

we are likely to have adhesions form round and about the site of mechanical insult which will transform a free ovary to a fixed one. With the pelvic organs restored to normal position, mechanotherapy may usually be relied on to enable the cystic ovary to take care of itself without surgical interference. I was formerly a very enthusiastic advocate of ovarian resection. After resecting about two hundred ovaries and carefully studying the results, I am forced to the conclusion that resection of an ovary is rarely advisable. If an ovary is grossly pathologic, remove it; if it is not grossly pathologic, leave it alone.

Operations of expediency, then, should be so planned and so performed that the patients, many of whom are young girls, will not suffer any deleterious consequences therefrom. They must be reconstructive, not destructive; by means of them healthfulness must be engendered, not endangered.

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ABSTRACT OF DISCUSSION

DR. FRANK T. ANDREWS, Chicago: The things I do in the matter of preventing adhesions class themselves under several heads. In the first place, prevention is what Dr. Wakefield speaks of in the use of his new retractors as opposed to the forceps. Then the repair of injuries done either instrumentally or otherwise in the handling of the peritoneum. That repair may be, of course, either the closing of lacerated surfaces or punctured surfaces or the burying or concealing of such points. Then again we have great planes of bleeding surfaces such as we get in digging out great pus tubes. We do not wish exactly to repair these; we do not wish to sew them up. These planes fall together and we use them because we want the adhesions. We have certain adhesions which we wish to sew and we deliberately go to work to irritate the peritoneum because we have at times certain uses for these adhesions which produce adhesions of other organs.

DR. T. J. WATKINS, Chicago: I concur in all that Dr. Wakefield has said and wish to call attention to two or three points. One is to emphasize the importance of this paper. One is to state that postoperative adhesions are usually more difficult to deal with than postinfective adhesions, which emphasizes the importance of using the greatest amount of care to avoid adhesions. Another is the question of the relation of strangulated tissue to adhesions. My associate, Dr. Curtis, did some experimental work on about 150 rabbits last year and made numerous observations regarding adhesions. He found that long pedicles practically always produced bad adhesions. When tissues were studied to note the effect of strangulation on adhesion formation the strangulated tissue was found to be the part that became the most firmly adherent. Since then it has been our plan never to leave long pedicles and never to use a suture that leaves blanched tissue. If the tissue becomes blanched we take out the suture and replace it or cut off the tissue whose circulation has been much affected.

DR. W. O. HENRY, Omaha: I think it wise to do the least possible damage to the abdominal and pelvic organs in operation. In the second place, we should cover up, as far as possible and as carefully as possible, all raw surfaces; and, in the third place, I use freely the sterile olive oil which I have found to be very helpful in preventing adhesions.

Pulmonary Tuberculosis and Chronic Appendicitis.—E. Sergeant calls attention to the frequent difficulty of a differential diagnosis between pulmonary tuberculosis and chronic appendicitis, and cites the work of Faisans and Brunon of Rouen in this line. His article is published in the *Presse Médicale Belge*, 1912, lxiv, 427. He maintains that chronic appendicitis often leads to conditions favoring the development of tuberculosis, and that the overfeeding of tuberculous patients causes intestinal irritation that may bring on a chronic appendicitis or aggravate one already existing.

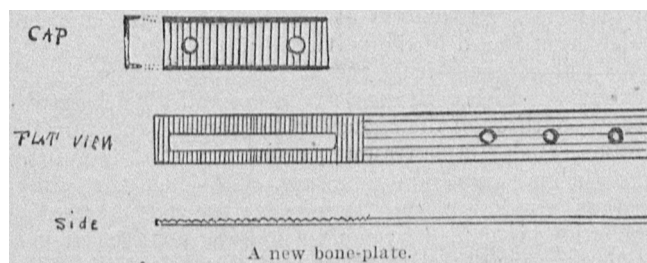
A NEW BONE-PLATE

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Surgeon to Our Lady of Lourdes Hospital

I trust that this modified plate will prove of undoubted value in certain cases. It is simply a modification of the well-known Lane bone-plate and has all the good features of the Lane plate with a well-merited improvement.

In the experience of most surgeons who have made use of the Lane plate, there has been more or less difficulty in getting an exact approximation of the fractured ends and unless extreme care is exercised in placing the screws there is likely to be a small space intervening. While this is not always



objectionable, yet at times it may determine the difference between union and non-union. This I have had quite clearly demonstrated to me in two cases during the past six months.

This plate differs from the Lane plate in that it is adjustable at one end, the upper surface of which is corrugated and has a slot in place of screw-holes. Over this end fits a cap in which are located the screw-holes. The under surface of the cap is also corrugated, in order to give a firm hold when the screws are tightened. From this it can readily be seen that when the screws are driven nearly home the fractured ends may be tightly adjusted and the screws tightened.

This plate has been used in fourteen cases and in none of these has there been any slipping.

SALVARSAN IN PREGNANCY

HAROLD J. LEVIS, M.D., ROCHESTER, N. Y.

It seems to me that the following case is of interest in showing the possibilities of salvarsan as an eradicator of hereditary syphilis, abortion and still-birth.

The patient, Mrs. S., aged 30, married, has had two previous pregnancies; both children are healthy. The patient's husband acquired syphilis from an extramarital intercourse when she was about four months pregnant. He received two intravenous injections of salvarsan of 0.6 gm. each. After his second injection he informed me that his wife was showing marked symptoms of the disease. I told him that it was his duty to have treated his wife first, if not for her sake, for the sake of the unborn child. He said that his family physician (a homeopath) had told her that an injection of salvarsan in her condition was not to be thought of. Nevertheless, they talked it over and decided to consult another physician. He argued strongly in favor of an injection.

May 11, 1912, the patient presented herself and received 0.6 gm. of salvarsan intravenously. At that time she was about eight months pregnant. Her condition was pitiable, both mentally and physically—mentally because of her diseased condition, for which she was not to blame. Physically she presented a skin eruption, intense angina, osteocopic pains and a persistent cephalalgia. Her husband had to help her into the office. Four days later she presented herself to report progress. The transformation was truly marvelous. She stepped into the office unassisted. Her symptoms had completely disappeared.

She received a second intravenous injection June 6, 1912, at 9 p. m. The next day at 5:45 and 6 a. m. twins were born, both healthy. I examined them again on July 25, and at that time they showed none of the classical symptoms of hereditary syphilis.

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