the inflammation extend into the joints, or the pus find its way into the palm of the hand. The finger in this affection soon becomes swollen and flexed, and is the seat of severe throbbing pain, the part is hot, and in the latter stages deep-seated fluctuation may be recognized. If this is allowed to progress, the whole finger may become involved, so as to present two swellings separated by a constriction corresponding to the joint.

The treatment of this affection is identical according to Mr. Allingham, with that of periosteal whitlow, from which, in fact, the tendinous inflammation can only be recognized with very great difficulty. Mr. Allingham is strongly in favor of treating these affections by lateral incisions, for on account of the difficulty of recognition of the locality of inflammation should the inflammation be confined to the periosteum, the central incition must be carried through the tendons to reach she bone, of course unnecessarily damaging the tendon. Mr. Allingham, therefore, recommends lateral incision, claiming for it the following advantages:

First.—As it is difficult to tell whether the whitlow is periosteal or tendinous, by the lateral incision, if it should be periosteal, no damage is done to the tendons by cutting through them.

Second.—By lateral incision the tendons cannot prolapse from their sheaths, and therefore the liability to gangrene is diminished.

Third.—After this method of treatment the finger can be flexed, and so relax all the structures and relieve pain, whereas by the central incision the finger should be kept straight, to prevent the tendons slipping out of their sheaths, at the same time straightening such inflamed part greatly increases the pain.

Fourth.—If the incisions are on the side they they are less likely to be pressed upon, for the cicatrix may become tender, which, if in the centre of the hand, is exposed to pressure every time the hand is closed. Again, a cicatrix in the middle line may contract, and cause the finger to become permanently flexed, whereas, if the incisions are at the side, such a result could not take place.

So much for the most recent opinions as to the surgical treatment of whitlow, a mode of procedure which is unavoidable when pus has collected.

The less severe forms of furuncular inflammation may be aborted in many cases, according to Dr. Weiss (*Medical Record*, November 27, 1886), by the inoculation of resorcin, a plan which he has employed, as follows:

A number of shallow parallel incisions about one-quarter of an inch long are made in and around the lesion and through the integument, pain being prevented by the use of a twenty per cent. solution of cocaine and ten per cent. resorcin. Lanolin salve is then applied in a very thick layer to the scarifications. The entire part is enveloped in a strip of lint, which, in turn, is to be thoroughly saturated with the salve, and over this a layer of guttapercha tissue, absorbent cotton, and moist gauze bandage may be applied in the order mentioned.

Dr. Weiss reports a number of cases in which the employment of this mode of treatment in twenty-four hours produced complete cessation of pain and arrest of inflammation.

Of course it can hardly be expected that this mode of treatment would operate in the more serious cases of periosteal or tendinous inflammation, but it seems well worthy of trial in the less grave forms of phlegmonous inflammation.—*Therapeutic Gazette.*

THE TREATMENT OF CHRONIC ABSCESSES BY INJECTIONS OF AN ETHEREAL SOLUTION OF IODOFORM.

Verchére (*Rev. de Chir.*, June, 1886) reports twenty-three cases which were treated in this manner, and gives the following directions in regard to the operation: The solutions of iodoform should be of varying strength, one of five per cent. being used for large abscesses, and one of ten per cent. for small ones, while small, superficial abscesses may be filled with a saturated solution. If the skin over the abscess is not affected, the needle of hypodermatic syringe is introduced in an oblique direction, so as to form a valvular fold; the pus is then drawn off, and the iodoform solution is injected. If, however, the skin over the abscess is quite thin, the pus is removed with an aspirator, and the opening made by the needle is sealed with collodion, after which a hypodermatic-syringe needle is inserted into the abscess cavity, and the injection is made as before. The object of these manœuvres is to prevent the ether from escaping through the puncture, as it at once tends to do on becoming volatilized. As the solution volatilizes, the iodoform deposited over the entire inner surface of the abscess, and is slowly absorbed—so slowly in fact that the danger of poisoning by the drug is said to be very slight. The phenomena observed after an injection are, briefly, as follows: Rapid and sometimes excessive swelling results from the volatilization of the ether, but this soon subsides. If the skin over the abscess is healthy, the abscess cavity will speedily be replaced by indurated tissue, without the occurrence of any external change. If the skin is already inflamed, it will separate in a few days in the form of a yellowish slough, after which healing will occur by granulation, the resulting cicatrix being slight. The advantages alleged for this method of treatment are the perfect safety of the operation, the rapidity of the cure, the fact that the patient is not confined to his bed during the treatment, and the non-recurrence of the abscess.

THE DOCTOR AS PATIENT.

"The study of medicine and personal devotion to the alleviation of suffering do not insure the