

and less distinct. In this way the organ can be mapped out with remarkable exactitude.

Next, let the bell be placed over the tumor. Here, if the mass is a gastric growth, the sound will continue to be heard close at hand, as over the stomach. On the other hand, if the mass springs from a neighboring organ, no matter how near it lies, the sound produced when the air is injected at once seems quite distant. So great is the difference in the transmission of the sound that no experience of previous trials is necessary for the examiner to say immediately and with certainty that the mass in question is or is not a gastric tumor.

The test is easily applied and, without upsetting the patient, gives valuable information. It would seem worth while to determine the position and outline of the stomach in this way every time a tube is passed on a new patient. I have examined a number in cases in which the diagnosis was in doubt, and the method has so far never failed me.

A glance at the illustration will be found helpful. *A* and *B* indicate palpable intra-peritoneal masses: *A*, a gastric growth; *B*, a tumor not springing from the stomach. Listening over the stomach or over *A* will give the same nearby distinct sound, while over *B*, though near the stomach, the sound is distant.

It is likely, too, that the same test will prove of value in examining growths in the left iliac fossa. By introducing the bucket into the sigmoid or rectum it is reasonable to suppose that the sound will be transmitted along the ascending colon. In this way tumors of the ascending colon can probably be distinguished from retroperitoneal and other growths.

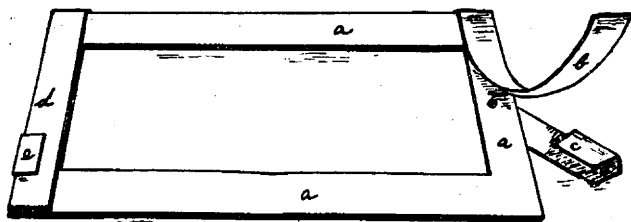
1418 Eutaw Place.

#### STEREOSCOPIC ROENTGENOGRAPHY WITH FILMS

HOWARD CUMM, A.B., M.D., MADISON, WIS.

One objection to the use of films in roentgenography has been the difficulty of holding the films in the viewing box. This may be done by placing the films between two clean glass plates and securing them with spring clips or adhesive tape. If but few cases are handled each week, this method will do very well, but becomes rather irksome if many cases are handled daily.

To meet this objection we have had made, for our use, a film holder which is shown in the accompanying sketch. The



Film holder for holding films in the viewing box in roentgenography: (a) frame; (b) brass spring; (c) clip; (d) spring and clip in place.

frame (a) is made of galvanized iron. It should be heavy enough not to bend easily. The outside dimensions are the same as those of the film with which the holder is to be used. Each side and end are from one-half to three-fourths inch wide, depending on the size of the frame and the weight of the material. Across each end is a brass spring (b). One end of the spring should bend around the edge of the frame and be riveted on the under side, so that the spring is free from the form on the upper side and will admit the film to the edge of the frame. The other end of the spring is brought down and held with a brass clip (c).

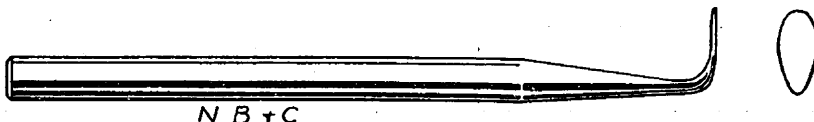
These film holders can easily be made by any tinsmith or plumber, and if a number are kept on hand, films may quickly be inserted for the viewing box.

With this arrangement, stereoscopic work may be done just as satisfactorily and easily as with plates, and especially is this true if the double coated or duplitized films are used, as they are stiffer and more easily handled than the single coated film.

#### DURAL SEPARATOR AND BONE ELEVATOR FOR CRANIOTOMY

ADOLPH M. HANSON, M.D., FARIBAULT, MINN.

This illustration, actual size, represents an instrument for separation of the dura from the internal table and elevator for fragments of the internal table following the use of the drill in craniotomy preparatory to the cutting of the osteoplastic flap. The instrument is inserted to the dura,



Dural separator and bone elevator for craniotomy.

portions of the remaining internal table are lifted up, and the instrument is rotated between the thumb and forefinger, separating the dura from the internal table well beyond the margins of the opening made by the drill.

#### RESECTION OF THIRTEEN FEET OF ILEUM

JOHN R. LITTLEFIELD, M.D., CUMBERLAND, MD.

S. W., a woman, aged 22, married, nullipara, weight, 110 pounds, admitted to the Western Maryland Hospital, March 23, 1919, had been operated on for pus tubes in September, 1917, drainage being required. This operation was followed by an uneventful recovery and good health until March 15, 1919, at which time she consulted her physician for the relief of abdominal pain associated with vomiting and preceded by constipation. Her condition increased in severity and, March 22, the vomitus assumed a fecal character. Small semisolid bowel evacuations occurred, March 17 and 18. On the night of March 22, she was placed on a train and brought to the hospital, a distance of 159 miles.

On admission the vomitus was of a distinct fecal character; the temperature was 97 by mouth; pulse, 120, and respiration, 20. The abdomen was greatly distended, and was very tender and rigid. Peristalsis was absent. There was no hernia in the scar of the previous operation. The old scar was excised and the peritoneal cavity opened, a moderate amount of blood-stained fluid escaping with the protrusion of a large segment of gangrenous and distended bowel. Large areas of peritoneum had sloughed from the bowel wall, and the muscular coat was plainly visible in these areas. The omentum was found to be rolled into a firm band and, with a knuckle of intestine, was firmly adherent to the left horn of the uterus. These adhesions were broken and the entire loop of gangrenous bowel was delivered from the abdomen. This loop, including sound tissue at each end, and measuring 13 feet, was isolated by ligating with small tape and then excised, the mesentery being rapidly transfixed and ligated as the resection progressed. An end-to-side anastomosis was made by sutures, an end-to-end anastomosis being impossible owing to the tension which would have resulted, there remaining only 6 inches of the jejunum and what appeared to be about 4 feet of the ileum. The abdomen was closed without drainage. One hour and ten minutes was required for the operation.

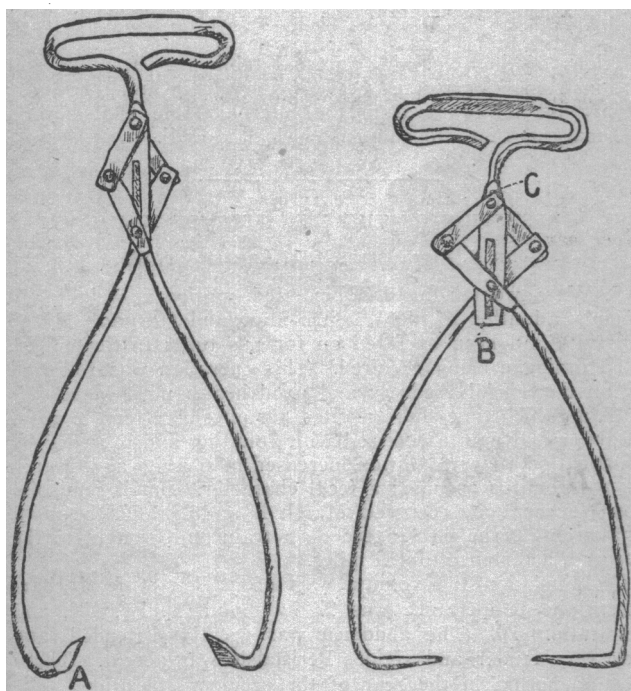
The after-treatment consisted of maintaining the Fowler position, rectal drip tap water for the first twenty-four hours, followed by a 10 per cent. solution of glucose during the next forty-eight hours. Hypodermics consisting of atropin sulphate,  $\frac{1}{150}$  grain, morphin sulphate,  $\frac{1}{8}$  grain, and a little digitalis were administered every four hours for the first

twenty-four hours. The stomach was washed every four hours, but the vomiting of a dark foul-smelling fluid continued for seventy-two hours. The patient complained of great thirst, and after the first twenty-four hours was allowed moderate amounts of water by mouth. Ten days after operation a small abscess developed in the incision which promptly healed after the pus was evacuated. The patient left the hospital, April 24, weighing 93 pounds. She slowly recovered her strength and, June 1, resumed her housework and has continued doing housework to the present time—June 29. She now weighs 109 pounds and eats well but complains of abdominal pains after eating coarse food, pastries, etc.

#### HOME-MADE ICE TONGS FOR EXTENSION

B. F. STEVENS, M.D., EL PASO, TEXAS  
Attending Surgeon, El Paso County Hospital

Ice tongs for extension may be easily and cheaply improvised from a pair purchased at a five and ten cent store, as here shown. To make them suitable for our use, the ends



Tongs for extension.

at *A* are cut off with a file, and new ones turned in, and then sharpened with the same tool or, better, an emery wheel. They are strong enough to sustain a pull of 30 pounds without bending. The opening at *B* is suitable for a wooden wedge, which may be placed after the tongs are adjusted, which will keep the points from approximating too closely and penetrating the bone too deeply. Another at *C* will keep the tongs from becoming unfastened in case anything should happen to the weight.

**The Drop in the Birth Rate in France.**—The *Bulletin Médical* quotes Rebeillard's official report to the Conseil général on the child wards of the state in the département de la Seine. He stated that the number of births which was 73,599 in 1911 was only 47,480 in 1918, and during this last year the number of children abandoned by their parents was 3,149. The proportion of children thus turned over to public charity has risen from 4.90 per cent. in 1911 to 6.90 per cent. in recent years. The infant death rate, which was 19.66 before the war, has risen to 40 per cent. in 1918. The almost complete lack of wetnurses has contributed to this high death rate. In 1912 the Assistance publique had 1,363 wetnurses at its disposal, but in 1918 the number fell to sixty-five.

#### ABSTRACT OF DISCUSSION

ON PAPER OF DR. EUGENE S. TALBOT.

(This issue page 805)

DR. G. V. I. BROWN, Milwaukee: The government has made a radical ruling during this war, distinguishing between the plastic surgeon and the facial surgeon who must have had a medical degree, and the dental oral surgeon who had only the dental degree. The National Dental Association is going to give quite a little consideration to this matter at its next meeting. I think that the question that Dr. Talbot deals with, and the suggestion that he makes in his paper of having an executive committee from this section attend meetings where there is discussion of dental education, representing in a more or less official way this section, is one that is worthy of thought.

DR. M. I. SCHAMBERG, New York: It becomes an absolute duty on our part, as a section, to take a definite position in the matter of the medical education of the dentist. At no time in the history of dentistry or medicine has it become so apparent to the medical profession, to the lay public, and to those of us who are vitally interested in this special feature, that medical education of the dentist and the complete medical education, is essential. I am convinced that there has been no period in the history of dentistry or medicine, when the opportunity is so favorable for this change. Men who take three or four years of study, which is almost paramount to the course in the medical schools, are entitled to a situation in this world, equal to the graduate of the medical school. It is asking too much of a man to spend that amount of time, and then be looked on as only obtaining partial medical culture. I would merely sound one note of caution in approaching the subject: that we do not put it quite in the way the chairman has. I think probably he might be induced to modify that term—of saying that they can have their mental training during the winter, and mechanical training during the summer, because that is almost a slap at mechanical training, which, after all, must be mental as well as manipulating.

DR. E. A. BOGUE, New York: There is in the dental profession, an idea of lack of recognition by medical men that is pretty general. As soon as our men are prepared the medical profession is prompt to recognize. If it were in the power of this section to encourage the younger men to go through the medical school it would be desirable. I knew pretty intimately Sir John Tomes and J. Smith Turner, who are responsible for the dental law of England; yet, with all the care which was given by them and their friends, the unqualified practitioner in number surpasses the other practitioners in England today. There are many in England to come up to the level which has been formed by our well qualified men during the war.

DR. FREDERICK B. MOOREHEAD, Chicago: One does not need to look far to discover the trouble in dental education. The whole fault lies in the organization of a separate training for dentists. The dentist should receive, in a large measure, the same training as the physician, and dentistry will never be a satisfactory component of medicine until the dentist and physician are on an educational parity. To bring about the necessary change in dental education, it will require several years and must be done by evolutionary rather than devolutionary methods. We face a condition, and not a theory, in the premises. The people must be cared for in the matter of dentistry, and with the increasing knowledge on the part of the layman of the dangers of mouth infections, there is going to be a corresponding increased demand for dental services. To meet this demand more dentists will be needed. It would seem, therefore, that the first responsibility in dental education is not to decrease the output of dentists, but strengthen the dental curriculum to a point which will bring about a change of character in the dental students. We have at present, a four year curriculum with a high school graduation for admission, and in 1921 the better dental colleges of the country will require one year of college for admission to the dental curriculum. This will necessarily decrease the