would not consent to have an incision made down upon the bone. However, as the pain became more severe, he gladly consented on the fourth day to allow me this privilege.

Under the influence of chloroform I made an incision, about a quarter of an inch in length, down through the periosteum, which allowed about half an ounce of bloody serous fluid to escape. The acute pain did not again occur, although it was necessary to place the arm in plaster-of-Paris with an opening in it over the incision. A small probe was occasionally introduced through the incision down upon the bone, that the fluid might have easy exit. This was not done after the first forty-eight hours. The swelling of the arm, which had by this time somewhat increased, gradually diminished. I feel certain that had this incision not been made, the epiphysis of the ulna would have became involved, thus seriously affecting the elbow joint. The arm was kept in plaster for two weeks, when it was removed, and motion in the joint was found perfect.

Case 4. Young man, 22 years old, a brakeman, allowed his knee to be caught between bumpers. It is a question as to the amount of space between the bumpers. The draw-bar of the tender of a locomotive is always stronger than that of any other car, so that it does not have any spring, otherwise I believe the knee would have been crushed and amputation been necessary. However, the epiphyses of the tibia and femur being injured made it necessary to give the parts complete rest. Here is a case where the pressure was so uniform that there was no particular part of the periosteum or bone involved. The force was not sufficient to seriously affect either, so that at the end of three days he was able to get about on crutches, which were used for two or three weeks. The tenderness about the external condyle of the tibia and femur was rather acute, and there seemed to be some question as to the extent of involvement, that is, whether or not there was the presence of periosteal effusion. This, I am certain, did not exist sub-periosteal. The fact that the course was short and the pain slight led me to believe that the effusion was so limited that operative interference was not necessary. This is a case where it was not necessary to resort to any surgical interference other than complete rest and the constant application of heat. *The International Journal of Surgery.*

OPERATIVE TREATMENT FOR STONE IN THE BLADDER.

Briggs (*International Medical Magazine*, February, 1894) contributes a most interesting article on this subject, giving his personal experience with two hundred and eighty-four cases of stone, and discussing the various methods of operation.

He performed lithotrity on five patients, all of whom recovered, but were very impatient over the amount of time required for treatment. He then tried litholapaxy on ten adult cases; in two, death resulted from renal complications. He selects this method of operation under four conditions: 1. Adult patients; 2. Capacious and tolerant urethra; 3. Small or medium-sized stone, or, if large, of soft consistence; 4. Bladder capacious and free from severe and persistent inflammation.

He prefers lithotomy in children, and has performed the operation on seventy-six children under sixteen years of age, and all recovered but one.

The supra-pubic operation he performed on seven cases for the removal of very large, hard calculi; resulting in recovery in five.

Forty-four operations by the bilateral method resulted in ten deaths. He then chose a modification of the median operation suggested by Civiale in 1829, and called by him the medio-bilateral method. He has performed that operation one hundred and seventy-one times, with a result of one hundred and sixty-seven recoveries and four deaths, three of the number not being attributable to the operation.

The advantages of the operation given are briefly: 1. It opens up the shortest and most direct route to the bladder; 2. It divides parts of the least importance; 3. It is almost a bloodless operation; 4. It affords a sufficiently capacious passage for the removal of any calculus; 5. It reduces the death rate to the minimum.

In conclusion, Briggs makes the following statements: "1. No method of operation is adapted to all cases; 2. Thorough preparatory treatment is essential to success; 3. Litholapaxy is *the* operation when the patient is an adult with a capacious and tolerant urethra, with a bladder free from severe chronic cystitis, and with a small or medium-sized stone, or, if large, of soft consistence; 4. The supra-pubic is the best operation for large and hard calculi; 5. The medio-bilateral should be chosen in all other conditions, because it is the easiest, safest and best."

PERSONAL.

Dr. Emory Lanphear, for many years editor of *Kansas City Medical Index*, has resigned the chair of Operative Surgery and Clinical Surgery in the Kansas City Medical College, and has removed to St. Louis. He makes the change in order to become Professor of Surgery in the St. Louis College of Physicians and Surgeons, one of the oldest and strongest medical schools of the West.