

A girl æt. 5, after a fall upon some sharp shingles, was found to have sustained a clean incised transverse wound over the right knee-joint extending from the outer condyle over the front of the joint about four inches, opening the joint freely and exposing the right condyle; and, in addition the patella was completely divided transversely, as if it had been cut through with a knife. Under methylene anæsthesia, the wound was thoroughly washed out with carbolic solution; the patella was then drilled in three places and the fragments securely wired together; a few vessels were ligatured with fine chromic gut and the edges of the wound accurately coaptated with carbolized silk, after which a drainage tube was inserted and the limb dressed with carbolic gauze and placed on a back splint. The child suffered no pain after the operation, and passed on to complete recovery with perfect use of the limb in a little more than two months.—*British Medical Journal*, November 15, 1890.

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CHEST AND ABDOMEN.

I. On the Surgical Treatment of Intraperitoneal Tuberculosis. By PROF. CZERNY (Heidelberg). The favorable view of the curability of tubercular peritonitis, as presented by the cases of Kimmell (*v. ANNALS*, 1887, December, p. 504), and others, has already been criticised by Spaeth (*v. ANNALS*, 1889, August), and is here again shown to be over-sanguine.

Tubercular inflammations of serous membranes may subside, but the process is so often dependent on adjacent foci (glands, urogenital tract, etc.), that other sequelæ are bound to follow. Pleurisy preceding tubercular bone and joint disease is a daily experience, if attention is given to this point in taking the history. Where the nucleus of infection is limited and removable, then permanent cure may be hoped for. His cases, briefly stated, are as follows:

1. Ovariectomy in the presence of miliary tuberculosis of the peritoneum (1878). Cure. Perfectly well 11 years later.

2. In operating for an inguinal hernia (man, æt. 38 years) that had

become painful, a piece of the attached peritoneum was removed and found to be studded with miliary tubercles. The patient had scrofulous cicatrices, and his parents had died of consumption. Uninterrupted cure. Still well 4 months later.

3. Maid, æt. 32 years. Removal of a pedicled myoma. The covering peritoneum was covered with miliary nodules. Good recovery from the operation. Death from chronic peritonitis 6 months later.

4. Tubercular alterations in the cæcum, at first thought to be a floating kidney. Suturing of the kidney to its proper place, with apparent improvement. Then relapse, demanding resection of the tubercular portion of intestine (cæcum and adjacent gut). Cure, verified 3 years later.

5. Tubercular tumor of cæcum, at first thought to be cancer. Resection of intestine. Injury of ureter. Extirpation of kidney. Death from peritonitis 6 days later.

6. Intestinal fistulæ starting from a perityphlitic abscess. Suspicion of tuberculosis. Double resection of gut and direct suture. At first cure; later, the fistulæ broke out again.

7. Tubercular ulcerations in the cæcum, cured by resection of the intestine. Man, æt. 40 years. Was well 14 months later.

8. Peritonitis tuberculosa with fæcal fistulæ. Amyloid degeneration of abdominal organs. Attempt at curing the fistulæ by resection of intestine. Death in 10 hours.

9. Broken-down tubercular lymphoma of the mesentery. Incision, partial extirpation, drainage. Death from septic peritonitis.

10. Cystic softened (tubercular?) lymph-gland of the mesentery. Extirpation. Cure.

11. Cheesy endometritis. Salpingitis. Peritonitis tuberculosa. Incision; resection of the tube. Death from miliary tuberculosis.

12. Exudative peritonitis with miliary tuberculosis. Incision. Death 3 months later.

13. Same, except exitus in 2 months.

14. Adhesive tubercular peritonitis. Partial extirpation of the tubercle nodules. Secondary fæcal fistula. Death 3 weeks later.

15. Adhesive tubercular peritonitis. Tedious extirpation of tuber-

cular deposits and tubes. Secondary formation of fistula. Death 4 months later.

16. Same. Death from phthisis 3 months later.

In only 2 of these 6 cases of tubercular peritonitis was the diagnosis correctly made before the operation. He concludes that for operative purposes we should separate that form of peritoneal tuberculosis where there is fluid effusion and miliary nodules, from the drier adhesive peritonitis, characterized by firm tumor like lumps, plats and strands. It is the first form that has yielded such results from laparotomy, whilst, as three of his cases show, the latter form is not surgically encouraging. One of his cases indicates that the form with effusion may by resorption and thickening, pass into the dry form.

The surgery of intestinal and lymph-gland tuberculosis is very difficult, and as yet has been practiced but to a limited extent; still from his cases he urges further attempts in this direction.—*Bruns' Beitrage f. klin. Chirg*, 1890, bd. vi, heft 1.

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II. On the Treatment of Peritonitis by Abdominal Section. By DR. MIKHAIL R. OSMOLOVSKY (St. Petersburg, Russia). The author has collected 231 cases of peritonitis treated by abdominal section. Of the number, 79 were taken from German literature, 40 from British, 29 French, 22 American (U. S.), 14 Polish, 12 Russian, 8 Italian, etc. Of the total, 75 died, 154 (67.2%) recovered, while in two cases the issue remained unknown. The writer divides his cases into 8 groups.

I. *Traumatic peritonitis* (developing after surgical operations or accidental traumata).—Nineteen cases are tabulated, of which 6 died, and 13 (68.5%) recovered. The time of operation varied from 2 hours to 4½ months after injury. (The group consists of cases published by Bardeleben, Barwell, Bouilly, W. Bull (2), Chavasse, Escher, Talaguié, Keetley, Kelly, Koeberlé, Koenig, Lannelongue, G. Owen, G. V. Pavloff, Poncet, Robertson, Steer and Vacher. Once Dr. Osmolovsky has thought proper to include into the series W. Bull's and Talagnier's cases of gunshot wound, treated by laparotomy in 2 hours