hereditary, and in the appearance of puberty with a corresponding muscular development. Though the epiphyses fuse naturally, there is scarcely any of the growth in length of the bones which is so characteristic of normal adolescence. Of progeria only two well-marked instances have been recorded. Its signs fall into three categories—(1) Premature ageing—leaness and wrinkling, baldness, atheroma, and fibrotic changes in the viscera. (2) Delayed development—stature and proportions of childhood and backward dentition. (3) Normal growth—sexual organs, cartilage bone, and brain.

SURGERY.

UNDER THE CHARGE OF
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ON THE MOSETIG-MOORHOF METHOD OF FILLING BONE CAVITIES.

Elsberg (Med. News, New York, 1905, April 15, p. 683) expresses a favourable opinion of Mosetig-Moorhof's method of filling bone cavities with iodoform wax, and, as a result of his experience, he has modified the procedure in certain details. The operation is suitable to cases of chronic osteomyelitis, whether pyogenic or tuberculous in origin, only when the cavities to be filled in, as well as the surrounding soft parts, can be rendered aseptic. The limb is prepared as for any operation, and is rendered bloodless by means of an Esmarch's bandage. The bone cavity is then freely exposed by raising the soft parts, including the periosteum, over it. The walls are then scraped or gouged away until a fresh, vascular, and sterile surface is exposed. The walls of sinuses are excised, and all infected tissues removed from the vicinity. Elsberg thinks that at this stage the Esmarch's bandage should be removed, in order that the bleeding from the rawed surfaces may be completely arrested before the iodoform-wax mixture is introduced. He has found irrigation with hot saline solution, irrigation with peroxide of hydrogen, and packing with adrenalin and dry sterilised gauze, efficient in arresting the bleeding. The mixture used by Mosetig-Moorhof consists of 60 parts of iodoform, 40 parts of spermaceti, and 40 parts of sesame oil. It is prepared by beating the spermaceti and the oil of sesame over a water-bath for half an hour, then adding the iodoform to it, and preserving the mixture in a sterilised bottle. When it is to be used, the mixture is melted by immersing the bottle in hot water, and it is poured, while still fluid, into the cavity. Elsberg only used 20 per cent. of iodoform, as he had one case of iodoform poisoning from the stronger mixture, and in place of pouring the fluid mixture directly into the cavity, he cools it in a basin of sterilised cold water, till it is of about the consistence of putty, and then packs it tightly into the cavity in the same way as a dentist fills a cavity in a tooth with cement. After this has been done, the soft parts are, if possible, brought together, and the wound is
dressed with an ordinary aseptic dressing, which is not disturbed for from seven to ten days. Primary union generally takes place. In some cases there is a slight rise of temperature and pulse rate for two or three days, and a small quantity of iodine is usually present in the urine for a day or two. The patient almost always complains of a burning sensation in the wound for a few days. If the operation is successful, the patient’s stay in hospital is materially shortened. Even if the filling is extruded, the healing process seems to be hastened.

A Method of Inducing Ether Narcosis by Rectum.

The idea of administering ether by the rectum for purposes of surgical anaesthesia has recently been revived. J. H. Cunningham and E. H. Lakey (Boston Med. and S. Journ, 1905, April 20, p. 440) record their experience of forty-one cases. The apparatus used by them consists of a bottle the body of which is 7½ in. in height, 5 in. being used for ether space and 2½ in. for vapour space. The bottle contains about 29 oz. of ether. This bottle stands in a water-bath at a temperature of between 80° and 90° F. An afferent tube leads to the bottom of the ether column, and through it air is pumped into the bottle. The efferent tube passes to the rectum and ends in a stiff rectal tube, which is introduced into the bowel for a distance of from 10 to 14 in. The ether vapour is forced into the gut by squeezing the bulb every five or ten seconds. In from one to five minutes of commencing the administration the breath becomes ether laden, the patient gradually becomes drowsy, the breathing stertorous, and he gradually passes into a state of complete surgical anaesthesia, without any stage of excitement. The same signs regarding the patient’s condition guide the anæsthetist as in administering ether by inhalation. The writers summarise their experience thus: There is comparatively little ether used; there is no stage of excitement; vomiting seldom occurs; bronchial secretions are absent; there is comparatively quick recovery from the effects of the anaesthesia; the bowels are slightly constipated. They have not met with diarrhoea or melaena after administering the drug in this way. They suggest that the method is specially suitable in operations about the head, mouth, and neck, as the anæsthetist does not come in the way of the operator. This, we confess, is the only advantage which appeals to us strongly.

The Surgery of the Prostate Gland.

No fewer than eleven different papers bearing on the surgery of the enlarged prostate appear in the April number of the Ann. Surg., Phila., vol. xli. No. 4. It is impossible for us adequately to summarise these, but we commend this series of articles to those of our readers who are interested in the subject, as they embody the most advanced views of American surgeons on the various aspects of this much debated affection. On the vexed question of the “priority in the adoption of the method of total enucleation” by the suprapubic route, Dr. Eugene Fuller enters an emphatic protest against the claims of Mr. P. J. Freyer, whose reply we await with considerable interest. In this connection it is pleasing to note that the pioneer work of the late Mr. M’Gill of Leeds receives
due recognition from several of the American authors. With regard to the complete removal of the gland by the perineal route, Dr. Francis S. Watson recalls that as early as 1873 Dr. Gouley of New York published a description of this operation.

To the question "Has the catheter a place in the treatment of chronic prostatic hypertrophy?" Dr. Paul Thorsdike gives a decided answer in the affirmative, and he indicates with convincing clearness his reasons for refusing to discard the catheter in certain cases. On the other hand, Dr. F. F. Watson asserts, with all the emphasis which italics afford, that "the really essential point for those who are experts in this special province is to bring home the fact to the profession at large, that the operative treatment of prostatic hypertrophy has been brought to a sufficient degree of perfection to make it evident that the patients should be given the benefit of it, and should not be submitted to the dangers of catheterism as they have been in the past, until it is hopeless to interfere surgically in many instances." "The mortality," he says, "attending the catheter treatment was even greater, except in the class of people of the best social status, than that attending prostatectomy, and the mortality of perineal prostatectomy, were it practised at a sufficiently early stage of the progress of the malady, would certainly prove to be far less than that associated with the catheter treatment, in all classes of persons."

Regarding the relative merits of the suprapubic and perineal routes, Dr. Howard Lilienthal says, "I believe that the suprapubic is the safest and most thorough of all the operations for the relief of prostatic obstruction;" and he expresses his opinion that the "two-stage method"—meaning by that the opening of the bladder at one sitting, and the enucleation of the prostate later—to be one of the important advantages of the suprapubic route. This modification is specially indicated when the urine is septic, as the suprapubic opening admits of the bladder being drained, the state of the urine being improved before the prostate is removed. In a number of his cases sexual power was increased after the operation, and in none who were potent before was it lost. As an internal urinary antiseptic he prefers salol, in 5-gr. doses, taken three times a day. Dr. Joseph Weiner, jun., also prefers the suprapubic route, and he performs the operation under nitrous oxide anaesthesia, even in the most desperate cases.

The superior claims of the perineal route are urged by Dr. Hugh H. Young, who says, "I have come to the conclusion that for most cases perineal prostatectomy is the safest and surest and quickest method of curing the patient." This surgeon found that in the majority of cases the sexual power has been maintained after the operation. Dr. Lewis S. Pilcher and Dr. F. W. Watson also support the perineal operation.

In a most interesting paper, Dr. Charles H. Chetwood deals with the subject of "Prostatism without Enlargement of the Prostate" (see also Edin. Med. Journ., 1905, March, p. 310)—a morbid condition which, he thinks, is best expressed under the title of "Contracture of the neck of the bladder." "It is," he says, "a fibroid stenosis of the vesical orifice. It is not a hyperplasia of the muscular elements of the sphincter, or of the adenomatous tissue; it is not a simple spasm or a mucous fold; but a fibrous infiltration, inflammatory in character." From an experience
of thirty-six cases, he concludes that the relief of the condition is safe and sure by means of a galvano-prostatotomy through a perineal opening.

Rupture of the Lateral Walls of the Vagina during Labour.

Lutaud (Journ. de méd. de Paris, 1905, February) refers to the frequency of rupture of the vaginal wall, the fourchette remaining intact. He found in 115 cases thirty-two with lateral vaginal tears, and in forty-nine cases combined with perineal tears. The prognosis is good, the wounds heal without suture, and the cicatrix may be of medico-legal importance as an aid to the diagnosis of a previous pregnancy.

Post-partum Psychoses.

Picqué (Bull. Soc. d'obst. de Paris, No. 1, 1905) distinguishes cases arising directly after confinement, and those manifesting themselves later. The former are nearly always associated with fever; the latter are, as a rule, pyretic. In the later, Picqué thinks mental degeneracy is often a predisposing factor. Many cases he found to be associated with morbid conditions of the uterus. Thus polyoid degeneration of the mucosa—ulceration of the cervix—he noticed especially frequent. In nine cases out of fourteen the mental affection improved, in six was completely cured, after local treatment. In no case was the mental condition made worse by surgical interference.

The Prophylactic Use of Ergot during Labour.

Prüsmann (München. med. Wchnschr., 1905, January) recommends a 15 per cent. aqueous solution of ergotin, with a few drops of carbolic added. He injects 2 to 4 c.c. into the gluteal region in the following cases:—(1) Spontaneous birth, when the head is almost born; (2) in forceps cases, when the instruments are applied; (3) in breech cases. In cases of Cæsarean section, 2 to 3 c.c. are given ten minutes before operation. The following are the indications for the use of ergot given by Prüsmann:—(1) All births requiring operative interference; (2) multiple births; (3) hydramnion; (4) fibroid tumours of uterus; (5) inefficient labour pains. In 293 cases delivered with forceps, 6—ED. MED. 601—NEW SER.—VOL. XVIII.—I.