

Meningitis Following Lead Poisoning.—MOSNEY and SAINT GIRONS (*Bull. et mém. Soc. méd. d. hôp. de Paris*, 1911, xxviii, 252) report a case of left hemiparesis in an alcoholic, aged forty-eight years, a painter for thirty-five years. During the last thirteen years he had five attacks of colic, the last three in six months. In this last illness, they noted the hemiplegia associated with hyperesthesia to pain, but both were so transitory as to disappear in a week. The systolic pressure meanwhile fell from 200 to 150 mm. Hg, but there was a persistent increase in the cerebrospinal lymphocytes—68 per cm. The Wassermann reaction was negative in blood serum and cerebrospinal fluid. The lead intoxication thus led to paresis by meningitis. LOEPER and PINARD, in the same journal (1911, xxviii, 226), report a case of acute meningitis in an electrician, aged thirty-nine years, who had headache, vomiting, and constipation, with cervical rigidity, Kernig's sign, and exaggeration of reflexes. It is only in occupations allowing of massive head intoxications, *e. g.*, in electrical works or china factories, that these incidents are possible. The symptoms simulate those of tuberculous or syphilitic meningitis; but the absence in one of the bacilli (even on guinea-pig inoculation) and in the other of the Wassermann, together with history and the favorable outcome, renders diagnosis simpler.

SURGERY.

UNDER THE CHARGE OF

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A Plastic Method of Operation for the Closure of Fistulæ Coming from Internal Organs.—ABRASHANOFF (*Zentralbl. f. Chir.*, 1911, xxxvi, 186) says that the essentials for the closure of every fistula through which the contents or secretion of an organ escapes are the removal of the cause of the fistula and the closure of its edges by sutures, as in bladder and intestinal fistulæ. Unfortunately such a method is not always possible, as in those coming from the kidneys, liver, and lungs. Since 1900 Abrashanoff has been employing a method of his own. A sufficiently large flap is prepared from the neighboring tissues, but is best made of muscle. After freshening the surfaces of the fistula by a sharp curette, the point of the flap is introduced into the fistula to its bottom, so that the whole canal is filled by the flap. In order to prevent the displacement of the flap, it is sutured at different points to the margins of the fistula. Within a few days it adheres and gives