from the position of the pelvis when the measurement is taken.

Dr. W. F. Peck, of Iowa, stated that, with reference to fractures of the condyles of the humerus, he had for fifteen years taught the importance of using no splints except for support.

Dr. Mudd, of St. Louis, remarked that the great point to be desired is the limitation of inflammatory action about the seat of fracture. Control that, and you control the amount of anchylosis of the joint. Put the fragments in good apposition, control the effusion into the joint, and prevent movement, and you get a good result. In fractures of the metacarpal bones, put the parts in position, put the pad near the joint, put on a splint, and bandage it firmly.

Dr. E. P. Cook, of Illinois, stated that in fractures of the lower end of the radius, the application of the posterior splint is all that is necessary. One case of this kind he had treated by applying a closely-fitting kid-glove to the hand, and a close bandage over the fracture, with direction to lay the arm on a pillow in any position that was most comfortable. The result was perfect.

Dr. Roberts stated that he had not attempted to bring out anything new, but merely to present some of the more common errors for discussion. He agreed with Dr. Peck, that many fractures would be better treated without any splints than the ordinary splints. In fractures of the upper end of the humerus, it was better, in most instances, to let the arm hang vertically. Sometimes, however, is is best to let the arm fall forward. In many cases we need no splints at all. If we reduce the fracture, the interlocking of the fragments will ordinarily keep the fracture in place. If the fracture is comminuted, however, it should be treated with splints.—*Cin. M d. News.*

OVARIOTOMY IN BERLIN.

BY H. R. BIGELOW, M.D.

Dr. Martin's polyclinic furnishes him with an exceptionally large material, and during five weeks just gone by he has completed considerably over 100 operations. His statistics are creeping up to those of Schroeder, whom he may soon pass, and his results are *extremely* good. With such large experience, with such daily association with grave disease, and with such facility of technique, it is not surprising that success should follow him. He arrives at a diagnosis speedly and almost faultlessly, and operates rapidly and with signal coolness. Dr. Duvelius, himself a surgeon of reputation, is his first assistant, another administers the anæsthetic, while another, in conjunction with an intelligent matron, handles the instruments, sponges, etc. Dr. Martin sits between the knees of his patient, and the two assistants are also seated. The galvanized iron operating table invented by the matron has an arrangement by which its middle third can be dropped, thus facilitating the placing of the dressings. Every one looks comfortable, and I am quite impressed with the advantages of this plan. The first assistant sits at the left of the patient, manipulates the abdominal parietes, keeps the intestines out of the cavity, covering them with a hot towel, and secures all bleeding points. The operations in abdominal surgery are all made in a special room, devoted exclusively to this class of work. It is literally saturated with carbolic spray. All the water used is boiled, and everything and everybody are made as aseptic as possible. The hair of the patient is shaved from the pubes, the abdomen is washed with brown soap and water, then with bichloride solution and then with lemon juice. The temperature of the room is kept well up, but even a higher grade, I think, might be advantageous. The tumor being removed and the stump being sewn up, the left hand is passed into the cavity behind the stump to the posterior cul-de-sac, the right hand then pushes a long pair of forceps through and into the vagina, an ordinary rubber drainage tube is then pulled through into the peritoneal cavity and left *in situ.* The other end drains into *the vagina.* Not altogether a safe proceeding, it seems to me, but where the results are so good it is hypercriticism to find fault.

His operations for total extirpation are done in another room.

The merit of Martin's procedure is that there ought to be very little blood lost and that the bleeding points can be easily made out and secured.

After making the first or posterior incision the vaginal wall and peritoneum must be firmly united by at least four sutures, and the incision should not be continued until all the bleeding has ceased, then it can be carried around, sutures being made as one advances. The only really difficult part of the operation is in getting hold of the lig. lata and passing the thread. If the uterus should be friable, or if the posterior adhesions are intimate and extensive, there will always be trouble.

Of Dr. Gusserow's and Dr. Landau's practices I have already written so fully (letters in the *Journal of the American Medical Association*) that in attempting anything further I should only be recapitulating. They represent the more conservative element of gynecology, a branch that is rapidly assuming large proportions and which has built up a well earned position among those whose clientèle numbers the rich and affluent. I do not know how largely they make use of the many adjuvants which characterize such fashionable practice at home, and whose use is very generally attended with such marked inprovement in symptoms, but I do know that they are not so prone to amputate cervices as many others, and that they believe much