

sleep, nervous composure, relief of delirium, and reduction of the pulse to 100. On one or two occasions subsequently, when there was manifested a disposition of these symptoms to return, the same remedies were applied with identical results, and under the usual treatment, the case terminated in recovery.

In the *treatment of acute peritonitis*, I have not as yet tested the powers of the cold poultice as an antipyretic and antiphlogistic. I feel very sure that in this class of cases poultices, at a temperature of 70°, applied systematically at intervals of one hour, would exert a beneficial influence.

There is a certain degree of art to be observed in the preparation of these poultices. They should not be spread so thick and heavy as to weigh down the patient and cause a sense of oppression, but not over a quarter of an inch in thickness, and then reduced to a uniform temperature, as tested by the clinical thermometer. In cases of temperature not exceeding 102°, I often order a cold poultice at first made with hot water, and then permitted to cool either by the atmosphere or application of ordinary hydrant or pump water, and find in such cases the effects excellent.—Dr. Brown, in *Virginia Med. Monthly*.

#### SIMPLICITY IN THE TREATMENT OF FRACTURES.

We should always bear in mind the three cardinal points which govern the treatment of all fractures:

1. Make an accurate diagnosis, if you can do so without doing damage to the parts already injured.
2. Restore the fragments to their normal position.

3. Apply such an apparatus as will keep them there and immobilize them.

How much more satisfactory would be our results if we would always keep these three points before us! There are also three things which I would impress upon your minds by my remarks, and they are these:

1. That the treatment of fractures is not as difficult a proposition as it sometimes seems.

2. That you should not treat fractures by any set rule other than the rule which says that you must keep the fragments in their natural position and thoroughly immobilize them.

3. That simplicity in apparatus will give you better results with the least amount of trouble.

Most surgeons upon their advent into the arena of actual practice are possessed with the erroneous idea that fractures are very difficult things to treat. I have seen surgeons make as much preparation for fixing up a simple fracture of the lower leg as some would do for their laparotomy. That sort of thing undoubtedly inspires

the ignorant with awe and respect, and enables the surgeon to charge large fees for his services, and might possibly serve as an advertisement for him, but such base methods should be beneath the dignity of him who relies upon his skill for his success. Confidence is what is needed, and that, of course, comes only with experience. In this enlightened age of ours the treatment even of compound fractures is not such a difficult thing with the proper understanding of aseptic methods, for we should be able to convert a large proportion of our compound fractures into simple fractures and treat them as such.

2. We should have no set rule for treating our fractures. We should make the rule fit the case and not the case the rule. I have seen surgeons work conscientiously for a considerable time to make a certain splint fit a case of Colles' fracture when the fact was that it was not the splint at all for that case; the surgeon did not fully understand the anatomy of the parts, but felt that he must make that case fit this particular splint. I have also seen a surgeon apply a roller plaster-of-Paris bandage to a fractured leg, take it off, and re-apply it in his earnest endeavor to make it fit when it would not do so, and when another kind of dressing would have served the purpose perfectly; but he was not enough of a mechanic to see it. The surgeon should study each case of fracture, its nature, the direction of the line, and the direction of the displacement, before saying what kind of an apparatus should be put on. He should study to put on an apparatus which will be light and of sufficient strength (and right here let me say that the tendency is to put too heavy splints on fractures), and which should be as comfortable to the patient as possible. Splints which fit the parts accurately are the most comfortable, and therefore splints which can be molded to the parts are the most serviceable. Heavy wooden or metallic splints are not needed. When I use wooden splints I do not have them over an eighth of an inch thick, and metallic splints I seldom use. To my way of thinking, splints which can be molded are the most serviceable, and I carry two materials which can serve that purpose—one, binder's board in strips, which, when soaked in water, become perfectly pliable, and can be molded to almost any surface; and the other is plaster of Paris, which, when made into a thick paste and incorporated into several layers of bleached butter cloth and folded into proper shape, makes a splint which can be made to fit any surface of the body, and when it becomes hard it will accurately support the parts and keep them perfectly immobilized. It is light, clean, and of good appearance. I have used this splint in almost every case of fracture of the leg below the knee and of the arm in the last three years, and I give it my unqualified approval. These splints can be made to fit