

opposite knee, and soon affected both knees; they gradually increased in size, and now, as you see, they are immense. One measures eighteen, and the other seventeen and a half, inches in circumference, and the calves of the legs are very much diminished in size.

For the last two years this condition has remained about stationary. The effusion is now so abundant that the patella of each knee is lifted from its articulation, and, as pressure is made upon it, it can be made to strike the bones below with an audible click.

By transmitted light a lake of fluid can be seen below the ligamentum patellæ, with a large collection of semi gelatinous material at its upper surface, presenting a very beautiful pathological appearance. These knees have received an almost endless variety of external applications, and his general system has received a great amount of medication, but all have failed to produce any change, and we now find them as they have remained for a numbers of years.

The effusion in this case has become so great as to preclude all possibility of its removal by absorption, simply because the excessive tension that has been made upon the absorbents has paralyzed their action in such a manner that absorption cannot take place.

The condition is analogous to that occasionally seen in ascites, when the pressure is so great from accumulated fluid that the absorbents will not respond to the influence of internal remedies. In that case, the removal of only a small portion of the fluid will in many cases reduce the tension sufficient to permit the subsequent removal of the remainder by the renewed action of the absorbents. This case, however, has been of so long standing that it is not probable that the removal of a portion of the fluid would be of any benefit, even though followed by the most constant and powerful compression.

In most cases, particularly in the sub-acute and earlier chronic stages, decided benefit can be obtained by pressure applied to the joints. This can be conveniently and effectually done by means of compressed sponge. Cover the joint which is the seat of the synovitis with compressed sponge, and retain it in position by means of a roller bandage. The sponge is then wet with warm water, which causes it to gradually expand and thus produce an equal amount of pressure over all the parts covered; and it can be kept up long as may be desirable. The sponge can be applied one or twice a day, according to the necessities in the case. Changing it every twenty-four hours is usually sufficient.

The question now arises, What is the best thing that can be done for the relief of the present condition of this case?

A free incision will permit the fluid to escape, but the risk of exciting an uncontrollable inflammatory action would hardly warrant such a procedure.

What I propose to do in this case is to remove the fluid by means of the *aspirator*. This also, is not altogether a safe operation, for inflammatory

action may follow its performance; but, under the circumstances, it is the best operation that can be resorted to. In such a case as this, a certain amount of risk must be taken, no matter what operative interference may be adopted.

In all probability, simple aspiration will fail to give any permanent relief, for the reason that the case has been of so long duration. It is also altogether probable that the synovial membrane has become changed in its anatomical structure to such an extent, that permanent benefit will only follow the adoption of some more active measure.

There is a chance, however, that the simple operation of aspiration, followed by elastic pressure, such as obtained by the use of compressed sponge and a roller bandage, may accomplish a cure.

If simple aspiration does not succeed, the fluid will then be removed by means of the ordinary trocar; and when removed, the cavity will be injected with Lugol's solution of iodine. The principal of treatment is precisely the same as that which governs us in the treatment of the tunica vaginalis in cases of hydrocele; namely, to excite a new action in the old and changed membrane, by means of an irritating agent; and for this purpose the solution of iodine indicated is much the safest agent to be employed.

In either case the patient will be placed in bed immediately after the operation, the knees will be firmly bandaged, locked in a perfectly immovable apparatus, elevated above the level of the body, and perfect rest maintained. In addition, icebags will be constantly employed if necessary. The object is to retain the inflammatory action *just within* the point of danger. In this manner we may reasonably expect to bring about complete recovery.

CASE III. Cancer of Lower Lip.—These growths, seen not infrequently upon the lower lip, are usually regarded as cancerous in nature. Some of them are not. Some of them bear so close a resemblance to the ordinary epithelioma of the lip, that they cannot be distinguished from each other by the naked eye. They are usually the result of constant and long-continued irritation.

Fortunately there is one plan of treatment best adapted to them all. Remove them with the knife, and that makes an end of them.

There are some steps in the operation which are necessary to be observed if you would make a nice operation, and one which will prove satisfactory to your patient. The ordinary operation is to remove the diseased mass, by making a V-shaped incision, large enough to embrace the whole of it.

Serious hemorrhage can be avoided, during the operation by having an assistant make pressure upon the facial arteries as they pass over the ramus of the lower jaw. The wound can be closed by means of sutures, or pins with the figure-of-8 suture. I commonly employ the pins. These are to be passed through the lips of the wound, and then its edges are brought together in such a manner as to avoid leaving any notch in the free margin of the lip. The attachments of the cheek may be loosened with the