weeks. Of the remaining 44 patients, all of whom had simple fractures—6 had sugar in the urine for periods of twelve or fourteen days; in none were there other signs of disturbed sugar metabolism or was the healing of the fracture influenced. The chief significance of these observations, in his opinion, is in their pointing to shock or cerebrospinal concussion as the principal cause of the condition. Such ephemeral glycosuria does not seem to have any influence on the healing of the injury. Nevertheless, he would postpone operations that are not imperative until the disappearance of the sugar. A more permanent glycosuria might possibly result from the shock of operation or the anæsthesia, and the chances of non-union be greatly increased. The secondary transitory glycosuria due to drugs or infection does not seem to affect the prognosis of surgical infections greatly, but, according to Halstead, it should cause the postponement of major surgery while the needed measures for its relief are being carried out. It is not a contraindication, however, to necessary minor surgical procedures, but rather the reverse. In long-continued suppuration, the possibility of a secondary glycosuria becoming permanent must be kept in mind. In erysipelas, sugar in the urine is of serious prognostic moment, as an index of the severity of the infection. In diabetes, imperative operations have to be risked, and, from his review of the evidence, Halstead does not think that we can always take the quantity of sugar excreted as a guide to the safety of an operation. Other substances, acetone, diacetic acid, etc., indicate a greater danger of coma than any quantity of sugar alone. He would try a thorough course of treatment in case a high percentage of sugar is present, before performing any operation that can be postponed. Under aseptic conditions, except in the lower extremities where the circulation is likely to be impaired, wounds heal readily in diabetes. The dangers incident to infection, however, are increased and operations that are avoidable should not be considered. Too much stress can not be laid on the importance of a rigid course of preliminary medical treatment. Inhalation anæsthesia, even by nitrous oxide should be avoided so far as possible. In case operation is unavoidable ether is the least, and chloroform the most harmful. Local or regional anæsthesia should be the form employed whenever possible. Halstead insists on the importance of prophylaxis as regards gangrene in diabetes. The danger of infection of even insignificant abrasions should be impressed on the patient, and corns, warts and calluses of the lower extremities should receive careful attention and should be treated only under the most rigid antiseptic precautions. When gangrene has occurred, the question when and where to operate is of importance, and the condition of the arteries will have to be considered. When the gangrene has reached the dorsum of the foot, obstruction of the popliteal at its bifurcation has possibly occurred, and amputation above the knee is always to be advised. A general anæsthetic is unnecessary in most cases as spinal cocainization will generally suffice.

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Exophthalmic Goitre.

E. S. McKee contributes to the *Lancet-Clinic*, the following resume of the symposium on exophthalmic goitre, at the last meeting of the American Medical Association: Physiology of the thyroid gland in