obstinate corneal ulcers and in suppuration after corneal wounds. He details one case in which this method was very effectual, and refers to others in which he has been satisfied with its results. He advises that the water be heated in a test-tube, or some other vessel, in order to secure a certain temperature, and then transferred by means of a dropper and applied as before described.—*Therapeutic Gazette.*

INTUSSUSCEPTION.—Lindeman (*Berl. klin. Wöch.*, June 27th, 1892) reviews the statistics of cases of intussusception, and says that out of sixty-six only twelve could be saved by an operation. Senn reported two which he had treated by inflation with hydrogen gas, and these recovered. One point was especially noticeable in going through the literature of the subject, namely, that in those cases which died after a simple laparotomy and disinvagination of the intussusception death took place a very short time afterwards, on an average about sixteen hours. This early death the author attributes to shock consequent on the pulling and stretching of the invaginated part of the intestine during disinvagination. Lindeman reports a case of intussusception with gangrene in a boy, aged eleven, who, whilst being treated in Berlin for middle ear disease, was seized with abdominal pains and vomiting on July 27, 1891. On July 29 the bowels were opened after introducing calomel, but the boy got worse and vomited everything. A tumour was found in the left epigastrium which extended downwards towards the pelvis. On August 1st he was sent to the Augusta Hospital for operation. He was a lean weakly-built boy. A rectal injection was given but only blood-stained shreds came away. Small doses of opium and a large water injection were tried, but without producing any amelioration of the symptoms. Laparotomy was performed, and the small intestines pulled out and laid upon warm cloths. The intussusception was found to be in the colon, the lower part in the right iliac fossa and the neck or upper part just below the margin of the left ribs. This intussusception was disinvaginated with some difficulty: at one point the intestinal wall was found to have a gangrenous patch about the size of a sixpence. Owing to the general condition it was considered not advisable to perform resection. The gangrenous part was fixed in the abdominal wound and the remaining part of wound closed with wire sutures. The patient was put to bed and fed on small quantities of wine and water and opium given at night. Next day he was much better. An artificial anus formed in the position of the gangrenous part of the gut, and all went well till August 21st, when the boy had an attack of typhoid fever. On October 22nd, having recovered from the fever, closure of the artificial anus was attempted. The intestine was forced from its attachment to the abdominal wall; only a small spur was found to exist, so the edges of the artificial anus were freshened and the opening closed with sutures of silk. The intestine was then dropped back into the cavity of the abdomen and the abdominal wound closed; this healed by primary union, and the boy was discharged well on November 22nd.—*British Medical Journal.*

PERFORATION OF UTERUS BY THE CURETTE.—

Lannelongue (*Arch. de Tocol. et de Gynéc.*, May, 1892) employed the curette for a woman, aged 64, a 4-para. The patient had total prolapse, with metritis. After dilatation, the irrigating curette was used; it seemed to pass indefinitely far without resistance, and the injected fluid did not return. As perforation was evident, vaginal hysterectomy was at once performed. The uterus was very flabby, and had been perforated at the angle between the body and the neck. The patient recovered. In a second case, the patient was 31, also a 4 para. She had endometritis and slight salpingo ovaritis. There was cystocele, rectocele, and ruptured perineum. After dilatation, the irrigating curette was used. In scraping the right cornu, it was noticed that the injected fluid ceased to return, yet the instrument did not seem to have passed beyond the uterine cavity. As the patient was young, and perforation not absolutely certain, the uterus was not removed. The cavity was swabbed, the cervix, much hypertrophied, was amputated, and colpoperineorrhaphy performed. By the second day the abdomen became distended; next day stomatitis set in and poisoning by sublimate was suspected; on the tenth day, diarrhœa occurred with albuminuria. On the nineteenth, erysipelatous patches appeared on the forehead, and the patient died; a soft, solid tumour had developed in the