

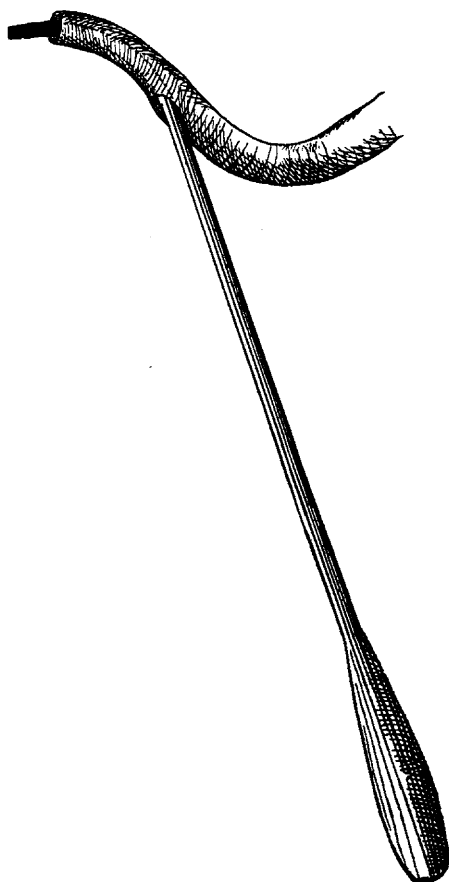
Louis Medical Society, wherein he advocated the use of pyoktanin in blennorrhœa. His method was to insufflate the dry powder. My plan has been to use a saturated solution as an injection, retaining the fluid for five or ten minutes and by pressure forcing it down to the isthmus.

I am sure that the treatment of the future will lie in getting some remedy which has the power of penetrating the tissues and hence reach the disease germs.

NASAL GUIDE FOR THE STOMACH TUBE.

BY L. H. PRINCE, M.D.,
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The forcible feeding of the insane through the nose with the stomach tube is frequently a most tedious operation, and in many instances becomes an impossibility, and resort is finally had to the



Nasal Guide and Stomach Tube in position for introduction.

use of the mouth-gag, so as to allow of the introduction of the tube through the mouth. As the passing of the tube through the nose, in most cases, is greatly to be preferred, the following is

offered as a simple and efficient method whereby the tube may, in nearly if not quite all cases, be quickly and easily passed through the nasal cavity and into the pharynx.

The instrument used is very similar in appearance to a small-sized urethral sound. It should be about six inches in length over all, and not more than one-eighth of an inch in diameter from the handle to the extremity, the curvature beginning about an inch and one-quarter from the end.

After thoroughly anointing the guide and tube, the point of the guide is inserted into the tube through the fenestra in the side, and passed along until it projects a little beyond the extremity. If the closed-end tube be used, which is not advisable, the point of the guide should fit into the pointed extremity. The tube and guide are then passed together into the nostril, the tube lying above the instrument, the handle of the latter being at first depressed. (See cut.) The tube is managed with one hand, the guide with the other. As the back of the nasal cavity is reached, the handle of the guide is raised, and the tube can then be easily passed down into the œsophagus, the guide being withdrawn as the tube passes over the soft palate.

The proper manipulation of the tube and guide may be easily acquired with a little practice.

CATARACT. HOW SHALL WE DEAL WITH THE CAPSULE? NEW CYS-TITOME FORCEPS.

BY EUGENE SMITH, M.D.,

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Local anæsthesia (cocaine) and antisepsis have been the means of producing a great revolution in the operation of cataract. Eserine, also, plays a somewhat important part. The Graefe modified linear extraction—linear incision combined with iridectomy—which has been so generally adopted as the operation for cataract, because of its supposed avoidance of iritis and consecutive destruction of the cornea, easier and better healing of the wound, etc., has, with the majority of the leading ophthalmic surgeons of the present day, been supplanted by simple extraction with a small flap (one-third of the cornea, De Wecker), and *without* iridectomy, a near return to the old classical operation, and the success of the operation is as great or greater than the Graefe method, and is in no small measure due to the use of cocaine, and the removal of all kinds of infectious factors which may exist in the conjunctival sac, lachrymal ducts, hands of operator or instruments, cleanliness and antisepsis being regarded as identical.

The adhesion to the Graefe method by some surgeons is no doubt due to a *fear* on their part, which has arisen from the *history* of the flap extraction as made in the olden time, where the flap, as suggested by Daviel, occupied two-thirds of the cornea, and was so frequently followed by suppuration of the cornea, prolapse of the iris, etc. These fears have been dissipated, with many, by statistics and experience, and I predict that ere many months, thanks to the efforts of De Wecker, Knapp, and others, simple flap extraction will be accepted by *all* ophthalmic surgeons as *the* operation, and the iridectomy relegated to exceptional cases, where it properly belongs.

An important step in the operation is the best means of opening the capsule. This feature is exciting the interest of many operators. Shall it be done with the knife while passing through the anterior chamber, before making the counter-puncture, *a la* Galezowski? Shall it be made with the cystitome, in the shape of a T, or peripherally after completing the flap, *a la* Knapp? or shall we, with a pair of cystitome forceps, extract the capsule, *a la* De Wecker, of Paris?

Each method has its advocates, but in my mind, the *beau ideal* method is the *extraction* of the anterior capsule.

With the forceps heretofore in use, this has been a difficult procedure, even in the hands of experienced and dexterous operators, because of the danger of catching a fold of the iris between the blades, and the danger of bruising the flap by the necessary *tilting* of the forceps in order to engage their points in the capsule.

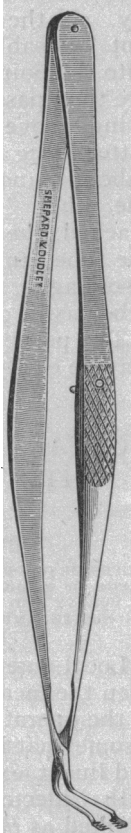
De Wecker, who first suggested removal of the anterior capsule, has forceps made with one or two sharp teeth placed near the points of the blades, but on the *under side* of the blades, after the style of the iris forceps of Leibreich and Mathieu. Knapp modified with more teeth and a slight separation of the blades to prevent catching and bruising a fold of the iris, the points of the sharp teeth being slightly directed downwards or backwards, to better seize the capsule, but owing to the necessity for tilting the blades backward into the pupillary space, their use for this purpose was nearly or quite discarded. Experiencing these difficulties, I sought to overcome them, and have succeeded to my own satisfaction, as I have demonstrated by their use in private, and before my class, in many cases.

My first forceps were simply a modification of Knapps, with four fine, sharp teeth on one blade

and five on the other. These I further modified by having three teeth and four teeth only, and having *only the points of the teeth* sharp, that they may sink into and *tear*, not *cut*. The principal modification, however, is the curving or dropping downwards of that portion of the ends of the blade which contains the teeth, below the plane of the blades, that the teeth may set down into the pupillary space *without tilting* the forceps. The forceps being introduced closed, as for iridectomy, the end of the forceps is pulled forwards till the curved portion, containing the teeth, is in the pupillary space, when the blades may be allowed to open to their full extent beneath the pupillary border, and by gentle pressure against the lens, the capsule is seized and more or less forcibly (within reason), by a little sudden twitch, extracted. The curve where the teeth are dropped is 1 mm. in depth, the part containing the teeth is 2 mm. long, the blades open automatically 5 mm., and the blades when closed, except that portion containing the teeth, are $1\frac{1}{2}$ mm. apart.

The forceps are most admirably made by Shepherd & Dudley, of New York, and the accompanying wood-cut affords a good general idea of the instrument.

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SUBSTITUTION AND ITS ATTENDANT EVILS.

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The evils attendant upon substitution and sophistication of remedial agents have long been surmised; they have not, however, until recently, received attention at the hands of the medical profession. Increased diagnostic skill, along with greatly improved facilities for the manufacture of medicaments, favor an approach toward mathematical exactness in computing therapeutic results. When these are wanting we challenge the character of the remedy. The question which presents itself is: Has our patient received the true medicament or a base counterfeit? However attractive in theory, it will be found impractical for the medical profession to drift away from the pharmacists, and it should be our aim to reward the faithful and bring the guilty to punishment. The friendly bond between the two professions should be honesty, as neither can afford to work independently; there is an interdependence which makes them mutually helpful.

It is said of Lawson Tait, that he has returned to first principles, and carries a mill with him, so that when ergot is needed, he prepares it fresh with his own hand. The reliable character of Squibb's ether has been maintained through his business sagacity in having it prepared chemi-