for two days in smaller doses and at longer intervals, and then discontinued.

Two other equally typical cases are also recorded in this paper.

PHYSIOLOGICAL REST IN THE TREATMENT OF PROLAPSE OF THE RECTUM.

Bryant (*Mathew's Medical Quarterly*, vol. i., No. 4) reports the case of a man operated on seven times for the relief of extensive prolapse of the anus, with its attendant distressing symptoms. Until the last operation, surgical intervention had been of little benefit. Bryant, to whom he finally came, made an artificial anus in the left groin, putting the patient to bed for two weeks, meaning to proceed to further treatment. But this operation was followed by so much relief and by such a marked diminution in the pressure that he was content to adopt no further procedure. He submits the following propositions as a conclusion to his paper:

That the proper performance of the physiological functions of the rectum contributes greatly to the advancement of rectal disease and to the sufferings of the afflicted.

That the complete vicarious discharge of the fæces through an artificial anus located in the sigmoid flexure reduces the physiological demands on each structure of the rectum to a minimum.

That the lessening of the physiological requirements is commonly in direct proportion to the diminution of the fæcal flow through the rectum.

That the cessation or lessening of the fæcal discharge per rectum exercises a palliative and curative influence on diseases of the rectum.

That in certain cases of obstinate rectal prolapse the formation of a vicarious channel for fæcal discharge is justifiable, both as a palliative and curative measure.

That the preliminary establishment of such a channel for the purposes of cleanliness and the prevention of infection is justifiable in many grave operations for the prolapse of the rectum.

That the dangers attendant on the formation of an inguinal anus are much less than those invited by the contact of fæcal discharges with large operative surfaces of the rectum.

That the case just presented has been, without special risk, greatly benefited, and may be finally cured, through the agency of an artificial anus.

That when cure takes place, great care must be exercised thereafter, otherwise the prolapse will return.

DIAGNOSIS OF APPENDICITIS BY PALPATION.

Dr. George M. Edebohls strongly advocates this method of diagnosing disease of the vermiform appendix. He uses the right hand only, externally, for palpation, placing two, three or four fingers, palmar surface downward, almost flatly upon the abdomen, at or near the umbilicus. While he draws the fingers over the abdomen, in a straight line from the umbilicus to the anterior superior spine of the right ilium, he notices carefully the character of the various structures as they come beneath and escape from the fingers passing over them. In doing this the pressure exerted must be deep enough to recognize distinctly the resistant surfaces of the posterior abdominal wall and of the pelvic brim. Pressure less than this will fail of its object. The appendix is recognized, on exerting this necessary pressure, as a more or less flattened, ribbon-like structure, when normal, or as a more or less rounded and firm organ, of varying diameter, when its walls have been thickened by past or present inflammation. When it is the seat of inflammatory changes, it is always more or less sensitive on pressure; normally it is not so. A good guide is formed by the right common and external iliac arteries, the pulsation of which can easily be felt. The appendix is generally found almost immediately outside of them. Its origin is practically always at McBurney's point, and at its base it is separated from the iliac arteries by a space of one-half to one inch, while lower down in its course it usually crosses very obliquely the line of the arteries. Starting from McBurney's point, any deviation from its usual course can easily be recognized.

The author gives one broad rule as regards operative interference in appendicitis: not to operate in chronic cases unless you can feel the diseased appendix, nor in acute cases unless by palpation you can recognize either the diseased appendix or the presence of a tumor. Anæsthesia, in some exceptional cases, may be necessary to decide the question.—*American Journal of the Medical Sciences*, May, 1894.

THE DANGER OF ANÆSTHETIZING DIABETICS.

Baxer (*Deut. Med. Woch.*, 1894) calls attention to the danger of narcotizing diabetics. He has reported three of his own cases and nine collected from medical literature. Even in slight cases of diabetics the patients became comatose and died. Coma did not develop until after the chloroform narcosis had passed off, in twenty-four to forty-eight hours. The patients then became indifferent, stupid, and confused. Finally, lost consciousness, urine and fæces were passed involuntarily, and they perished in coma. This communication is important, since it shows that the administration of chloroform is dangerous even when there is a slight degree of diabetes, it being impossible to predict whether or not coma will develop.