

have partial extirpation, with its good functional results, performed early.—*Archiv. für klinische Chirurgie*, Bd. XLIV, Hft. I.

FRANK H. PRITCHARD (Norwalk, Ohio).

#### CHEST AND ABDOMEN.

**I. Primary Carcinoma of the Nipple.** By G. MANDRY (Tübingen, Germany). The writer operated on a woman of sixty-one years, who presented a tumor of the nipple of the size of a pea, which on microscopical examination proved to be an epithelial carcinoma. He extirpated the entire mammary gland and cleaned out the axilla. The patient recovered without complication. Mandry regards the orifices of the galactophorous ducts as the primary seat of the disease. Examination of German literature revealed but very few cases, while foreign literature yielded a number of cases under the term Paget's disease, that were partly epithelial carcinomata.—*Beiträge zur klinischen Chirurgie*, Bd. X.

FRANK H. PRITCHARD (Norwalk, Ohio).

#### EXTREMITIES.

**I. Treatment of Severe Injuries of the Extremities.** By P. RECLUS (Paris). In grave injuries of the extremities, as from railroad accidents, machinery, etc., the writer rejects primary amputation, or exarticulation, for various reasons. In the first place, the shock will only be increased by operation, and again, it is impossible to determine, in the crushed tissues, the living tissue from that which will necrose. Hence in such cases it is best to proceed most conservatively. Wrap the patient in warm clothes, and inject subcutaneously caffenin, ether or artificial serum. Then cleanse the injured member by energetically irrigating it with sterilized water at 55–60 Raumer. Every corner and crevice should be cleaned, the water at this high temperature being both hæmostatic, disinfectant and warming. Then pack all portions of the wound with a weak iodoform

gauze, or a gauze containing a salve of boric acid, antipyrin, salol or iodoform, and the limb finally wrapped in cotton batting. In the course of four weeks the necrotic tissue will have separated from that which is living, and the bone only remains to be severed if amputation be required. The soft parts will then heal quickly as they are granulating. Two cases are used to illustrate the application of these principles. They were a crushed foot and leg and knee respectively. —*Gazette des Hopitaux*, No. 17, 1893.

**II. Treatment of Fracture of the Femur in the New-born.** By C. J. ELLEFSON (Christiana). The writer has recently had opportunity to try a method of treatment of this form of fracture which he found recommended in Bouchut's *Maladies des Enfants*. Fracture of the femur in the new-born is accompanied by difficulties which can only partly be overcome. The various kinds of bandages which have been employed are nearly impossible to keep clean and dry; frequent changing interferes with healing. At a breech presentation where the midwife was so unfortunate as to break the femur at about an inch from the hip joint, he was called to dress the fracture. Two splints were applied, covered with flannel and corresponding with the anterior and posterior surfaces of the femur; then cotton wadding, and around the whole a circular bandage. The thigh was fixed in extreme flexion upon the child's abdomen by a few turns of the bandage. A little cushion is placed between the child's leg and thigh. The few turns of circular bandage will naturally become wet through, but they can be changed easily without disturbing the fracture. After fifteen days the bandage was removed and the fracture was found to have healed without shortening or disfiguration of the thigh. The forced flexion of the thigh and fixation to the abdomen did not seem to have disturbed the infant, which was perfectly well during the whole time.—*Norsk Magazin for Lægevidenskaben*, No. 7, 1893.

FRANK H. PRITCHARD (Norwalk, Ohio).