

the origin of our association, the personnel of a few of its founders, the broad and enduring basis upon which the organization was builded, its purpose and scope, as indicated by its constitution and transactions, the high order of work being done, the celebrated men composing its ranks in the past as well as the present, the esteem in which our fellows are held at home and abroad, the continually increasing number of worthy men who are knocking at our door, the delightful democracy that pervades our deliberations, and, leave it with you, sirs, to judge whether or not we are justified in saying: The wisdom of the past is a prophecy of the future!"

Fractures of the Lower Extremity and Their Treatment. By J. H. Downey, Gainesville, Ga. *American Journal of Surgery*, March, 1915, pp. 93-102.

The advantages obtained by the use of the double angular plaster-of-paris cast, in the treatment of fractures of the lower extremity, are:

First.—It maintains the exact distance between the ends of the bone that has been fractured. In case of tibia and fibula our fixed points are the angle at the knee and the swell of heel and instep. In case of a femur the fixed points are produced by the angles at the hip and knee.

Second.—By these angles we not only get fixed points, but we prevent any possibility of rotation or telescoping, thereby reducing over-riding and eversion or inversion to the minimum.

Third.—This position gives natural muscular relaxation, which is a great comfort to the patient and incalculable aid to the surgeon in the prevention of deformity.

Fourth.—It gives us perfect control over the long fragment so we may make it conform to the natural axis of the short one, over which we have no control.

Fifth.—It gives the patient a natural sitting position and attitude assumed in use of crutches, this giving patient freedom of almost any movement after three to six days.

Sixth.—The perfect fixation afforded by the angles at the hip and knee and coaptation offered by a well-fitted plaster cast gives almost absolute freedom from pain.

Seventh.—Your anatomical results are just as perfect as the care used in reduction, and the function is always good.

Eighth.—The period of disability is very materially shortened.

Cysts of the Mesentery with a Report of Three Cases. By Edward G. Jones, Atlanta, Ga. *Surgery, Gynecology and Obstetrics*, July, 1915, pp. 56-60.

The author discusses the rarity, genesis, classification and infrequency of correct diagnosis of mesenteric cysts. Information as to the origin of these cysts is based upon the study of the contents and of the cyst-wall. Attention, however, is called to the fact that pressure, time, inflammation, etc., may so change the histology of the cyst wall and the character of the contents as to invalidate the information furnished by these sources.

In three cases reported by the author there appeared no findings of particular significance bearing on the subject of genesis.

One of his cases presented a history of possible recurring attacks of volvulus covering three years prior to operation. The cyst in this case had encroached on the intestine so as to interfere seriously with the lumen, and the whole mass had fallen over so as to twist the gut into a volvulus.

In the second case the cyst was found in the sac of an enormous scrotal hernia. The cyst was too large to be reduced through the inguinal canal. No other mesenteric cyst has probably been found in a hernial sac, except perhaps a blood cyst in the case of Morton's, referred to by Moynihan.

In the third case three cysts lay in the mesentery of the colon at the hepatic flexure.

In the first of these cases resection was done. Enucleation was done in the second and third.

A Further Clinical Study of the Contradictory Findings in the Wassermann Test. By A. L. Wolbarst, New York, N. Y. *Interstate Medical Journal*, February, 1915.

The purpose of this paper is to call attention to the fact that two or more serologists working simultaneously with the same blood serum often obtain contradictory results. Two may report negative on a serum, while the third serologist may report strongly positive, on the same specimen of serum, taken from the arm at the same moment.

In 85 private cases, the same serum was examined simultaneously by three serologists. In 49 cases, two serologists examined the serum, with these results:

Three serologists examining 35 cases:

Agreed in 42 per cent of cases.

Differed in 19 per cent of cases.

Contradicted in 39 per cent of cases.

Two serologists examining 49 cases:

Agreed in 65 per cent of cases.

Differed in 23 per cent.

Contradicted in 12 per cent.

As a result of this study of 134 private cases, and many others in hospital and dispensaries, it appears that there is a great danger of convicting non-luetic persons of having syphilis, on the strength of a single laboratory report, which may be contradicted by two or more other serologists, who find a negative reaction in the same serum, and vice versa. The cardinal lesson to be learned from this study is that we have no right to make a diagnosis of syphilis on a single laboratory report alone, unless such finding is corroborated by the history or clinical data offered by the patient. All serologic tests should be made simultaneously by two or preferably three serologists working independently.

The Preparatory Treatment of Urological Operations. By Frank Hinman, Baltimore, Md. *Johns Hopkins Hospital Bulletin*, May, 1915, pp. 158-160.

A complete history, through physical examination, microscopical and chemical examination of the urine, blood pressure estimation and a total