

edges of it drooped over and covered the fractured surfaces. This is what is usually found in the fracture and explains the want of bony union so common at this point. The edges of this aponeurosis he trimmed, washed out the clots from the joint and tissues around the joint, and, with catgut, united the lateral expansion of the aponeurosis and that portion covering the bones and completed the operation with mattress sutures of catgut, using a drain at each angle, of rubber tissue. This drain is removed in three days and passive movement allowed in four weeks.

The next was an appendicitis. He mentioned as an important diagnostic sign of appendicitis the rigidity of the lower part of rectus as compared with the upper part rigidity found in gall bladder trouble. In removing the appendix the top was torn off as it was adherent and in walling it off with the gauze he stated there was always a possibility of causing adhesion and strangulation if we were not careful in using the gauze against the small intestines, but as far as the large is concerned no such danger exists. His treatment of the stump was to invert the mucous membrane after ligating the mesentery and dividing the appendix and then with two Lambert sutures of black silk to close the serous layer.

The next patient was a soldier who had been wounded at the charge of San Juan Hill—A Mauser bullet having comminuted the left clavicle and lodged somewhere in the chest. An X ray showed it to be near the sternum and in the first intercostal space. To locate its depth he probed with an electric bullet finder whereby one can hear a click if the probe—a sterilized hat pin—comes in contact with the bullet. The hat pin must have been frequently passed during the search through the larger blood vessels, and on two occasions he remarked, "Gentlemen, the pin is now through the aorta as I can feel the impact of the blood current." The procedure is apparently harmless if the needle be aseptic, as I saw the patient at the clinic the following week and he had suffered no ill effects.

Abbe, in doing the suprapubic operation does not use either vesical distension or the rectal bag and as the next two cases were vesical calculi we had an opportunity of seeing the operation done. He, with blunt scissors and his forefinger, works down behind the pubic bone and raises up the peritoneum and prevesical plexus of veins. The catheter inserted in the incision is sutured to the skin and