six months. On admission he was seen to be a strong, muscular young man. He complained of attacks of abdominal pains which caused him to roll on the floor during an attack. These attacks were accompanied with nausea, vomiting, and giddiness. Deep in the abdomen and on the left side of the umbilicus there could be felt two tumors, each the size of a walnut, very sensitive to pressure, and only slightly movable. The stools were regular, normal in color, amount, and consistency; the urine also was normal; the diagnosis was retroperitoneal tumor. Laparotomy was performed on Sept. 10th, an incision being made 15 centimetres long in the linea alba. The tumors were then found to be masses of lymph glands, each about the size of half the fist, one being situated on the left side of the root of the mesentery, and the other in the mesentery close to the small intestine. The one at the root of the mesentery easily shelled out, and was found to consist of caseating gland. The other tumor was removed with greater difficulty; it was adherent to the peritoneum, covering it, and had to be scraped away, some parts being nothing more than pus-containing cavities. After complete removal of the tumors, the cavities left were filled with a solution of iodoform in alcohol and ether, and the peritoneum united with catgut sutures over them. The peritoneal cavity was now cleansed, and the parietal wound closed with silk sutures. After the operation no further attacks of pain, nausea, vomiting, or giddiness took place. A few days after the operation an abscess formed in the abdominal wall at the seat of the wound, but this was relieved by removing the suture, and the patient soon recovered. On October 8th he was discharged quite well, and remained so till October, 1891, when he was last heard of.—*British Med. Journal.*

THE RADICAL CURE OF HYDROCELE BY INCISION.

By Dr. W. Joseph Hearn.

For many years the treatment suggested for the radical cure of hydrocele of the cord was so unsatisfactory that I was led to adopt the mode of treatment suggested by the title of this article. The first case was a boy ten years old, in the wards of the Jefferson College Hospital. The cyst was almost behind the cord. There was great danger of wounding some of the vessels should I attempt to puncture the cyst. I incised the tissues overlying the cyst-wall, and treated the case in the manner detailed below. The boy was out of bed on the second day. From the satisfactory results following the operation on encysted hydrocele, I was led to adopt the same treatment for the tunica vaginalis. I usually employ the following method: After the parts are shaved and thoroughly cleansed with soap and washed with a hot bichloride solution, I freeze the line of incision at the most dependent part of the sac. For freezing I use the chloride of ethyl, which, by the way, is the most reliable and satisfactory agent of which I know.

I then, through the frozen line, make a free incision into the sac. Catching the edges of the sac with forceps, or needles armed with ligatures, that I may hold the sac up and open, I empty and thoroughly dry it out with sterilized cotton or gauze. Then with cotton or gauze saturated with pure carbolic acid (the crystals liquefied with heat) I mop the entire cavity of the sac. A small tent of iodoform gauze is inserted at the lower angle of the incision for capillary drainage. The tent is removed in from twenty-four to forty-eight hours. But the sac and overlying skin are closed with catgut sutures, within one-half inch of the lower angle. An incision one inch long gives every facility for drying out the cavity. The line of incision is covered with aristol or iodoform, and then covered with antiseptic dressings and rubber dam. Purulent inflammation never occurs if strict antisepsis has been observed.

Where the patient is timid or prefers it, ether can be used with great satisfaction, but it is not necessary. There is no more pain, and the recovery is just as rapid as in the carbolic acid injections, which I have always used and preferred previous to this mode of treatment. It is not claimed that this mode of procedure can take the place of partial excision or Volkman's operation in those cases where the sac is covered with calcarous plates or so thickened that the walls cannot collapse. It is adapted only to sacs with thin walls, whether they be translucent or not.—*Therap. Gazette.*

SYPHILIS AND PREGNANCY.

Fournier (*Gazette des Hopitaux*) believes that two of the most important factors in the diagnosis of hereditary syphilis in a family are great frequency of abortion and high infantile mortality. Abortion is least frequent when the father alone is syphilitic, more frequent when the mother alone is syphilitic, and most constant when both parents are infected. In the latter cases as many as nineteen abortions have been known to occur. Fournier attended a family in which the first three children were all born at term and all robust. Then the father contracted syphilis, and his wife became infected; she aborted three times in succession. Fournier found that at the Lourcine Hospital 145 out of 167 of the children born of syphilitic mothers died in the institution. Collecting