wound cannot be covered it should finally be left to granulate.

Skin grafts after Thiersh's method are not satisfactory except with special surroundings.

If the inner end is closed up, a short tube is placed in the angle also. The tubes should be removed in 48 hours, unless otherwise indicated.

The best material for sutures is silk-worm gut. Next, reliable cat-gut. Tension sutures of large silk are appropriate sometimes.

The ordinary iodoform and gauze dressing is to be applied. The wound will be redressed in 24 hours, the drainage tubes so placed in the dressing that they can be taken out next day without disturbing the overlying gauze. The arm bound loosely in a sling. Redressing will depend on the nature of the wound. If there is no surface left to granulate, redressing will not be required unless some accident permits suppuration. The granulating surface must, however, be looked after. The patient may be allowed to be up about the fourth day if she does ordinarily well. Even in granulating cases I think the patients do better out of bed,

If the resulting cicatrix looks unhealthy, or if the wound fails to heal, it is unwise to be in a hurry to operate on it, as such conditions frequently ultimately get well.—*Med. Mirror.*

CATARRHAL GASTRITIS.

In examining an old work published at the beginning of this century, giving an analysis of the admissions to the dispensary of Plymouth, England, I was struck by the nosologic entities that have disappeared from the average statistical table in the last ninety years. Among others, the general term febris has given place to a better nomenclature of the pyretic diseases. Anasarca has been succeeded by terms that reflect a better understanding of the protean conditions that underlie this symptom-group. Atrophia, convulsio and palpitatio have shared a like fate. The term dyspepsia, however, seems to occupy the same place, in our nomenclature that it filled at the beginning of the century. The cause of this is to be found in the obscurity that has until recently surrounded the organic and functional disorders of the stomach. Of late, an immense gain has been made in our knowledge of the diseases of this viscus, notably in the increased precision attending the examination of the stomach-contents. It would seem as if the time had now arrived for discarding the term dyspepsia altogether as a pathologic entity and of relegating it to the limbo of broad symptom-groups occupied by such terms as heart-disease, paralysis, and deafness.

W. H. Flint, in his excellent article on the disorders of the stomach in the *Reference Handbook of the Medical Sciences*, does not use the term. It is true that so able a clinician as Dujardin-Beaumetz, as late as 1886, insisted upon retaining the designation, though he significantly referred to the fact that his pituitous dyspepsia is called by the Germans catarrh of the stomach. Dyspepsia, too, remains a convenient term for the manufacturers of certain digestive ferments who advertise their wares as useful in dyspepsia, overlooking that by so doing they are as unphilosophic and uncientific as they would be in exploiting a remedy for the cure of blindness, paralysis, or fits.

The term dyspepsia is proper when it is used to express a condition, just as debility and nervousness are used, but the former is in no sense a diagnosis more than is the latter.

The American people are said to be a nation of dyspeptics, and by all odds the most frequent form of stomach-trouble presented by them is the simple chronic catarrhal gastritis. By this term is meant a slight degree of inflammation of the mucous lining of the organ, which in the mildest cases does not present any appreciable structural change. It is invariably accompanied by an over-production of mucus and an impairment of the digestive power, though fairly good digestion is compatible with the lighter forms of the disease.

Catarrhal gastritis is an affection frequently found associated with or complicating other disorders, both acute and chronic. On looking over my case-books for some years, I find that a diagnosis of chronic catarrhal gastritis has been made 118 times. Carefully examining these records, I find that there are only 17 cases in which the disease can be considered primary; that is to say, excluding all cases in which the disease was associated with heart and lung diseases, liver and renal disorders, rheumatism, anemia, and neurasthenia. So intimate is the relation between the condition last named and catarrhal gastritis that Bartholow regarded neurasthenia as but an effect of the diegestive trouble, claiming that there was no symptom belonging to the category of neurasthenia that may not be due to purely reflex causes having their origin in the digestive tube. This view, while it is not to be accepted in its extreme application, has a certain basis of fact in that a large number of neurasthenics present more or less disturbance of the digestive tract, and very commonly the clinical picture of catarrhal gastritis that has existed for years without the patient presenting any of the symptoms of neurasthenia.

Of the 17 cases in which we could exclude all complicating disorders and the grosser structural alterations, such as ulcer, tumors, and dilatation, the symptomatology was briefly as follows: In 12 cases the tongue was heavily coated; in 3, slightly coated; and in 2 it was clean. Constipation was present in 11 cases. Pain in the epigastrium, both on pressure and after eating, was present in