pect to the ordinary nursing of the insane indeed a great revolution is necessary, akin to that which is being brought about in ordinary nursing by Miss Nightingale by the Misses Merryweather, and by their fellow-philanthropists.

CHLORATE OF POTASH AND GLYCERIN INJECTIONS IN CHRONIC DYSENTERY.

Dr. Theodore Mead advocates the injection in chronic dysentery of half a drachm of chlorate of potash rubbed up in half an ounce of glycerin and mixed with three to four ounces of warm water. This should be thrown into the bowel thrise daily, and should be retained as long as possible. He gives two cases as illustrative of the results of this plan of treatment.

1. A young man, æt. 27, was first attacked with dysentery in 1861, and had never been rid of the disease, or had a natural stool, up to June, 1868, when he came under notice. He was then having twenty to thirty stools in the twenty-four hours; was weak and anæmic; muscles atrophied; skin dry; pulse weak, and his general appearance indicated approaching dissolution. The use of opium and whisky, which had always been ordered him in large quantities during his sickness, was at once prohibited; he was given quinine, iron, strong beef-tea, and forty grain doses of subnitrate of bismuth suspended in mucilage. The injections were at once commenced, and at first gave him intense pain and were rejected as soon as thrown up, but a decided effect was produced. In a short time the unpleasant sensation subsided, and in a few days he could hold the injections an hour. In twelve days his stools were reduced to eight or ten in the twenty-four hours, and were almost free from pus or mucus. In three months he was able to resume daily work, and has continued it ever since, with no return of his dysenteric troubles.

2. In the second case the dysentery followed an attack of bilious fever, was very obstinate, resisted all the ordinary remedies, and brought the patient to the verge of the grave. The treatment was substantially the same as in the other case, and recovery was complete in two and a half months.—[New York Medical Journal, Sept.

SURGERY.

ON THE DRAINAGE OF WOUNDS.

By Prof. Wood, Kings College.

I attach much importance, as I have said, to free drainage in dressing wounds, and when made by the surgeon a good deal more may be done to favour this by a judicious choice of the direction of the incision in resections, &c., and the position of the flaps, &c., in amputations. The plan of making a puncture in the political space, proposed and practised by Mr. Jonathan Hutchinson in excision of the knee-joint is one which illustrates my meaning. The wound would, if possible, be made to slope towards that part which is most dependent when the patient is laid in bed. In amputations of the thigh, I think, for this reason, that the circular operation is most objectionable, on account of its forming a hollow funnel-shaped wound, which, in the necessarily raised position of the stump upon a pillow, holds the discharge like a bucket, only slightly tilted. Very good drainage is accomplished in the late Mr. Teale's excellent plan of a single square anterior flap. I have practised Mr. Teale's method with the best results, but for other reasons I prefer in the thigh an oblique double flap, with the outer end of the incision placed lower than the inner, and the front flap placed somewhat outside the limb, and longer than the hinder. After many trials, I am quite convinced that this both gives the most complete drainage, prevents the bone protruding, and makes a very shapely and serviceable stump, with the cicatrix placed well behind the point of pressure. An important point bearing on this matter, in favouring the escape of discharges from the interior of a wound, lies in the manner of securing the arteries. When an artery is twisted in, as in the ancient Roman system, revived by Amussat and Velpeau, and lately tried by Mr. Cooper Forster (Trans. Clinical Society, 1870). and Mr. Bryant ("On the Torsion of Arteries," Med-Chir. Trans., ii., p. 199), or when it is secured by a pin or wire, as advocated by the late Sir James Simpson, and practised at Aberdeen and elsewhere, or when it is secured by an antisceptic catgut ligature, cut off short on the vessel, as revived by Professor Lister, and tested and practised by Mr. T. Holmes, the theory is, that the wound should heal in the deeper parts as well as in the more superficial by the direct adhesive process. But this in the amputation of an extremity, or a large resection, is not the rule, and, moreover, in large cities is not usual.

Now the parts that are most disposed so to heal are the smoothly-cut, self-adapting, and vascular cutaneous tegumentary structures, and these sometimes close up by adhesion, leaving interior cavities, especially about the bone and between the muscles, containing decomposing blood or pus, which afterwards accumulate, burrow, give trouble, and delay the cure, or cause by pyæmia the death of the patient. To prevent this subsequent inconvenience. after experience of it, seems to be the only rational explanation of the continental method still employed, of stuffing the whole wound with charpie, so as to ensure healing from the bottom, which seems so strange to our notions. If we could be quite sure that by torsion, metallic or antiseptic ligatures, we could secure complete adhesion throughout, the case would be made very much stronger in their favour. But this is certainly the exception, and not the rule. There are other elements at work influencing this, even more powerful than the local treatment. Now I believe, with my esteemed colleague, Sir W. Fergusson, that so long as we have this want of entire union, ligature threads may have the advantage of keeping open channels for the escape of discharges from the close neighbourhood of the tied arteries, the accompanying veins of which are frequently the sources of effusions of blood after the wound is dressed, which afterwards clot, and may putrefy. These ligature-threads I usually have well steeped in carbolised oil, and saturated so as to be unable to absorb discharges, but utilised to spread around an antiseptic influence sometimes in deep narrow wounds. I place them within or alongside of a drainage-tube. They can thus be made into channels for the introduction of antiseptic agents to the deeper parts. and this consideration may add to the much greater sense of security given to the patient, as well as to the surgeon's mind on leaving him, by the use of a safe knot, and a string to remove it by when it has performed its work. There is one point in the section of flaps which may I think have influence sometimes upon the introduction of pus or septic matter into the cut veins. When these are cut obliquely with the face of the flap, they are opened in a large conic section in the shape of a pen, and left, when placed on the underlying flap, in an attitude well adapted for receiving and conducting into their interior pus and putrid discharges which gravitate from the surrounding hollow and often funnel-shaped sides. To obviate this, I invariably, after a flap amputation, cut off the larger veins transversely.

OBSTETRICS.

BREECH PRESENTATIONS—RAPID DELIVERY.

The infant's body is delivered with its back superior, the patient lying on her back. First draw the cord down a little way; then, if the head has passed the superior strait, the face is in the hollow of the sacrum; if not, bring it down, according to the usual rules, as rapidly as possible. Then introduce the index finger of one hand into the mouth of the child, drawing the chin down; at the same time with the fingers of the other hand push the occiput up, thus securing perfect flexion. This accomplished, the face of the child will present at the vulva; and immediately withdraw the finger from the infant's mouth, and pass two fingers into the rectum of the patient, and you readily reach the vertex and use these fingers as a lever, lifting *upward* and *outward*, while a similar movement is communicated to the body of the child with the other hand placed below it. If you are on the patient's right side, your index and middle fingers of the right hand will be against the vertex of the child; if upon your left, those of your left hand. If unfortunately you have failed to deliver the body with the back superior, and you have the face towards the pubes, the same general steps are necessary, save that the finger of your right or left hand, as the case may be, should be *kept* in the child's mouth while the upward and outward movement is made with the fingers on the vertex. This method of delivery is applicable to all cases where the body of the child is born first. By it the head can be delivered in less time than required for the application of forceps, and it is much safer for the mother at least. Pursuing it, I have never lost a child in breech presentation, or in podalic version.—*Dr. Langdon, in the American Practitioner.*

THE PNEUMATIC ASPIRATOR.

An interesting case is reported by M. Dieulafoy, in which an infant six hours old, was poisoned by a dessertspoonful of laudanum, and from whose stomach the poison was extracted, before it had taken fatal effect, by means of the pneumatic aspirator.