

testifying to the unsatisfactory state of the therapeutics of the thyroid as well as to the success of my labors. This is most gratifying to me, and greatly to the credit of my professional brethren, well illustrating their broad and progressive spirit in contrast to the opposition to methods electrical manifested in other quarters. Improved apparatus and methods have retrieved past failures, and rendered possible results hitherto unattainable.

The discussions elicited by my former papers disclosed a decided variance of opinion as to the value and range of applicability of electrical treatment, and demonstrated the need and incalculable usefulness of our Association. I have again to report progress and state the deductions from a year's further experience. My aim has been to shorten the period of treatment, while extending the interval between *séances*, to improve technique and to discriminate the treatment most appropriate to each case.

The percutaneous method, using strong currents by means of flexible clay electrodes, has received considerable attention. I have found it very tedious, and have come to the conclusion that its chief utility lies in combating the hyperæmic condition, in reducing simple hypertrophy, in stimulating liquefaction and absorption of recent fibroid growth, and lessening the œdema of older cases preparatory to more active measures. It may also be employed where puncture would not be well borne, and occasionally to alternate with puncture treatments.

Thyroid hyperæmia occurring at the menstrual period or during pregnancy, and disappearing at their termination, does not call for interference, unless there be accession of size at each period or gravid state. Galvanization of the sympathetic should then be resorted to, with occasional clay pad percutaneous treatment if necessary. This remark also applies to goitrous cases of amenorrhœa, whether primitive or secondary.

In the slighter forms of hyperplasia, the clay electrode treatment is indicated, the positive electrode at the back and the negative over the goitre, starting with 20m.a. to 30m.a. The patient will, after a few sittings, gradually tolerate 100m.a. to 150m.a. for ten or twelve minutes two or three times a week.

In vascular forms, by diminishing excessive blood-supply and stimulating absorption, we induce a process of partial atrophy. The negative electrode, a large clay pad, is placed at the shoulders, while the active surface of the positive (a properly insulated platinum needle) is introduced within the capsule of the gland alongside a tenotomy knife. Of course, a local anæsthetic is first used. From 50m.a. to 150m.a. should be employed for eight to ten minutes every ten or twelve days.

In distinctly fibroid forms, the nutritive process may be lessened by the positive puncture, with occasional resort to the negative needle to hasten absorption. In some advanced fibroid cases where, owing to the small proportion of healthy tissue left, the process of absorption and atrophy was slow, I have hastened matters by the formation of a central cavity or artificial cyst. This I have done by large negative needles, treating it as an ordinary cyst and maintaining drainage. It requires specially careful manipulation. In very large fibroids, I frequently discard the clay pad, and use instead a second needle in another portion of the growth.

Thin-walled unilocular cysts are the most amenable to treatment. The positive pad is placed at the shoulders, while the negative electrode is an insulated canula, through which the cyst is aspirated and a solution of chloride of sodium introduced. From 50m.a. to 100m.a. is employed for ten minutes, the cyst again emptied and firm pressure maintained by broad adhesive straps. A single treatment may suffice, but frequently in the thick-walled and