

rash and unsurgical. The hemorrhage must be provisionally controlled by prompt and firm pressure beneath the mastoid process, and then the vessel must be thoroughly exposed, the sternomastoid being cut across if need be. It is highly expedient, therefore, that the surgeon be not destitute of competent assistance; he must not depend for help upon the anæsthetist, for that individual may find that he has already quite as much as he can manage with safety.

If a considerable amount of diseased skin has had to be cut away, or if a layer of friable tuberculous cicatrix has needed removal by the sharp spoon, no attempt should be made to close the wound. A clear course having been made by the sharp spoon down to the depths of the diseased area, drainage will take place without special provision being made for it. But if there has been only a slight sacrifice of skin, and the surgeon thinks himself justified in attempting to secure primary union, it is better to leave in a slender piece of drainage tube, or a small strand of horse hair. There is sure to be considerable exudation following the scraping, and unless the fluid escapes freely into the dressings, it is apt to cause tension, pain, and disappointment. A scraping operation is very different from a clean incision through healthy tissues, and often there is a considerable amount of discharge for a week or more.

When a new operation is introduced, it takes some time to settle down to its true value and proper place. Too much is expected of it. Too much is promised for it. The last note, therefore, in connection with the radical treatment of tuberculous glands is one of caution. It is in every respect a most excellent operation. In some cases its success proves greater than could have been expected, but in others it proves, in the first attempt, somewhat disappointing. Experience has not yet indicated exactly what class of cases are likely to need a second clearing, but it has abundantly shown that the chief element in begetting disappointment is delay in subjecting the child to the ordeal. Another element is the paving of the way to the operation with solid promises of immediate and complete relief. The wise surgeon promises no more than he can assuredly perform, and, following the advice of a mighty statesman, he never prophesies unless he knows.—*Epitome of Medicine.*

DEATH DURING ANÆSTHESIA.

The *British Medical Journal* of January 16th, 1892, contains an interesting article on chloroform by Dr. Lombe Atthill, in which it is stated that the report of the Second Hyderabad Commission "affirms distinctly that death from chloroform is due to asphyxia." This is entirely a

mistake. The Hyderabad Commission has affirmed over and over again that the only danger of asphyxia during chloroform inhalation is that it leads to gasping inspirations, and so to rapid and frequently irremediable overdosing. No doubt the nerve centres are more susceptible to poisoning with chloroform when asphyxia is present than when it is absent.

In the same issue of the *British Medical Journal* there is a letter on "Death During Anæsthesia," by Dr. Horatio C. Wood, of Philadelphia. Professor Wood says: "Denial of the existence of the other side of the shield has been persisted in by many an honest and capable man, but in the long run the world learns for itself, and so I leave this controversy with the hope never to return to it." I trust sincerely Professor Wood will reconsider his decision and fight it out like a man to the end. The Hyderabad Commission has never denied the existence of two sides of the shield. On the one side are the true followers of Simpson and Syme. Syme's cases and my own form a series of chloroform administrations extending over forty-five years, without a single death. On the other side are Professor Wood, the Glasgow Committee, Professor MacWilliam, and their disciples the anæsthetists. On that side deaths under chloroform have been numerous, and have increased in frequency of late years in exact proportion as their teaching has gained ground.

We may well ask what is the difference between the two sides of the shield; and is it incapable of adjustment so as to make both sides alike? The main practical difference is this: The fundamental principle of chloroform administration on our side of the shield is that it is useless and dangerous to take the pulse as a guide. On Professor Wood's side, on the other hand, it is an essential principle of chloroform administration to watch the pulse continuously during the whole time of the inhalation. Our principles are founded upon uniform clinical and experimental data, and are characterized by uniform results; but on Professor Wood's side there is a conspicuous absence of uniformity in everything except the death-rolls from anæsthetics and antagonism to the Hyderabad Commission.

Our experimental data show that chloroform never affects the heart directly, and we are prepared to produce chloroform anæsthesia with uniform results in any laboratory or operating theatre in the world. If we can do this anybody can do it. The want of uniformity on Professor Wood's side is illustrated by Dr. Wood's statement that the heart is paralyzed by chloroform; by Professor MacWilliam's statement that it is dilated by chloroform; and by the Glasgow Committee's finding that the great danger of chloroform is sudden stoppage of the heart through the vagus; while the anæsthetists tell us through their cham-