

made to impregnate the gas much more strongly with H_2S , and is much cheaper.

Everything being in readiness, and the gas bag connected, the H_2SO_4 is poured into the generating bottle. The marble chips should be previously tilted to one side of the bottle and made to remain there as much as possible by gently returning the bottle to the upright position. This prevents too rapid evolution of gas; and when the marble in the bottom of the bottle has been utilized fresh marble can be precipitated into the acid by gently shaking it. If the evolution of gas is slow it will be sufficiently pure for all practical purposes. If it bubbles through rapidly and violently the wash bottles will do but little good, and the gas will be pungent and irritating. The number of wash bottles could be increased to half a dozen if it was not thought to be properly washed.

I have had no "colicky pains" reported as a result of the gaseous injections, although I send away from my office bags large enough to last patients from two to three days. I think the reason is that my gas bags are of heavy rubber, through which osmosis must be difficult, and to any appreciable extent, perhaps impossible.

I have nothing to report clinically, except that all the patients upon whom I have used this treatment have shown improvement in some of the symptoms. I am not prepared to say that there has been arrest in any case, though one patient has used it faithfully for seven weeks.² It is, of course, too soon to express a final verdict; and we can only work on, hoping that it will prove something more than another chimera added to the long list of "consumption specifics." If its power of controlling symptoms should prove to be reliable, and prove to be its only value, Bergeon would still deserve well of his generation.

Respectfully,

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Fort Wayne, Ind., May 24, 1887.

TAPPING VS. INCISION OF THE CYST IN OVARIOTOMY.

Dear Sir:—In the letter of Dr. N. Senn, published in THE JOURNAL of June 4, there occur on page 641, in reference to an ovariotomy by Mr. Langton, the following remarks: "The abdomen was opened by an incision through the linea alba about four inches in length, and the cyst tapped with the large trocar of Spencer Wells. The puncture was followed by a free escape of fluid along the sides of the trocar, and some of it entered the abdominal cavity, and the wound was freely irrigated with the cyst contents. . . . It has always seemed to me that the use of a large trocar with a truncated cutting edge in tapping a tense cyst is attended invariably by extravasation of fluid, and consequently increases the risk of peritonitis. When the cyst contents are fluid, the patient should either be placed upon her side during the tapping, and proper precautions adopted to prevent entrance of fluid into the abdominal cavity, or the cyst should be emptied sufficiently to bring it

into the wound by the use of a small trocar or by aspiration. In case the contents are colloid they will escape through no tube, and incision of the cyst with the patient on her side, and traction upon the cyst wall, so as to keep it in uninterrupted accurate contact with the abdominal wall, are the only measures which will accomplish the desired object with safety."

I heartily endorse the foregoing suggestions of Prof. Senn. Having for many years observed the inadequacy of the various forms of trocar in preventing the escape of cystic fluid along the sides of the instrument, I have latterly dispensed with it entirely in some cases, and opened the cyst with a knife instead. Dr. Carl Braun uses the same method.

The cyst having been exposed and the investigation of adhesions finished, a *dry* piece of antiseptic gauze folded into a pad of eight or more thicknesses is placed between the cyst and the incised abdominal wall on the side towards the operator. The patient is then rolled strongly over on the corresponding side, and the cyst pressed forward into the wound by the hand of an assistant applied against the flank. At a selected spot a small incision or puncture is made with the point of knife, the opening being subsequently enlarged to any extent desired. Besides the dry pad, and the intra abdominal pressure of the cyst, an additional guard against the entrance of cystic fluid into the peritoneal cavity may be furnished in the following manner: Take a piece of tin plate eight or ten inches long and four inches wide, and bend it lengthwise into the form of a half cylinder. The end of this trough, held against the cyst immediately below the point of the intended incision, will serve to convey any fluid which may possibly escape from the cut away from the field of operation. This device will be found of great service in whatever manner the cyst may be opened.

So soon as the cyst wall becomes sufficiently relaxed, I seize it in folds with strong dull-toothed vulsella, and by constant traction keep the opening and collapsing cyst outside the abdominal wound until complete extraction is accomplished.

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BOOK REVIEWS.

DISEASES OF WOMEN. A handbook for physicians and Students. By DR. F. WINCKEL, Professor of Gynecology, and Director of the Royal University Clinic in Munich. Authorized Translation by J. H. WILLIAMSON, M.D., Resident Physician Allegheny General Hospital, Allegheny, Pennsylvania. Under the supervision of THEOPHILUS PARVIN, M.D., Professor of Obstetrics and Diseases of Women and Children in Jefferson Medical College, Philadelphia. 8vo., pp. xxix—674. Philadelphia: P. Blakiston, Son & Co. 1887.

It is a little more than a year since Professor Winckel's work was issued in Leipsig. As a teacher of obstetrics and gynecology he has but few rivals,

² This patient died June 5th.