

mis are broken up with needles. (3) The acid should then be allowed to evaporate spontaneously or with the aid of a moderate application of warmth. The specimen is now ready for staining. For this purpose the following preparation may be used:

Concentrated alcoholic solution of methylene blue . . .	30 parts.
One per cent. solution of potassium hydrate . . .	1 part.
Distilled water	100 parts.

A still better method of staining is Gram's differential method, as follows:

A few drops of gentian or methyl-violet solution in aniline water is added to the specimen, on a slide or

cover-glass, and allowed to act for from five to thirty minutes. The specimen is then washed with absolute alcohol, after which Gram's iodine solution is added to the specimen, or else the cover-glass upon which the specimen is placed, may be floated in the iodine solution for from one to five minutes. The preparation is then again washed in alcohol and dried, being now ready for examination, the fungi or micro-organisms which may be present being the only portions in which the coloring matter is retained. This method is given by Dr. Payne in the "Transactions of the Pathological Society of London for 1886," in connection with an article upon erythrasma.

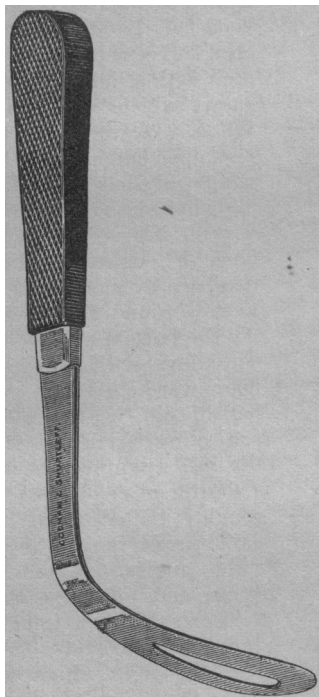


FIG. 1.



FIG. 2.

Clinical Memorandum.

ON EXAMINATION OF THE THROAT, WITH ESPECIAL REFERENCE TO THE MANNER OF USING THE TONGUE-DEPRESSOR.

BY JOHN W. FARLOW, M.D.

ANY one who has instructed students in examinations of the throat, must have noticed the great difficulty that is often experienced in depressing the tongue so as to get a satisfactory view of the pharynx, and, more particularly, how great an undertaking it is to hold the unruly member under control long enough to admit of the use of the rhinoscopic mirror. Whoever has had his own throat looked at, must have noticed how much easier it is to breathe quietly, and allow a thorough inspection of the throat, when the one holding down the tongue understands how to do it, than when some well-intentioned, but uninstructed, member of the family makes a number of desperate, but ineffective attempts, which result only in gagging.

I do not propose to say anything about the use (only too common) of the spoon, lead-pencil, paper-cutter, or other domestic article, other than that the sooner they are given up, and a proper tongue-depressor sub-

stituted, the more satisfactory to both patient and physician will be the examination.

Let us suppose the patient to be seated in a comfortable position, before a good light. A few preliminary directions to him will be of great service. As soon as he is seated, he usually opens his mouth as widely as possible, contracts his throat, and thrusts out his tongue to its utmost extent, which, together with his grimaces, make him thoroughly ill at ease before a word has been said. He should be told, at the outset, not to open his mouth too widely, as a more moderate opening is much better. He should be particularly requested not to contract his throat or distort his face. In other words, he should open his mouth gently, a little wider than if he were to say "ah!" in his natural voice. The tongue should not be forcibly extended, but should rest against the inner side of the lower front teeth. Be sure that he does not hold his breath, as this only tires him.

It would seem as if it were easy to say "ah!" correctly, but here is another stumbling-block. It is usually formed in a contracted throat, and exploded as if it were the offending, foreign body which had caused the patient's grimaces when first opening his mouth. A good way is to tell him to say "ah!" after you sev-

eral times quietly. Not until you are satisfied that these preliminaries (seemingly trivial, but, in reality, of great importance) are well carried out, should you use the tongue-depressor.

What are some of the essential features of a good tongue-depressor? It should be simple in construction, so as to be easily cleaned, and not liable to get out of order or break. It should be firm, so that a strong tongue can be held down. Here is a source of weakness of the folding depressors. When the patient throws his head back, the tongue-holder tends to fold up, unless the outer blade is pulled forward. It should not be too large; otherwise, it would project too far back on the tongue, or take up too much room in the mouth. Many tongues are so large, that they need all the room they can get. Some lower jaws are so narrow as to admit only a rather small instrument between the teeth. It should not be too heavy, for it would tire the tongue. It is better to let the hand use what force is necessary, as it can do it intelligently and accurately. In order to hold the tongue better, and to make the instrument lighter, it is often fenestrated. This fenestra is sometimes so large, that the portion of the tongue which projects upward through it is of such size as to interfere seriously with the view of the pharynx. This is a fatal defect of the open-wire depressor. Another important point is that the blade should *look* clean, for which reason nickel-plated ones are better than hard rubber or iron. The handle should be one that can be firmly held, and, to my mind, indented wood or hard rubber is better than metal.

The instrument figured here (Figure 1) is no new pattern, but I introduce it as illustrative of some of the points of which I have been speaking. I have found it to serve a very good purpose, and, although this is the smaller size, I use it for both children and adults. It is nine inches long, and weighs not quite one-and-a-half ounces. The part that goes into the mouth is three inches long and one inch wide at its widest part. The greatest width of the fenestra is one-half inch.

The tongue-depressor should be taken firmly between the thumb and fore-finger (Figure 2). The patient should quietly say "ah!" and, during expiration, the instrument should be put into the mouth, till its end is a little farther back than where the tongue begins to curve backward and downward. Be careful not to put it too far back, but, at the same time, it should be far enough back, so that the base of the tongue can be drawn well forward. The middle finger, placed under the patient's chin, steadies the hand, and also holds the patient's head under control. The tongue is now depressed, and then its base drawn forward by lifting and pulling forward the handle of the instrument by the third and little fingers, the thumb and forefinger acting as a sort of fulcrum.

The head, tongue, and tongue-depressor are thus easily controlled by one hand, and the patient, feeling that he is firmly held, no longer tries to free his tongue and move back his head, and, consequently, is quieter, and gags much less than when he is held in the usual loose fashion.

In Figure 2, the left hand holds the instrument. It is better to use the left hand, so that the right may be free to use the rhinoscopic mirror, probe, or whatever is necessary to complete the examination or treatment.

— Dr. Olshausen of Halle, succeeds to the chair of Prof. Schroeder at the University of Berlin.

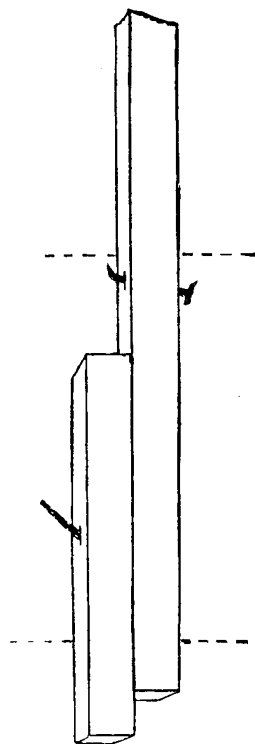
Hospital Practice.

BOSTON CITY HOSPITAL.

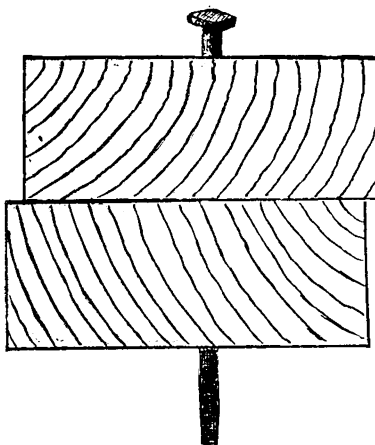
A CASE OF SEVERE PERFORATING WOUND OF THE THIGH, WITH OTHER INJURIES. RECOVERY.

SERVICE OF G. W. GAY, M.D.

REPORTED BY OLIVER H. HOWE, M.D., FORMERLY HOUSE-SURGEON.



as he fell. The slats entered behind and a little below the great trochanter of the right thigh and passed through the thigh, behind the femur, to a point at the inner side, just below the scrotum, where the square ends projected about an inch and a half.



quarters of an hour and was finally released by a policeman.

He was brought to the hospital with the slats (in all, about eleven inches long) in his thigh. The slats were one and seven-eighths inches wide and three-fourths of an inch thick.

Ether was given, and Dr. Bolles, who happened to

On the morning of January 31, 1886, J. F., a boy sixteen years of age, employed as a telegraphic line-man, was walking upon the roofs of buildings in the city. The roofs were covered with a light coating of snow, which had freshly fallen. Owing to this fact, he stepped upon a skylight, which gave way under him, allowing him to fall through a ventilating shaft, a distance of four stories (forty-two feet, by measurement), to the ground floor below. At the bottom of the shaft (on a level with the ground floor) were piled up a number of old bedsteads and projecting vertically from this pile was a bed-slat with a shorter piece of the same roughly nailed to it, two nails projecting at nearly right angles. Upon the square ends of these slats, the boy's thigh was impaled

The boy hung, impaled in this way, partly supporting himself by standing on his left leg, until his cries brought assistance to the spot and he was released by the slat being sawed off below. As the place where he fell was difficult of access, he is said to have hung there from half to three-