

cal examination by Dr. Mallory, who reported the actinomyces. The patient then entered the City Hospital, and under ether all suspected tissue was curetted and dissected and preserved *in toto* for examination, one colony being found. Ten days later a small area at one edge of the wound that looked suspicious was curetted out, and three colonies were found. Five days later another similar looking spot was thoroughly cleaned out, but no colonies were found. The patient is still under treatment, but without any evidence of further relapse.

The pathological examination was made in each case by Dr. Mallory.

All the face cases showed invasion of the soft tissues only, the bone being free. In none of them could any definite trace of the original infection be found.

All the cases were given iodide of potash, and the wounds treated with peroxide, tincture of iodine in full strength or solution, and packed in iodoform gauze until all evidence of presence of the fungus had disappeared.

TENDON SUTURE.¹

BY EDWARD S. HATCH, M.D., BRIGHTON, MASS.

D. J. A. entered the Carney Hospital, as an accident case, on August 28, 1899. This afternoon he plunged his right hand through a window and cut the anterior part of his wrist on the ulnar side. When he entered the hospital he had a cord tied around his arm which was not arresting the hemorrhage.

I applied a rubber tourniquet, and after having the patient etherized I cleaned up the cut and parts surrounding it with a solution of chlorinated soda, then soap and water, and finally with corrosive. The cut was about two inches long. This cut I enlarged, both vertically and horizontally, and found the following structures divided: The tendons of the palmaris longus, flexor carpi ulnaris, and flexor sublimis digitorum. The ulnar artery and the median nerve were also found cut. The ulnar nerve was cut about halfway through its structure. The tendons of the flexor profunda digitorum were slightly nicked. The tendons and nerves were united with fine silk sutures. The ulnar artery was tied, both the proximal and distal ends. No attempt was made to unite the tendon sheaths. The skin wound was united with interrupted silkworm-gut sutures. Sterile gauze was put over the wound, and the arm was put up in anterior and posterior splints, with fingers semiflexed. The operation took two hours and fifteen minutes, and the patient was put to bed in good condition.

August 29th. Patient feeling well today, has little pain. Says he begins to have feeling in fingers.

September 2d. Dressing and splints removed, wound healed by first intention. Sense of feeling not so good over the distribution of median nerve.

September 8th. Dressing removed. Sensation slowly returning. Fingers can be moved a little. Stitches removed.

September 12th. Patient is able to move all fingers slightly. Sensations better than on previous days. Hand put up in anterior posterior splints. Anterior splint shortened.

September 16th. Movements of fingers improved. Hand dressed as before. Patient left the hospital. Is to be treated as an out patient.

September 25th. Movements of fingers improving. Hand put up in more extended position.

October 2d. Sensations and motions gaining. Hand put up still more extended.

October 18th. Motions improved. Anterior splint left off today.

October 28th. Splints all removed. Not any pain. Motions better. Massage started today to be continued three times a week.

November 13th. Fingers gaining in extension all the time. Only a very light dressing put on.

February 15, 1900. Patient has had massage three times a week up to this time. Extremely good flexion and extension; good sensations. Massage discontinued.

April 4th. At the present time the patient has normal flexion and extension, with normal sensation over the distribution of the ulna and nearly normal sensation over the distribution of the median nerve. It is interesting to note in this connection that the nails of the thumb, first and second fingers, died and then grew again, so that now on these fingers he has half of the dead nail, which is being thrown off, and also half of the new nail. He can separate the fingers and draw them together again with perfect ease.

A METHOD OF TEACHING PRACTICAL MEDICINE.

BY THOMAS F. HARRINGTON, M.D., LOWELL, MASS.

SINCE the publication of an article presented to the American Medical Convention at Columbus, Ohio, in June, 1899,¹ entitled the "Philosophy of Sickness," several articles have appeared in the medical journals, either elaborating my ideas or suggesting similar methods of reaching the same end, therefore I thought it best to explain in detail what I had merely given in outline, in order that the profession could judge rightly of the value or uselessness of my method of giving medical instruction to classes at the medical schools. It is not my intention to criticise existing methods as practised in the best medical schools today, nor to attempt to offer a different plan for doing the work, but simply to give the views of one who has felt the shortcomings of the modern schools, and who has given considerable thought to the correction of the same.

I believe the courses offered in the best schools in this country are capable of giving the greatest amount of good to the largest number. It is not the addition of new courses, but rather the appreciation of the value and possibilities of the present courses that I would like to emphasize. Much of the criticism of to-day on the method of teaching medicine is due to a misunderstanding, both on the part of the teacher as to the needs of the student, and on the part of the student as to his duty in the work. It will be my object first to try to clear, to a degree at least, some of the causes leading to this state. That there is a science of medicine as well as an art seems to have been overlooked by those who are protesting against existing methods, and it is to the neglect of this funda-

¹ Read before the Surgical Section of the Suffolk District Medical Society, April 4, 1900.

¹ Boston Medical and Surgical Journal, August 17, 1899.