodlessly, and by any operator possessing ordinary skill. The gutter cannot and will not close.

**Present Knowledge of Focal Localization Along Visual Paths.** By C. Barck, St. Louis, Mo. *Annals of Ophthalmology*, January, 1915.

The author gives a complete historic outline of the development of this field, anatomically, physiologically and pathologically. Then he presents his conclusions, dividing our present knowledge into positive and relative. As positive knowledge the following is stated: In the optic disc and immediately behind it, the macular bundle of the optic nerve occupies a temporal sector, comprising about one-fourth of all the nerve fibers. Then it turns toward the center of the optic nerve and reaches this position

about midway between the eyeball and the optic foramen. It retains this central position in the posterior portion of the nerve as well as in the chiasm and in the optic tracts, although its configuration changes. The primary visual center is situated in the lateral and mesial geniculate bodies, in the thalamus opticus and in the hypothalamic nucleus, but mainly in the first one of these ganglia. A differentiation between them as to function or localization is at the time impossible. The fibers for the pupillary reflex also undergo a semi-decussation in the chiasm, so that each eye sends pupillary fibers to both reflex centers. The pupillary fibers accompany the visual fibers into the lateral geniculate bodies. There they depart from them and proceed into the superior corpus quadrigeminum. This is the pupillary reflex center and it is connected with the retina of both eyes. The communication between the primary and the ultimate center is by way of the optic radiation, a well defined set of fibers. The ultimate center is located in the occipital lobe. It occupies the mesial portion of this lobe around the calcarine fissure; and its three gyri, the cuneus, the lobus lingualis, and the gyrus descendens, participate in it to about an equal extent. This area coincides with the portion in which Gennari's stripe is constantly found. All further knowledge is, at the time, relative.

## AUTHORS, ABSTRACTS.

### Surgery, Gynecology and Genito-Urinary Diseases.

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**Exposure of Appendix by Cullen's Method. A Simple Way of Removing an Adherent Retrocecal Appendix Through the Ordinary Gridiron Incision.** By William Neill, Jr., Baltimore, Md. *Journal of the American Medical Association*, January 23, 1915, pp. 299, 300.

In the above type of cases, after a gridiron incision has been made, it is often impossible to expose the appendix, without being forced to cut across some of the abdominal muscles.

The longitudinal band of the caecum is followed down and the base of the appendix located. A blunt Kelly forceps is then pushed through the meso-appendix at this point and grasps a piece of tape, which is pulled through and the two ends grasped in the tip of the forceps.

Strong traction can be exerted on this, without injury to either the caecum or appendix. Traction invariably brings up from three-fourths to one inch of the appendix. Another forceps is passed through the meso-appendix at a point lower down and a second piece of tape grasped in the same manner as with the first, and a further portion of the appendix exposed.

As many of these tapes as is found necessary can be employed; usually two or three will suffice. Usually by traction on the third tape the tip of the appendix will be exposed.

The meso-appendix is now clamped from tip to base and ligated, and the tapes removed. The appendix is now free and can be treated in the usual way. Thus, a difficult and tedious operation

is often rendered a simple one by the aid of the "hand over hand" procedure with the tapes.

**Keloid Formation in Negro.** By A. G. Brenizer, Charlotte, N. C. *Annals of Surgery*, January, 1915.

The keloid, since it is histologically a fibroma, and histogenetic studies have established the fact that it does not grow through changing the surrounding cells into tumor cells but grows as a mass of cells from an original focus, and does not (as for example, the tubercle and gumma) involve the surroundings directly in the process, differs from all known effects of bacteria. It could only be an absolutely specific adaptation of the parasite to the tumor, which is so perfect that it immediately becomes absorbed by the cells from which the growth springs. For how could one imagine a parasite which might affect certain cells, prompt them to continuous growth and immediately lose the power to affect other cells!

There is a striking relation between outward injury and the formation of tumors. Even normal cells are prompted to proliferation and alteration by outward injury, but there is a return to normal or to a state of equilibrium of growth. Whatever checking force there is to control the growth and shaping of the body tissues again exerts its influence. It would seem that, in the case of normal cells, there is first a paralysis and then a regeneration of an inhibitory substance, while, in the case of tumor cells, the paralysis is followed only by a more or less feeble restoration of inhibition; it remains a vague speculation as to what this inhibitory influence is.

A keloid may arise following an irritation of the slightest intensity.