The morning and evening record may be stated as follows:

Day.		T. (F.)	P.	R.	
3	a. m.	101.4	92	24	Quinin and iron given.
	p. m.	101.8	98	25	Quinin and iron continued. Complaint of nausea.
4	a. m.	101.4	100	24	Expectoration less. Quinin withdrawn. Iron continued.
	p. m.	102	108	26	Quinin repeated, gr. xl, followed by gr. xxx in one hour. Iron continued, M. x every three hours.
5	a. m.	99	100	27	Quinin and iron both discontinued, owing to irritability of the stomach. Patient was not seen in the evening.
6	a. m.	100	96	17	Feeling better. No medicine given.
	p. m.	99.4	100	16	Strych. gr. 1/60 every three hours while awake. Practically no expectoration.
7	a. m.	98.6	98	17	Strych. gr. 1/60 t. i. d. with tr. nux et gent, āā M. v. before each meal. Breathing regular and painless. No adventitious sounds and only slight mucous expectoration. No dullness on percussion.

The temperature, pulse and respiration have remained normal, and the patient feels well, though weak. (Eighth day.)

I might add that I did not give such large doses as suggested by Dr. Galbraith; owing to a very irritable stomach. She complained a good deal of tinnitus, but not after quinin was withdrawn.

I would like to ask if people in the southern states are more tolerant of quinin, or if this patient would probably have retained a larger initial dose better than the smaller, and if the effect would have been more permanent.

AN IMPROVED RECTAL OPERATING TABLE.

W. I. LEFEVRE, M.D.
CLEVELAND, OHIO.

Since publishing a description of my table in the *Medical Record* several years ago the table has been remodeled and improved as shown in the following illustrations: Figure 1 shows a front view of the table. Figure 2 shows a back view with the side shelf folded down and the leg rests up in position. The leg rests are adjustable as to height, the padded pieces being hinged on the round supports so that they automatically adjust themselves to the leg, thus assuring a comfortable position. At the same time the buttocks are brought

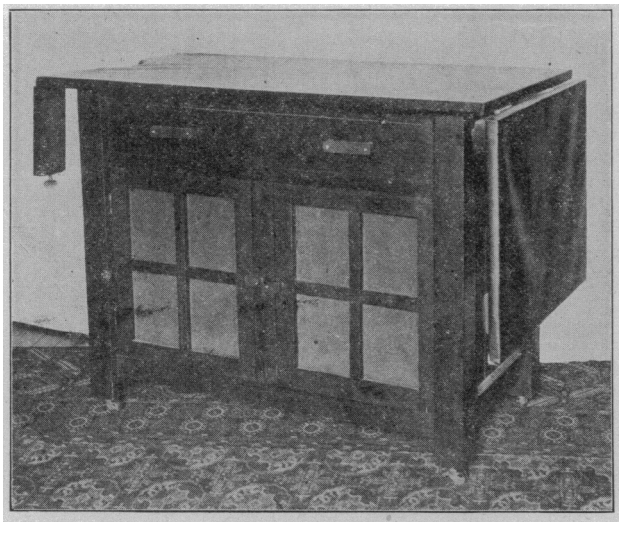

Figure 1.

to the end of the table, making the parts easy of access for the operator. When the side shelf is adjusted and locked in position, as shown in Figure 3, and the top tipped to an angle of 90 degrees, the patient is then in position for a proctoscopic examination. With the patient in the Sims position the side shelf can be adjusted and a practically knee-chest position secured, with little or no discomfort to the patient. This is particularly desirable when examining a woman.

While the table is designed especially for rectal work, it is suitable for all ordinary office examinations.

708-712 Rose Building.

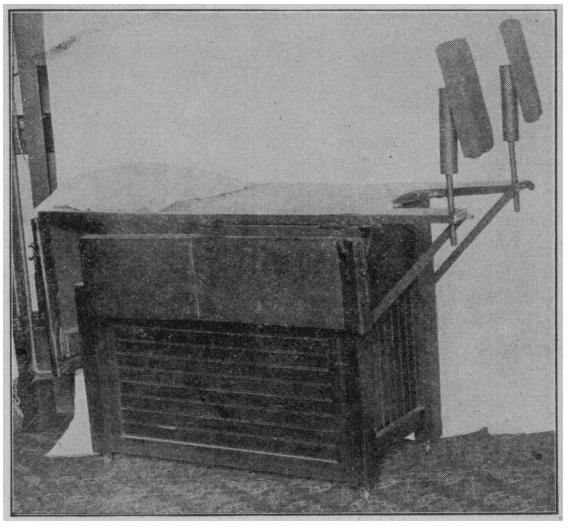

Figure 2.

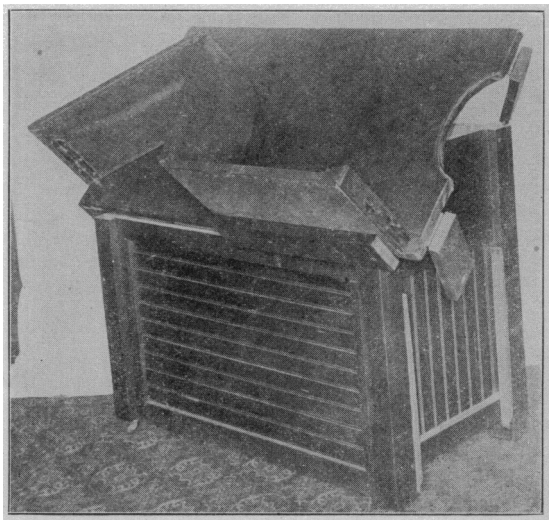

Figure 3.

LOCATING FISTULÆ IN THE LOWER INTESTINAL TRACT BY INJECTING HYDROGEN DIOXID THROUGH THE ANUS.*

H. A. ROYSTER, A.B., M.D.
Professor of Gynecology and Dean of the Faculty, Medical Department of the University of North Carolina; Gynecologist to Rex Hospital; Surgeon-in-Chief to St. Agnes' Hospital; Surgeon to the Southern Railway.
RALEIGH, N. C.

It occasionally happens that in operating for the closure of a fecal fistula the surgeon encounters much difficulty, or even failure, in finding the aperture in the bowel. Especially is this likely to occur when the field of operation is a network of adhesions and the intestinal opening is obscured by blood. To illustrate such a difficulty and to suggest, if possible, a way out of it, I report the following case, in which the technic, so far as known, was original.

Patient.—In 1903, Miss J., aged 22, had a hysterectomy performed. During this operation the sigmoid flexure was injured, and, though the abdominal wound apparently healed, after a

* Read by invitation before the South Carolina Medical Association, Columbia, April 18, 1906.