stomach; that they can't bear the taste of that "horrid stuff." I tell you, gentlemen, after a good many years of experience, that cod-liver oil can *always* be tolerated, provided you do your whole duty as a physician. First then, see that you have a good, pure, and sweet oil, and that it *is* cod-liver oil; for it is not always cod-liver oil that is sold as such. Nor is all that *is* cod-liver oil fit to put in your patient's stomach. Now if your patient can take it straight, with a table-spoonful of whiskey after it—all right. If the stomach revolts at it or rejects it, you may have to make an emulsion of it with Pancreatin, or a pancreatic emulsion, reducing it with the oil till it is of sufficient consistence, and then add some syrup—syrup of hypophosphites if you prefer—and you have a mixture that almost any stomach will tolerate. If you feel fearful that you may make your patient a drunkard by administering liquor in this way, let me assure you that in all my experience I have never known of such a case. I do not know why, but I suppose the oil prevents the deleterious action of the alcohol on the tissues.

Did this case present evidence of organic changes going on in the spinal column, I should at once proceed to adjust some suitable external means of support—the plaster jacket, the felt jacket, or some other means of allowing the bones and cartilages to resume their normal condition, if that were still possible; and if they had undergone such structural change as to preclude the hope of restoration, to at least secure anchylosis in the best possible position.—*Kas. City Med. Record.*

THE TREATMENT OF GUNSHOT WOUNDS.

We give herewith the following extract from a lecture delivered in Bellevue Hospital by Sir William MacCormack, of St. Thomas's Hospital, London. Speaking of the Franco-German war—he said, we had certainly a large number of operations to perform immediately, in the line of amputations and dressing fractures and wounds of all kinds, but we left all resections until a later date. Such a vast and varied experience is rarely given to any one in so brief a time, and, of course, we availed ourselves of the opportunity as well as we could. We, however, had numerous difficulties to contend with, for we were treating French soldiers who were demoralized by defeat, and, on account of the vast number of patients, they suffered for a time from inadequate nourishment and from an insufficient supply of appliances necessary for all. It was only for a short time, however, that we were thus embarrassed, for soon large extra supplies were forwarded to us. Yet at that time we did not have the advantages of the antiseptic methods of treatment which have since effected such favorable results, and it was quite distressing to see, in spite of all our care, our patients, with wounds and compound fractures, die of blood-poisoning or erysipelas, which spread from one to another.

I said that we left our resections for a later day. I agree with Von Langenbeck that we should be very careful how we perform resections as primary operations under such circumstances. Primary resections are not satisfactory, or favorable to life, and I think they are infinitely risky. These late resections then performed were many of them on soldiers who were soon after sent away, and they could not be all followed up, but very satisfactory results were sometimes obtained. There are many reasons why such operations as resections should be performed late, after the primary inflammation has subsided, for, after that time, those cases in which amputation should be performed have been selected out, and, besides, the numerous small pieces of bone which are always found in comminuted fractures about the joints have become separated and have disappeared in the discharges, so that the amount of bone that can be saved may then be determined more accurately. A fracture made by a gunshot wound is almost always a comminuted fracture, and later on you can always ascertain the limitations of the diseased process more accurately than at first. We can however, here perform partial operations immediately, and I think that recent experience has clearly shown that these partial operations are not only less dangerous than primary resections, but that they are often followed by more satisfactory final results. Later on, the periosteum about the fractured bones becomes thickened and tough, and rapidly produces new bony tissue, while in the early period the periosteum over a newly fractured adult bone is especially thin and easily torn, besides which it possesses very little osteogenetic power. For these reasons I think that resections are more wisely performed at a late period. * *

I think, then, that I have shown you, in the first place, that operations of this kind—namely, resections—had better be performed in the secondary period, that they had better be partial if possible, and that certain joints, viz., wrist, ankle, elbow and shoulder joint, are more fitted for operations of this character than others.

Now, another thing which I think I have learned, and desire to teach you, is to avoid probing gunshot wounds altogether, or as far as possible. I have seen great harm come from this practice, and the fact cannot be too strongly impressed upon you that the bullet itself is of very little importance in these cases. I know that nearly always the first thing that a patient who has been wounded will ask the surgeon is, "Where is the bullet lodged?" and then he will expect to be relieved by its removal. I think that under these circumstances the surgeon is too often apt to be so inconsiderate as to try to