The Indications for Cholecystectomy. By Fred B. Lund (Surgery, Gynecology, and Obstetrics, March, 1917).—An argument often adduced in favour of performing cholecystostomy instead of cholecystectomy is that the latter operation removes the channel of drainage which relieves infection of the ducts. If, however, the bile is sterile and the infection is situated in the bladder wall, the argument falls to the ground. Where jaundice is due to the pressure of a stone, or the swollen neck of the gall-bladder, upon the common duct, the whole condition clears up when stone and gall-bladder are both removed. Often a small stone impacted in the cystic duct can only be dealt with by cholecystectomy. Acute cholecystitis without stones may, but probably will not, be cured by drainage alone, and here cholecystectomy is indicated. Other conditions in which the removal operation is preferable are—chronic cholecystitis without stones, and acutely inflamed gall-bladders, particularly if gangrenous.

In cases where the common duct has to be incised, or where there is much manipulative trauma, the bladder may be saved lest cholecystenterostomy should become necessary. The gall-bladder should be only drained where there is acute cholecystitis, and the patient's condition or technical difficulty render removal unsafe. Cholecystectomy should not be performed in pancreatitis with jaundice. Either cholecystenterostomy or cholecystostomy is to be preferred.—Charles Bennett.

The Relative Merits of Cholecystostomy and Cholecystectomy. By Charles H. Mayo (Surgery, Gynecology, and Obstetrics, March, 1917).—Cholecystostomy gives a high percentage of cures when disease of the gall-bladder is slight, stones are present, and gastric symptoms absent. It is also the treatment when there is associated pancreatitis, since the prolonged drainage thus provided is necessary. In old patients, and during pregnancy, the gall-bladder should be only drained. In cases where there is cystic gall-bladder with destroyed mucosa, in empyema, and in the well-known "strawberry" condition of the organ, the method of election is cholecystectomy. If cholecystitis severe enough to give rise to symptoms is present, the infection of the gall-bladder wall cannot be eradicated by measures short of removal. When
there is evidence of associated functional derangement of the stomach, the gall-bladder should be excised.—Charles Bennett.

Cholecystostomy versus Cholecystectomy. By John B. Deaver (Surgery, Gynecology, and Obstetrics, March, 1917).—The author points out that cholecystectomy takes longer to perform, and that with it there are operation dangers not incurred when the simple drainage operation is done. Yet excision must be faced when called for. He inclines to the view that removal is the proper treatment when the gall-bladder is obviously diseased and presumably the primary and residual seat of biliary infection. This covers the vast majority of cases. But when the condition seems rather more cholangitic and intra-hepatic in nature, or when the major lesion is in the pancreas or common duct, he prefers to leave the gall-bladder and use it for external drainage by cholecystostomy, or internal by cholecystoduodenostomy.—Charles Bennett.

Isolated Disease of the Scaphoid Bone of the Foot (Kohler’s Disease). By W. B. Hetzel (Amer. Journ. of Orth. Surgery, March, 1917).—The author reports this case as an addition to the records of the disease. Kohler published the first three cases in 1908, and since then nine others have been put forward.

The patient was a boy of seven, of good family history, and in whom Wassermann and Von Pirquet reactions were negative. He had been limping for three months, without known injury, and complaining of pain in the left foot on weight-bearing. Examination showed redness and swelling over the inner side of the dorsum of the foot, and there was marked tenderness over the scaphoid. Temperature remained at 100° F. for a few days, but the pulse-rate was not increased. In skiagrams the scaphoid appeared smaller than normal, irregular in outline, increased in density, and with no distinction between cortex and spongy portion. Treatment by immobilisation in plaster of Paris, with the use of crutches, was adopted. After nearly four months weight-bearing was gradually resumed, and there was a clinical cure. Skiagrams after three months showed the scaphoid increased in size, and with density approaching normal.

The author concludes that Kohler’s disease, of which the above may be taken as a typical example, is a clinical entity, and that it is probably of osteochondritic nature.—Charles Bennett.

ANÆSTHETICS.

A Method of Anaesthetising Soldiers. By W. J. M’Cardie (British Medical Journal, 21st April, 1917).—Having at the 1st Southern General Hospital opportunities of anaesthetising many soldiers, Mr. M’Cardie found that they are mostly strong and fit men accustomed to tobacco, and consequently with irritable throats; nearly all have colds due to exposure; their nervous systems are on a much higher plane of tension than that of the normal individual during ordinary times, so that altogether as a type they are much more difficult