

well padded iron troughs shaped to fit the limb above and below the knee. These troughs are connected with an adjustable hinge having a circle stop which will permit the splint being applied and firmly held either straight or flexed at any desirable angle. It can thus be used straight in treating fractures of the patella, or bent to meet the requirements when used in other cases. The two screws shown underneath the brace can be turned by a removable thumb-key and are attached to sliding heads running in slots cut in the troughs. To these heads are attached the straps C C which places the amount of traction on the patella completely under the control of the operator. Underneath these straps are placed two well fitting pads which hold the patella in its proper position. The bands B B are made use of to prevent the pads from slipping too far over the patella. The bands A A hold the extremities of the splint firmly to the limb.

In applying the splint the bands A A and B B should be first adjusted; then after tightening the straps C C (using the buckles), traction can be made with the thumb-screws until the edges of the fractured bone are brought together. If, however, the ligamentum patellæ is too strong to be overcome by this measure and thus prevents a complete reduction of the fracture, I believe it would be safe to perform at least partial tenotomy of the ligament and thus render its reduction by this method possible. Whether or not the pressure of the pads will cause sloughing in some cases I have not been able to determine, for in a country practice cases of this kind are seldom met with.

I have had several surgeons examine the splint and they all believe the principle to be a good one.

I have not had the opportunity to make a practical test of the splint since I had it made, and in presenting it to the profession I hope that some one who may deem it worthy of a trial, and having an opportunity of trying it, if not for a fracture of the patella, some other accident at or in close proximity to the knee, will report the result."

TREATMENT OF PALMAR GANGLION.—The *Lancet* June 27, 1885, lays down the following rules for treatment of palmar ganglion, as in accord with, the best and most recent views of surgical authorities on the subject. The first point of importance is to attempt the cure of the cases as early as possible. No good can come of delay, which merely leads to greater distension of the cyst, and is especially to be deprecated as endangering the adjoining tendons, which become stretched, and even in some cases severed, by the pressure to which they are subjected. Second, the free evacuation of the cyst and the removal of all the "melon-seed bodies" it contains, whether these be free in its interior or adherent to its walls. For this purpose an incision about an inch and a half long, not a

puncture, should be made in the most prominent part of the swelling, above the annular ligament, avoiding, of course, the radial vessels and the tendons, which can be felt through the skin. Pressure should be made in the palm to force out the fluid and as many of the loose bodies as will thus escape. Then a sharp spoon should be introduced, and the whole cavity scraped, to detach any "bodies" which may be still fixed to the synovial membrane. The "spoon" is much the best means of doing this. Some have trusted to injecting a fresh stream of fluid into the cyst, but this will not remove "bodies" which are still firmly adherent to the cyst-wall.

Volkman passes a large drainage-tube through the cyst, and draws it sharply to and fro, and trusts to that to detach any adherent "bodies;" this is, however, an uncertain method, and if the cyst be old and large, with pouches extending from the main cavity, they escape the friction of the tube altogether. Having thus carefully removed all the contents of the cyst, whether solid or fluid, a solution of chloride of zinc, 40 grains to 1 ounce, should be applied to the whole interior of the sac, the purpose of this being so to modify the nutrition of its lining as to prevent any recurrence of the dropsy. A solution of iodine has been used for the same purpose, and some surgeons may be inclined to use iodoform instead. The most important steps in the treatment are those to be taken to secure healing of the wound without supuration, at any rate without septic supuration. As a preparatory step the parts must be thoroughly cleansed before the incision is made, and the operation should be conducted under an antiseptic spray or irrigation, and some efficient antiseptic dressing should be finally applied. A drainage-tube should be introduced into the wound and passed down beneath the anterior annular ligament, and only removed when the discharge through it is reduced to a minimum.

Dr. Weiss shows that if pressure be carefully applied over the palmar part of the cyst, all retention of fluid can be carefully obviated. The hand should be kept fixed on some kind of splint applied to the extensor aspect, until the wound inflicted is healed. As soon as that is accomplished, the fingers should be liberated and the patient be encouraged to move them. The results of this treatment are entirely different from those formerly met with. When the antiseptic precautions are carefully carried out, there is no danger whatever of blood-poisoning or of profuse local suppuration, and the final result is the restoration of a thoroughly useful hand. The tendons are not bound down by cicatricial bands, and after a time it may be impossible to find any trace of the previous mischief beyond a linear scar in the forearm. Weiss considers that the process of cure of the synovial cyst is analogous to that obtained in a