hydrocele by injection, or in dropsy of a joint treated by injection of iodine. At present no case of a recurrence of the ganglion after a septic incision and drainage has been reported.

IMPROVEMENTS IN EXCISION OF THE KNEE-JOINT, AND LIGATURE OF LARGE ARTERIES.—Mr. Edward Thompson says on this subject: There are some points in the treatment of excision of the knee-joint, both at the time of operation and subsequently, which seem to me to deserve particular attention. I have had a good many of these cases under treatment from time to time in the Tyrone Infirmary; and the suggestion I have now to make, and which I desire shortly to detail, are the outcome of my experience.

In the first place, I always make the first incision nearly straight across the limb, and as small in extent as possible; with one sweep of the knife the ligamentum patellæ is cut through, and the joint opened. The upper end of the ligament is then seized and dissected off the bone, and the patella removed. The subsequent steps of the operation require no comment. When the bleeding has ceased, the cut surfaces of bone are placed in close apposition, and the divided ends of the ligamentum patellæ are strongly stitched together with carbolised silk; the skin-flaps are brought together in the usual manner, and the wound closed, no drainage tube being inserted. The limb is at once put up in plaster-of-Paris, with a back splint of strong hoop-iron; another strong piece of iron is bent over the situation of the wound, so as to allow the application of the proper dressings; two side-splints of hoop-iron, about eighteen inches long, and slightly hollowed over the wound are placed lengthways, across the site of the joint, and over the plaster-of-Paris, the whole being firmly secured by a bandage. A completely rigid and comfortable bed is thus secured for the injured limb. The upper and lower portions of the limb are padded with French wadding, and, close to the wound, with carbolic tow. If there be any discharge from the wound it will penetrate the tow, which can be readily removed and replaced without disturbing the limb. I have heard a great many discussions, and read a great many elaborate articles, on the proper method of treating these cases; but, as yet, I have seen no apparatus which is so easy of application or so reliable as the plaster case I have attempted to describe, and which is coming into very general use.

The chief points I wish to emphasize are—1, the small extent of the primary wound really necessary; 2, the preservation of the ligamentum patellæ, not by its non-division, but by the divided ends being stitched together; 3, the enormous anterior support afforded by the preservation of the ligament, and the lessened tendency to displacement; 4, the increased power given to the limb by preserving almost intact the insertion of the powerful crureal muscle; 5, that stitching the patellar ligament seems quite as efficacious as the recommendation by some authors of its non-division; and that, while effecting subsequently the same purpose, it in no way hinders, or renders more difficult, excision of the joint.

In all my recent cases of amputation of the thigh, I have tied the femoral artery with a strong carbolised silk ligature, and cut off both ends short. The wound has healed, and remained healed, in every case. Thus a troublesome cause of irritation—one end of the ligature being left hanging from the flap—and a very great impediment to the healing of the flap-wound by first intention, has been effectually got rid of.—*British Medical Journal*, Nov. 7, 1885.

DISEASES OF THE PLACENTA AND CORD DUE TO SYPHILIS.—The following are the conclusions of Dr. Saxinger of Tubingen, concerning this affection:

1. There exists a placental syphilis, which, in a fair proportion of cases, is recognizable on microscopic examination.

2. Placental syphilis generally accompanies fœtal syphilis. It is also found in maternal syphilis with a healthy child.

3. The placenta may be diseased in an isolated lobe and throughout its density, or solely in its fœtal portion, or its maternal portion.

a. If the mother has been infected by the fecundating coitus, with the fœtal syphilis, the placenta is found to be more or less diseased throughout. Ordinarily, the umbilical vessels themselves are diseased.

b. If the mother is not infected, generally, besides the fœtal syphilis, only the fœtal placenta and the cord are diseased. Nevertheless, the morbid process may extend to the maternal placenta, and infect the mother by intra-uterine repercussion.

c. If the mother has been infected some little time before conception, if the mother has been fecundated by a healthy man before the outbreak of general symptoms, and if she has undergone treatment during pregnancy, a healthy child may be born to her. Here the maternal portion of the placenta is generally the only one diseased.

d. If the mother has been infected some considerable time before the fecundating coitus, ordinarily it is the placenta alone which is diseased. Under the influence of the progress of the morbid process, the fœtal placenta and the whole of the placenta may be involved in turn, and the fœtus participate in the infection, if indeed, from the the disturbance of the circulation, it is not destroyed.

e. If the mother is fecundated by a healthy man, and if she is not infected until later, in spite of the immunity of the fœtus, the placenta is al-