

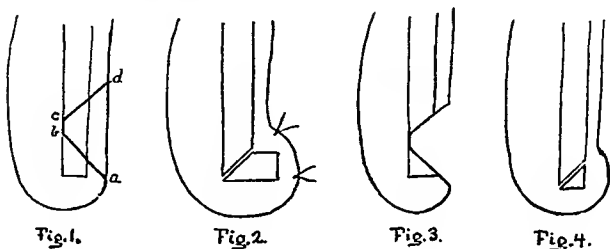
EXTREMITIES.

I. The Operative Treatment of a Large Myelogenous Sarcoma of the Tibia. By DR. NEUMANN (Halle). A patient suffering from sarcoma of the upper end of the tibia was operated upon by Professor Von Bramann. The growth involved the whole upper extremity of the left tibia, extending to below the tuberosity, so that the only remaining bone was a thin shell on the posterior aspect. The cartilage at the place of attachment of the crucial ligaments was broken through. The operator opened the joint by the curved incision of Bergmann, and removed ten centimetres of the tibia with the skin and soft tissues lying in front of it, and sawed off the articular surface of the femur. In order to make the bones fit upon one another, he sawed off five centimetres of the sound fibula. The portion of fibula still projecting above the tibia was then sharpened to a point which was introduced into a corresponding hole bored in the outer condyle of the femur. This kept the bones in firm apposition. A year later the patient now walks about without any further support than an elevated sole. No recurrence. Microscopic examination of the tumor showed it to be giant cell sarcoma. —*Verhandlungen der deutschen Gesellschaft für Chirurgie*, xxii Kongress, 1893.

II. The Plastic Improvement of Amputation Stumps of the Leg. By DR. A. BIER (Kiel). The procedure which he adopts to improve the bearing capacity of long stumps is as follows: A wedge, $a b c d$ (Fig. 1), is cut out, just above the place of amputation, in the soft parts of the anterior aspect of the leg. The soft parts of the interosseum are also divided on the same level. The point of beginning, the wedge incision a , lies about an inch above the lower end of the bone—not higher, or the “foot” of the stump would be too long. The wedge is truncated at $c b$. This line should be an inch long. After dividing the soft parts, the tibia and fibula are sawed first in the line $a b$ and then in the line $c d$, and the wedge $a b c d$ of skin, muscle and bone removed. The anterior tibial artery

is twice cut through and ligated; the posterior remains intact. If the operation is carefully done the bridge of periosteum, *c b*, can be preserved. The flap is then turned up as in Fig. 2.

In the case of short stumps the wedge is cut out nearer the end of the bone, and the stump formed as in Figs. 3 and 4. The shortening in this case is very small.



The first method can be carried out in uncomplicated cases, at the time of the original amputation. But the last procedure—and in complicated cases also the first—should be done as a secondary operation after the amputation wound has healed.—*Verhandlungen der deutschen Gesellschaft für Chirurgie*, XXII Kongress, 1893.

JAMES P. WARBASSE (Brooklyn).

GENITO-URINARY ORGANS.

I. On Suprapubic Cystotomy in Two Stages. By N. SENN, M.D. (Chicago). The author discusses the difficulties and dangers attaching to suprapubic opening of a bladder the subject of septic cystitis. The wound frequently becomes the seat of sloughing and phlegmonous inflammation in spite of the most rigid precautions. He proposes to avoid this by securing in the incision through the pre-vesical tissues a granulating surface before incising the bladder. He summarizes his propositions as follows:

(1) Necrosis and phlegmonous inflammation of the margins of the wound and the tissues in the pre-vesical space (*cavum Retzii*) not