**SURGERY.**

Fractures of the Lower End of the Humerus. By I. A. Arnold (American Journal of Surgery, December, 1916).—Permanent ankylosis at the elbow after fracture is rare except in certain compound and complicated fractures, and the outlook for future function is good, provided proper treatment is employed. The erroneous impression concerning the outcome of these cases is due to views formed from fractures in children, which should be in a class by themselves, and to the results in badly diagnosed cases. The mistake is to treat fractures not individually, but on the basis of one definite lesion. Again, opinions should not be formed six or eight weeks after the injury, because patients often exhibit considerable improvement twelve or eighteen months later.

T-shaped fractures may easily be diagnosed as merely supracondylar since the line running into the joint may not be detected. These are best treated by a rigid splint, with only slight flexion at the elbow, and lateral pressure over the condyles. As there is danger of ankylosis, although the author has not seen it occur, the splint is removed on the fifth or sixth day, a little passive movement carried out, but not beyond the point of resistance, and then re-applied.

In the author's experience fracture of the internal condyle is as common as that of the external, but it is a graver injury. The external epicondyle is rarely fractured, but the internal is fairly often.

In children under twelve years the results of fractures of the lower end of the humerus are almost invariably good, because ossification occurs later, and a separated epiphysis remains better in position, once corrected, than a fracture. Although in general early movement is liable to increase the amount of callus, yet the author believes that in the elbow it is better to take the chances of exuberant callus being absorbed than to have permanent ankylosis.

—Charles Bennett.

Torticollis. By Arthur L. Fisher (American Journal of Orthopedic Surgery, November, 1916).—Torticollis as a term was first used by Rabelais in the early sixteenth century; as a surgical condition it was described by Isaak Minnius in 1641.

Summation of the best evidence on the pathological anatomy points to there being a primary degeneration of muscle fibre followed by an increase in the connective tissue. No general agreement has been reached regarding etiology, but the principal groups of causes suggested are (1) traumatic, (2) infectious, (3) intrauterine.

Among defects accompanying or following torticollis are secondary skeletal alterations of which scoliosis (cervical) and asymmetry of the skull are the most common. There may also be ocular defects (not causative). Symmetrical narrowing of the field of vision has been observed, but not nystagmus. Other occasional accompaniments are atrophy of the entire half of the body, lowered temperature, small hand and foot on the same side, smaller lung excursions on the same side, difference in the carotid pulse, and lowered intelligence.

Diagnosis is usually easy, but rotary luxation, cervical Pott's disease, or cervical rib may offer resemblances.
Treatment consists of subcutaneous tenotomy or, better, the open operation. Part of the trapezius and of the scalenus anticus may have to be divided in addition to the sterno-mastoid. Mikulicz sometimes removes the whole sterno-mastoid, while Wullstein operates on the sound side and shortens the muscle there.

—CHARLES BENNETT.

Books, Pamphlets, &c., Received.

A System of Case-taking, with Explanatory Notes, by George William Ross, M.A., M.B., and Julian Loudon, B.A., M.B. Authorised for use in the Faculty of Medicine, University of Toronto. Toronto: The Macmillan Co., Limited. (2s.)

The American Year-Book of Anaesthesia and Analgesia, by F. H. M'Mechan, A.M., M.D. New York: Surgery Publishing Company. 1916. ($4.)

Manchester Babies' Hospital; Slade Lane, Levenshulme, Medical Registrar's Monthly Reports, August, 1915, to July, 1916. Manchester: Longmans, Green & Co.

Transactions of the College of Physicians of Philadelphia. Third series. Vol. XXXVII. Philadelphia: Printed for the College. 1915.

The Basle Anatomical Nomenclature (BNA): Being an Alphabetical List of Terms showing the Old Terminology, the BNA Terminology, and the suggested English Equivalent, by E. B. Jamieson, M.D., M.B., Ch.B. Edinburgh: W. Green & Son, Limited. 1916. (6s. net.)

Collected Papers on Circulation and Respiration. Second series. Clinical and Experimental, by Sir T. Lauder Brunton, Bart., M.D., D.Sc., LL.D. London: Macmillan & Co., Limited. 1916. (5s. net.)

Military Surgery, by Dunlap Pearce Penhallow, S.B., M.D. With Introduction by Sir Alfred Keogh, K.C.B. Original drawings by the Author. London: Henry Frowde and Hodder & Stoughton. 1916. (15s. net.)

The Panel Doctor: His Duties and Perplexities, by T. M. Tibbetts, M.D., M.R.C.S. Birmingham: Cornish Bros., Limited. 1916. (1s. 6d. net.)

Surgical Anatomy, by John A. C. Macewen, B.Sc., M.B., C.M. Second edition. London: Baillière, Tindall & Cox. 1916. (10s. 6d. net.)

Les Blessures de l'Abdomen, par J. Abadie. Préface de J.-L. Faure. Collection de Précis de Médecine et de Chirurgie de Guerre. Paris: Masson et Cie. 1916. (4 fr.)

Les Séquelles Ostéo-Articulaires des Plaies de Guerre, par A. Broca. Collection de Précis de Médecine et de Chirurgie de Guerre. Paris: Masson et Cie. 1916. (4 fr.)

Formes Cliniques des Lésions des Nerfs, par Mme. Athanassio-Benisty. Préface du Professeur Pierre Marie. Collection de Précis de Médecine et de Chirurgie de Guerre. Paris: Masson et Cie. 1916. (4 fr.)