tion is modified by the state of the rectum. We showed in a paper read before the International Congress that its height in the pelvis varied also from hour to hour according to the degree of strength or fatigue of the muscles in its so called ligaments or supports. For the uterus to lie helpless on the pelvis flow is not a normal position because every movement communicates a jar to it.

It matters little whether it is anti-verted or retroverted, as long as it is floating or suspended. The result of the appreciation of this fact will be that, fresh air, good food, removal of corsets and healthy exercise, wtth iron and strychnine, will be prescribed more, and pessaries less and less.

Principally owing to the teachings of Lawson Tait, a new method of treating peritonitis has been introduced. Instead of keeping the bowels rigorously locked with opuim he gives large concentrated doses of salines (we prefer sulphate of soda in ʒss doses), repeated several times and aided by large turpentine enemata. Dr. Baldy (American Journal. Obstetrics, Dec. '87) says the symptoms begin to subside almost immediately when the bowels commence to discharge watery stools. Osmosis takes place from the lighter to denser fluid, so that if the saline solution is many times denser than the peritoneal effusion, the latter will be drawn into the intestine and thus leave less pabulum for the microbic fermentation. Besides there will be less chance for the formation of adhesions, and even when formed they may be broken up.

Some doubt has been cast on the abilty of electricity to kill an extra uterine fœtus, and consequently laparatomy has been advised the moment intra uterine fœtation is diagnosed. We can say that 125 milliamperes of the constant current does not kill it when applied directly to it in the uterus, for in the case mentioned above, the fœtus was born alive after having had that strength applied several times. But of course it had been applied without shock.

We shall review some other advances in Gynecology in a future article.

THE MORBID CHANGES AND SURGERY OF THE NAIL.*

By J. Leslie Foley, M. D., Bishop's College, L. R. C. P., of London, formerly Professor of Anatomy, Medical Faculty, University of Bishop's College.

Mr. President and Gentlemen: I read this paper more for my own instruction than for yours, hoping that it may provoke discussion, and that I may thereby learn the views of members of riper experience and maturer judgment than my own. The nail seems a somewhat trivial and ordinary subject to occupy the minds of learned members of this Society, but it is only by contemplating the smaller objects that we are fully able to appreciate the larger; and in practice, as in life, the careful attention to little things often tends greatly to one's success. In order properly to understand the morbid changes of the nail, it is necessary to be familiar with its normal structure. Pardon me, therefore, if I refresh your memories by briefly referring to its anatomy. A nail is a peculiar arrangement of epidermal cells: the undermost of which are rounded or elongated; the superficial are flattened, and of a more hairy consistence. That modified portion of the corium by which the nail is secreted forms the matrix, and extends beneath its root and body. The back edge of the nail or root is received into a shallow, crescentic groove in the matrix. The front part is free, and projects beyond the extremity of the digit. The intermediate portion of the nail rests by its broad under-surface on the front part of the matrix, which here forms its bed. The part between the root and free extremity of the nail makes up its body. The matrix beneath the body is not uniformily smooth on the surface, but is raised in the form of longitudinal and nearly parallel ridges, on which are moulded the epidermal cells of which the nail is made up. The growth of the nail is effected by a constant production of cells from beneath and behind.

Excessive growth of nail substance occurs either by multiplication of the nails or increase in bulk. This anomaly includes the occurrence of nails in unusual places, such as on scapular region, on last phalanx of supernumerary fingers or toes, double nails on fingers or toes, etc.

Both go by the name of onychauxis or hypertrophy. These vary. In the first it appears spherically curved, glossy on surface; a grayish-white color, unshapely, thick, opaque, has a massive feel, and is very hard. When the whole nail is affected, its free border has a tendency to curve downwards. It may occur in various directions, according as it is disturbed in the vertical or transverse way (onychogryphosis). In its simplest form, it becomes clam-like. In other cases, it may curve spirally.

Symptoms. Loses its elasticity; becomes thickened. Loss of tactile sense. It is very much diminished, and reduced to a minimum. Patient unable to execute fine work, and, when enlargement considerable, incapacitated for work. When toe-nails affected, walking interfered with; and, at the same time, most unpleasant effects (inflammation and suppuration) are produced by nails enlarged laterally. If uncared for, they penetrate toward the lateral groove and grow in. In the second form they are slightly lustrous, dirty, yellowish-brown, or yellowish grayish-white. Externally, have well-marked longitudinal ribs; at

*Read before the Surgical Section of the Suffolk District Medical Society, April 6, 1887.