

merely represented by a stump, owing to exfoliation of the whole of the first phalanx. There was, moreover, thickening of the corresponding bone in the little finger of the left hand, and the patient stated that this finger recovered without any abscess forming, some years ago when his hands were affected. Over the middle of the metacarpal bone of the left thumb there was a deep cicatrised hole. All these lesions developed when the patient was about fifteen years of age. At that time he had been apprenticed to a saddler, and in the course of his trade he was required to hold between his knees a large contrivance, commonly seen in saddlers shops, for keeping the piece of work in position while the latter was being sewn. The result of the pressure applied by his knees was the development of a large abscess on the inner side of his right thigh, which, at the time, was opened, while on the left side, in the corresponding situation, a hard lump, freely movable, could now be felt, which was undoubtedly the calcified remains of an abscess. On inquiry, a strong family history of tuberculosis on his mother's side was elicited, a number of his maternal relations had died of phthisis. No lesion of the skin had developed in this case.

The last case was one of mercurial teeth. The patient, a young man of 23, came to show himself, whose teeth were typical of those which had suffered from the effects of the administration of mercury in early life. The enamel was defective, the teeth were thin and discolored, and the first molars, as was usually the case, wholly carious, while the bicuspid were fairly good. On inquiry it was elicited that he had had convulsions in infancy, for which so-called soothing powders were given containing mercury. Associated with convulsions it was common to find lamellar cataracts, and examination showed that in this patient this lesion was present, though not to a degree which interfered much with vision. There was no reason for supposing that the administration of the mercury had anything to do with the development of the opacities in the lenses.—*The Medical Press.*

A NEW METHOD FOR REDUCTION OF FRACTURES OF THE LOWER END OF THE RADIUS.

The particular method of reducing fractures of the lower end of the radius, to be described, has proved so satisfactory during the past few years in my services at the Pennsylvania and Polyclinic Hospitals and elsewhere, and in the hands of others to whom I have frequently demonstrated it, that I now feel justified in giving it wider publicity. The method is as follows:

The surgeon stands in front of the patient and interlaces his fingers beneath the supinated wrist

and palm of the injured member, so that his two index fingers lie crosswise beneath the lower end of the upper fragment of the radius. The palms of the surgeon's hands are then closed in upon the thenar and hypothenar portions of the patient's hand respectively, while the surgeon's thumbs rest parallel lengthwise upon the upwardly displaced lower fragment of the radius. The parts are thus firmly grasped by the surgeon while the following movements are made: The patient's wrist is excessively extended by carrying his hand upward. When hyper-extension has thus been secured the surgeon makes powerful traction upon the wrist in line of hyper-extension. While this traction is maintained the hand is suddenly carried into full flexion, and at the same time powerful downward pressure upon the upwardly displaced lower fragment of the radius is made by the surgeon's thumbs opposed by the interlaced index fingers beneath the lower end of the upper fragment.

The excessive extension of the first portion of the movement has always, so far in my experience, loosened or disentangled the displaced lower fragment, while the subsequent traction, flexion, and direct thumb-pressure have not yet failed to accurately force the lower fragment into its proper position. Separated epiphysis of the lower end of the radius is likewise easily reducible by this manipulation. For comminuted or complicated or very oblique fractures extension and moulding alone are called for in most instances.

Anesthesia is unnecessary for making a single effort at reduction by the proposed method. The patient does not anticipate what is coming, the two movements are made with lightning-like rapidity in a small fraction of a second, and, in nearly every case, perfect reduction has been accomplished before the patient realizes that he has been hurt. Should the manipulation fail to secure perfect reduction at the first attempt, I would not repeat the manœuvre until anesthesia had been induced, for the pain of repeating it would be intolerable. Failing in one effort, then, I would etherize and try again, first this, and afterward, if necessary, any other method that seemed advisable to secure perfect reduction. But thus far in cases that have been seen within a week of the accident I have never had to anesthetize since evolving the method mentioned; all have been reduced at the first attempt.

In cases older than one week, with displacement persisting, I anesthetized before making any effort at reduction. The new method may then first be resorted to, and will often be found the best means of performing refracture and reduction.

For making a diagnosis I have also found a modification of this method most useful. If the surgeon will take the hand and wrist in which fracture is suspected into his hands, as above