As soon as the peritoneum is incised hæmostatic forceps are placed upon the serous margins, everting them. This wound has presenting in it the anterior surface of the kidney, which is incised about an inch exterior to the insertion of the colon, which in the decortication is displaced internally. The two margins of the incision in the peritoneum of the kidney are caught with hæmostats and dissected up slightly and united to the peritoneum of the parietes on either side along the entire margin of the abdominal incision. There has thus been formed an opening through the abdominal wall down to the kidney, with the peritoneal cavity entirely shut off from the wound. Through this opening the kidney can be readily removed without danger of infection.

In cases of malignant tumors of the kidney the nephrectomy should be extracapsular; in cases of suppuration try the same process, but remember that more frequently it will be necessary to do a subcapsular nephrectomy.

The Disinfection of the Field of Operation.—Numerous methods have been employed with varying success for the disinfection of the skin in the field of operation; it is known that the bacteria are held in the natural fats of the skin and that their removal is essential to the destruction of the germs. LANDERER and KRÄMER (*Cent. f. Chir.*, 1898, No. 8) find that methods heretofore employed are none of them entirely satisfactory, since in a large percentage of cases treated by any of these methods bacterial colonies are found in large numbers. These bacteria are also found in the glands of the skin as well as upon the surface, and a method to be successful must penetrate deep into the skin.

They propose the employment of a 1 per cent. formalin solution for this purpose, and their experiments show that 80 to 90 per cent. of the cases are absolutely sterile.

The technique of the method is simple: After an ordinary soap-and-water bath, a compress wrung out of 1 per cent. formalin solution is placed over the part protected by a water-proof covering and held in place by a moist bandage. The action commences at the end of six hours. The bandage is continued on an average of from twelve to thirty-six hours, and is renewed once or twice during that time. If it is allowed to remain more than two days the skin is hardened and primary union interfered with. The ordinary means of sterilization are employed just before the operation.

Three Cases of Nephrectomy for Pyelonephritis Followed by Recovery.—COELHO (*Rev. de Chir.*, November 10, 1897) reports three cases of pyelonephritis in which the kidneys were so involved by the disease that nephrectomy was the only method of treatment that held out any chance of recovery.

The author does not believe that it will occur very often that three cases of pyelonephritis will be found that can be justifiably treated by nephrectomy. Many cases can be treated by medical means, and the great majority can be cured and leave behind, after a nephrotomy, sufficient functional ability in the kidney to be of great service.

The author does not believe that the good results which he has had in these three cases, the only ones he has operated upon, in any manner affect the

statistics or the gravity of this method of intervention, and says that he himself realizes more fully since these cases the gravity of the operation.

All three patients were between thirty and forty years of age; in all the pyelonephritis was of long standing; there was much difficulty encountered in each operation from the adhesions and connective tissues formed about the kidney and binding it down. The secretion of urine gradually increased in all the cases after the first twenty-four hours. The recovery was uneventful, with no fistula in any case. In all the cases the kidney was the seat of multiple individual abscesses of which, in instances, one or two communicated. There was, however, no microscopical secreting kidney structure remaining, the tissue being connective and adipose.

The Mechano-therapy of Movable Kidney.—Eccles (*The Lancet*, January 29, 1898) says, of twenty-one cases treated by abdominal massage, exercise, rest, and an abdominal pad and belt, that the results obtained are for the most part so satisfactory that they bear favorable comparison with records of those treated by operation. Early diagnosis, reposition, and the maintenance of the organ in position by methods which also conduce to the improvement of the general health, would appear to go far toward the relief of the patient from the necessity of having the kidney stitched into its place or removed from the body. These cases should at least be subjected to this form of treatment before operation is determined upon; the time required is not wasted, as the patient is all the time gaining strength, and is in better condition for operation if it becomes necessary.

The author reports in detail seven cases, of which he says that in all there were physical signs, local and general symptoms which are attributable to the dislocation and mobility of the right kidney, and the results show that much suffering and chronic illness can be averted by means entailing none of the risks possibly incurred by operation.

In these cases of floating or movable kidney, no less than in other forms of enteroptosis with so-called functional disorder of digestion, the indications are to restore healthy tone and to induce the redeposition of fat and flesh to the abdominal walls, as well as to improve the nutrition of the viscera and replace the packing material of fat, which in many cases has vanished. This, he believes, is best secured by a rest-treatment, carefully regulated diet, exercise in increasing amount, while precautionary measures are taken to replace the kidney and keep it in proper position.

The Immediate Correction of Angular Deformity of the Spine.—Clarke (*British Medical Journal*, February 12, 1898) was induced to try this method of treatment by the fact that after what was apparently a perfect cure by means of splints, and the spine was firm and free from tenderness, the slight curve that remained would gradually increase.

In a favorable case in a child, two and one-half years old, he performed forcible extension, straightened the spine, and applied a plaster jacket strengthened by iron bands. At the end of six weeks the plaster had to be removed, and it was found that most of the deformity had returned. The spine was again straightened and a plaster and metal apparatus so arranged that the spine was over-extended and extension could be applied to

the armpits and lower limbs. The patient was perfectly comfortable in this position for a month, when the spine was again examined. The deformity was certainly diminished, but not removed. The part was now free from tenderness, and on giving an anæsthetic it was found that there was now more resistance, pointing to some bony ankylosis having taken place, so the deformity was not corrected. The patient was replaced in the apparatus. A fortnight later a Chance's splint, with an occipital head support, was applied. Three and three-quarter months after the first operation the child could sit up without discomfort and without fatigue.

The author prefers the Chance's splint to Thomas's splint. The author's experience leads him to await the results of others before applying this method in his own cases further.

Trephining the Skull.—The various means now in vogue for trephining and the different processes by which large bone and skin flaps are raised in modern operations on brain tumors, are discussed at length by BRAATZ (*Cent. f. Chir.*, 1898, No. 3). He believes that the best method is by the use of Gigli's wire saw, which is passed between the dura mater and the bone, through small trephine openings or drill holes, which are placed at convenient intervals in the line of the flap which is to be removed.

The perforations through the skull, he believes, can be more readily made by employing a simple mechanical drill which he has devised for this purpose, than by the use of trephines or ordinary drills.

The use of the Gigli saw has the advantage of destroying only a small amount of bone substance, so that if it is desired the bone flap can be replaced. By making the cuts slightly bevelled the bone is prevented from pressing on the brain, while thin bone periosteal flaps may be made that will lap over the cut-out point, and thus securely close it.

A Case of Fatal Acute Dilatation of the Stomach Following Cholecystotomy.—FENGER (*The Clinical Review*, February, 1898) reports a case under the above title, from which he draws the following conclusions:

1. During the course of convalescence from some acute or chronic disease, the stomach may undergo rapid dilatation.

2. This condition is marked clinically by a sudden and violent onset; vomiting is violent and intractable: large quantities of fluid are ejected; the fluid is usually greenish, due to admixture of bile. The patient is reduced to a state of collapse or exhaustion, which may prove fatal in a few days.

3. During the progress of the disease the abdomen becomes distended, the right hypochondrium remaining flatter. The bowels move spontaneously, and a splashing sensation may be elicited over the site of the distention. Sensorium usually cloudy.

4. If treatment is unsuccessful the abdomen becomes more distended, vomiting ceases, and the patient dies of exhaustion.

5. Indications for treatment are:

(*a*) Supportive measures.

(*b*) Use of stomach-tube one or more times daily, as early in the case as possible.

(*c*) Rectal feeding.