ter, inasmuch as the "safety" point is the principal one. As to the other letter, as Mr. Buxton agrees with Mr. Braine, I need not enter further into this point, nor need I dilate much on the sequelæ point, as Mr. Buxton agrees with me in considering that the after-effects of ether are far worse than those of choloform. I think few doubt this. When the ether wave came from the West I made an experiment on myself, and in consequence obtained an accurate idea of what I should think must be the prodromata of suicide. Later, when I tried the drug on patients, I found that whilst the symptoms preliminary to complete anæsthesia were no less terrifying than those of chloroform, the symptoms succeeding were far worse and more prolonged. One old gentleman on whom I operated for cataract had a profound melancholy for several months, which he attributed to ether; and I was repeatedly asked by the matron of St. Paul's Eye and Ear Hospital not to give ether, as the patients were so much more sick and ill, and longer in recovery.

Since writing the above I have received from the Registrar-General a return of the deaths from chloroform and ether—practically of chloroform alone—for the ten years 1864-1873. The numbers are: males 106, females 24, total 130. The lowest year was 1866, with four males to one female; the highest year was 1872, with 19 males to 4 females.

The following is the copy of the Report furnished me by the Registrar-General:

ENGLAND AND WALES.

"*Deaths from Chloroform and from Ether registered in England and Wales in each of the years 1874 to 1883.*

Year.	Males.	Females.	Persons.
1874	13	6	19
1875	16	5	21
1876	20	6	26
1877	12	7	19
1878	13	6	19
1879	14	9	23
1880	17	9	26
1881	24	7	31
1882	27	10	37
1883	24	9	33
Total in the 10 years	180	74	254"

—Dr. Walker in *Lancet.*

FALSE DOCTRINES IN THE TREATMENT OF FRACTURES.

A paper on this subject was read by Dr. John B. Roberts, in the course of which he said: The great point in the treatment of fractures is, not the kind of dressing that is used, but simply the keeping of the parts at rest. Very little ensheathing callus is formed if the parts are held in coaptation. This is proved by post-mortem examinations. Where the fracture involves the joint, it is important that careful passive motion be commenced at as early a period as possible. Where the joint is not involved, there is no need of passive motion, and hence should not be commenced sooner than the fifth week. Passive motion should never be made while acute arthritis is in progress. Again, splints are frequently worn too long. In simple fractures of the fibula, one week of confinement is all that is necessary. In compound or otherwise serious fractures, a much longer period is required. Another erroneous view is that which opposes the conversion of simple fractures of the cranium into compound, where the case is obscure and an accurate examination can not otherwise be made. The danger of the wound is rendered little, if at all, more serious, and a definite diagnosis can be made. Another error is in the treatment of fractures of the nasal bones by the application of splints or adhesive strips. The proper method of holding the fragments in apposition is by transfixion with pins. Another error in this connection is the placing of canulæ in the nasal cavities to aid in holding the fragments in position.

The important factor in the treatment of fractures of the clavicle is to apply such a dressing to the sternal end of the bone as shall prevent it from sliding forward, as it would do from the weight of the upper extremity. This is to be accomplished by entending the angle of the scapula, and not by the wearing of an axillary pad, which can not succeed in holding the bone in position, unless the pad be so large as to render its use unadvisable. He also claimed that the use of the angular splint for fractures of the neck of the humerus is an error. In fractures about the middle of the forearm, interosseous pads are seldom required if the fragments are put into accurate apposition, and the arm carried in the prone position.

Another error is the use of the straight splint in fractures of the lower third of the radius. The straight splint will do very well for the external surface of the arm, but not for the internal. In most cases the fracture of metacarpal bones can best be overcome by placing adhesive strips over the part attached to the fingers, and to a splint placed under the hand, and, if desired, projecting a little beyond the ends of the fingers.

Finally, it is an error to rely upon measurements of the lower extremities for the estimate of the result obtained from our treatment of fractures. It is surprising that, although the fact that the extremities differ greatly in length has been repeatedly brought to the attention of the profession, it is an almost universal custom for surgeons to measure their broken limbs. Very often, too, where there is no natural difference, there is an apparent one