scalpel as large as the meatus urinarius and the rectum would admit, without injury to those parts.

I found the obstructing membrane thicker than I supposed, and tough. I explored with the finger and cut with the knife, so as to enlarge the opening the full size of the vagina, until I felt something like the distended membranes in a case of labor just before they are ruptured. I held my finger against this membrane, as I discovered a contraction of the uterus and abdominal muscles returning, which caused a sudden rupture, and gush of restrained menstrual fluid took place, to the amount of one gallon or more, and fetid, so much so that the assistants left the room. The uterus seemed to contract periodically, and the contents would issue in a stream. I made pressure over the uterus until the discharge ceased, then injected warm water, freely and continued the injection for several days. The patient had no difficulty in voiding urine. After the operation she took light tonic and nourishing diet, and recovered rapidly without any unpleasant symptoms. She is now a healthy and fine looking lady for one of her age.

A few days previous to my being called, and after her situation became very distressing, she applied to the nearest physician, who claimed to have experience and skill in treating female diseases. He, without examining the parts, gave her emmenagogues and diuretics, furnished her a female syringe, and advised her to use vaginal injections. The medicine could do her no good, but might do harm, and the syringe she could not use.

Now admitting the above case is no novelty, and that closure of the vagina is common, I think it shows, at least, the importance of physicians being on their guard, and to examine women carefully whose menses are obstructed.

Management of Fractures of the Ulna and Radius.

By PROF. R. A. GUNN, M. D.

At the present it would seem almost useless to occupy space in a medical journal in describing the management of fractures of the forearm, if it were not for the great discrepancies found in the writings of those who are considered authority upon the subject. One author recommends an interosseous compress and circular roller before the application of splints; another uses the circular roller and afterwards applies his splints; another condemns the circular roller but strongly advocates the interosseous compress; while still another dispenses with both and applies his splints directly to the forearm. In the subject of splints as much diversity of opinion exists as in the application of bandages. Some recommend that the splints extend from the elbows to the ends of the fingers; others extend them above the elbow joint, while others again prefer that they only extend from elbow to wrist. The advocates of each of the above methods claim for their own some advantage over all others, and point out defects in all that do not agree with them. Thus we find that persons of limited experience in the treatment of fractures are likely to adopt the method recommended by the author whose works are in their possession, and should the result not be entirely satisfactory, some rival practitioner, (who may have read a different work on the treatment of such fractures,) after having learned how the case was treated, may declare that the treatment was not proper, and thus give rise to a suit for mal-practice. In court, a case is often decided contrary to the facts established, and yet the decision may be based upon the opinions laid down by generally recognized authorities. The modern surgeon, however, does not accept many of these authorities, more particularly the older ones; and yet should he fail, from any cause, to have a perfect limb, the law would hold him responsible, no matter how rational his treatment may have appeared, if he did not follow the directions of recognized authorities.

Thus we find difficulties often arising, whether the authorities are followed or not: and for that reason we think that living surgeons of large experience should be acknowledged as authority before any works that may be produced in court.

The method of treating fracture of the ulna and radius that is usually adopted at the present day, consists of two splints a little wider than the forearm and long enough to extend from the elbow to the wrist, which after being well padded, are applied to the dorsal and palmer aspect of the forearm. By careful extension and manipulation the bones are brought as near as possible to their normal position and then a roller is applied over the splints sufficiently tight to prevent their motion, and not so tight as to cause strangulation. The splints being wider than the forearm the roller is prevented from pressing the bones towards each other, and thus causing vicious union. The interosseous compress is not considered necessary, as the splints, when applied properly, press the muscles of the forearm into the interosseous space. The roller applied before the splint is not considered practical, as it may, if applied tightly, either cause gangrene by strangulation or crowd the extremities of the bones toward each other, and vicious union with impaired