

of the special curved needles described above, being threaded with a carrying thread. It is preferable to insert the outer or lower suture first, so as to get perfect coaptation of the edges of the flaps. The sutures are brought out on the margin of the new canal upon the mucous surface and not upon the denuded surface. As each suture is passed it is clamped by pressure forceps and handed to an assistant to hold. All the sutures on both sides (three on each side being usually sufficient) are inserted before any are tied. Then the flaps are separated, and they are thoroughly irrigated with a solution of bichlorid 1 to 2,000 or 1 per cent. solution of lysol. The sutures are tied from without inward, or from below upward, tying that at the angle last. The ends are cut about an half an inch from the knot, the vagina is washed out, and the patient is removed from the operating table to the bed. No dressing is applied to the cervix or vagina.

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CIRCUMCISION NOT NECESSARY IN YOUNG CHILDREN.

Read in the Section on Diseases of Children, at the Forty-seventh Annual Meeting of the American Medical Association, at Atlanta, Ga., May 5-8, 1896.

BY W. B. PARKS, M.D.

ATLANTA, GA.

I do not propose to discuss the theory offered by the laity and some doctors that circumcision is necessary from a sanitary standpoint, nor do I propose to criticise a Jewish custom or change a church ordinance, but I desire to show the etiology of a long or abnormal phimosed prepuce in male children. I desire also to show how this abnormal prepuce can be shortened without circumcision. We will first notice these long prepuces found in children. The cause can be found by the following examination: If we retract the prepuce as far as we can without using any violent manipulations, we find at the juncture of the mucous membrane with the true skin a constricted band that has at some time undergone an inflammatory process; this constricted band plays just in front of glans penis, the action of which pulls down and forward resulting in a mechanical action, lengthening the prepuce. This mechanical force that pulls downward and forward is very slight, yet, if we will remember how loose the true skin is that covers the whole organ, the least traction together with a little aid from gravitation is enough to make this long abnormal prepuce. What causes this constricted band which has at some time undergone an inflammatory process. No doubt it is caused from improper adjustment of the cloth or napkin that is constantly used on babies which is intended to keep them dry, but keeps them wet, ordinarily, with careless nurses. This napkin steeped in hot urine, with the little organ imbedded in its fold or pushed on either side with undue force will be quite sufficient to set up an irritation causing the ordinary adhesions of the prepuce to the glans penis and the constricted band.

Treatment without circumcision consists in the plans laid down in the standard works on diseases of children, Starr, Keating and others, which operation is dilating prepuce, breaking up the constricted band. Much care must be observed in dilating this constricted band. A small sized uterine dilator or ordinary dressing forceps is a very good improvised instrument, but the dilation must not be too rapid. You must dilate every second day and as much as the

child can bear each time, leaving the instrument in the stretched prepuce from three to five minutes at each operation. If the operator should use rapid dilation he would find on the second day much inflammation, and, while waiting for the traumatism to subside the constricted band and phimosis would be aggravated and this is the reason why so many can not see what they accomplish by this dilating process. When you succeed in relieving this constriction in a dilated state, the prepuce will gradually shorten until it is in the normal position. To complete this operation it takes from twelve to fourteen days. I have used very successfully in the after-treatment, or when the adhesions are broken up, campho-phenique with equal parts of olive oil. I inject this under the prepuce with a common rubber ear syringe, lubricating and distending prepuce, at the same time allaying irritation and preventing a return of the adhesions.

This constricted band was brought to my notice in the treatment of a young man for the ordinary specific urethritis. After making the first prescription for him he passed from under my observation for about three weeks on his summer vacation. On his return instead of prepuce showing one-third of glans penis (which I noted when he applied for first treatment) it had elongated almost an inch. On attempting to retract the prepuce I found this constricted band at the juncture of the mucous membrane with true skin, and retraction was a physical impossibility. After waiting for the inflammation to subside I practiced this dilating process until band was broken up, and in a few days prepuce had retracted and, instead of showing one-third of glans penis, it showed fully two-thirds, convincing me that when we have an abnormally long phimosed prepuce there is an abnormal cause and this can be removed by a very simple operation. By relieving this condition without the knife you save the patient from mutilation, besides you protect a gland for which nature has provided a covering. I saw an article in the *New York Medical Journal* a few years ago advancing this theory: That instead of having a congenital stricture of meatus it was caused from an exposed gland robbing it of its natural moisture that the gland secreted and, thereby atrophying the tissue, also contracting the caliber of meatus.

The following are a few of the fifty successful cases treated within the last two years:

Case 1.—A boy aged 10 years, long prepuce with adhesions. Commenced treatment July 3, 1894; broke up adhesions after inflammatory symptoms had subsided; practiced dilating process every second day. On the 14th day constricted band was completely broken up with no inflammatory action and could notice a perceptible shortening of prepuce. Saw patient twelve months after operation, prepuce had shortened to normal length.

Case 2.—A boy 4 years of age, long prepuce with adhesions with the usual nervous symptoms; broke up adhesions with considerable inflammation to prepuce, used distention of prepuce with carbolized oil for six days, commenced dilating six days after adhesions were broken up; dismissed patient eighteen days after first treatment without any noticeable shortening of prepuce. Saw patient at intervals from one to three months; at the expiration of one year prepuce was shortened to normal length. This patient, however, had one convulsion two months after operation.

Case 3.—A boy aged 5 years, long prepuce. Commenced treatment Aug. 2, 1894; broke up adhesions; removed considerable amount of smegma; commenced dilation second day after first operation; dilated every second day for fourteen treatments. Constricted band relieved. Saw patient one year afterward, prepuce normal length.

This operation will not at all apply to that class of

patients who have reached the age, or near the age of puberty, for in those cases, after the constricted band has been relieved by dilation, there is a redundancy of tissue that will not allow the shortening to take place. Hence all those cases which have passed the age of 10 to 15 years can not be treated by the plan herein outlined, unless of recent origin caused from acute inflammation.

DISCUSSION.

Dr. BELL—I would like the doctor to give us the means of dilating.

Dr. PARKS—The small uterine dilator or dressing forceps, or any forceps with which you can make gradual dilatation, will answer the purpose. After each dilatation and after the adhesions are broken up, I distend the prepuce with carbolized oil, which insures their non-return.

Dr. J. W. BYERS, Charlotte, N. C.—Is the infantile prepuce not normally very long and adherent?

Dr. PARKS—Always. The point brought out in the paper is that the constricting band is the cause of the long prepuce. By breaking up the adhesions and then dilating this band, you shorten the prepuce without circumcision.

EXAMINATION OF EYES IN THE PUBLIC SCHOOLS OF BALTIMORE.

Read in the Section on Ophthalmology, at the Forty-seventh Annual Meeting of the American Medical Association, held at Atlanta, Ga., May 5-8, 1896.

BY HERBERT HARLAN, M.D., AND
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BALTIMORE, MD.

The control and management of the public schools of Baltimore is in the hands of a board of twenty-three commissioners, one being elected by the city council from each ward, and the mayor, ex-officio. The city council must appropriate all the funds used by the board.

Early in the fall of 1895, a resolution was passed by this board to have the eyes of all children in the public schools examined by an oculist of recognized standing, provided such examination could be made without any expense. Later the matter was left in the hands of the committee on health, which committee was composed of three physicians. We were asked to consult with this committee as to what could best be done. As a result the following plan was adopted: First, to have the teachers instructed how to test the eyesight of all the children. Second, to have the eyes tested by the teachers and a blank (A) kept for each child showing the result of this testing each year. The blank to be transferred from grade to grade and school to school with the child. Third, whenever the vision was found to be below a certain standard or there were complaints of the head or eye pains produced by studying a notice was to be sent to the parents advising them to have the eyes examined by an oculist.

We expected by this means first, to have attention called to many unsuspected defects of vision. Second, to show by a glance at the record whether the vision grows worse in any case from year to year during the eight years of school life the Baltimore system contemplates. Third, possibly to show that there is a greater percentage of deterioration of eyesight in certain badly lighted and ventilated schools. Fourth, to have parents' attention called to defects in children's eyes and to have rest with them the responsibility for the proper care and treatment of the eyes.

In December the following circular and accompany-

ing blanks and test cards were sent to the principals of all schools, and just afterward a meeting of the principals was called at which a practical demonstration was given of the method to be used in making the tests.

This plan was worked out in detail and submitted to the board and later our attention was called to an article by Dr. Allport, reprinted in the current number of the *Health Magazine*, from the paper published in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, March 2, 1895.

The two plans are almost identical and it would seem that like circumstances, such as gratuitous services and large numbers of children, resulted in a similar evolution as the best that could be done under the circumstances.

The chief objection to the plan is having the examinations made by the teachers. This objection can be greatly lessened by some trouble taken to enlist their hearty coöperation and care in the wording of the instruction for making the tests.

So far as the children are concerned occasional mistakes are of little moment as in cases of defective vision, the work is reviewed by an oculist if the parents do their part. So far as the statistics obtained are concerned, while interesting, there should not be much reliance placed in them, but, inasmuch as that is our opinion of all statistics, they are presented for what they are worth.

The eyes of 53,333 pupils were tested. Of these a little over 43 per cent. were found to have 20-20 vision in each eye, and 39 per cent. additional as good as 20-30 in the better eye. Fifteen per cent. came between 20-30 and 20-200, and 303, or 0.56 per cent. had less than 20-200 in the better eye. The lowest percentage (35 per cent.) of normal eyes was found in the first or lowest grade, and the highest (56) in the eighth or highest grade. Three things are to be considered, however, in explanation of these figures. 1. Many children in the first grade know their letters very imperfectly and so get credit for much less vision than they really have. 2. These reports are based on tests made with the correcting glasses on, whenever children wore such glasses, and defects have been frequently discovered and corrected by the time children reach the higher grade, and 3, unquestionably many children fail in their examinations and leave school before reaching the higher grades, on account of defective vision.

The standard was fixed at vision as good as 20-30 in the better eye and no complaints of head or eye pains caused by studying. Bringing in subjective symptoms, especially when many children are prone to prevaricate, was objectionable but it was the only way to include low astigmatism and hypermetropia with normal visual acuity in the number referred to the physicians for further examination.

Now, as to the results. Many parents paid no attention to the notices and public sentiment is not yet far enough advanced to enable a school board to require a return certificate, and we will next year omit them from the notices sent to parents. The greatest defect is closely associated with the question of dispensary abuse. Baltimore has good schools and even the books are free, and the people with comparatively few exceptions expect everything connected with the schools to be also free. The result was that, notwithstanding the wording of the letter of advice, almost all the children were sent to the dispensaries. The