

able to say "*fort mit dem Spray.*" Professor Esmarch's wonderful statistics aided greatly in confirming the confidence of surgeons in rest, support, and infrequent dressings. Much evidence was offered, and many opinions were given which supported the views of Mr. Sampson Gangee as to a dry form of antiseptic dressing. Since the Congress the dry method of treating wounds with infrequent dressings has made wonderful strides, and bids fair to supplant Listerism as a form of antiseptic treatment. Under dry dressings, wounds heal much more rapidly than under moist warmth, which encourages putrefaction. Iodoform dressings have been most generally used in Germany, but so recklessly that many cases of poisoning from it have been recorded. As much as 7 to 8 ounces have been stuffed into abscesses and excised joints at one time. No case of poisoning has been reported from Germany where less than 3 drachms was used. Wherever possible I have employed the dry form of dressing, and I think with success. My method of dressing a fresh wound (for which I claim no originality) is as follows: After all bleeding has stopped, and the wound has been accurately closed by cat-gut ligatures, and when necessary by wire ones in addition, I sprinkle over the wound a little iodoform, cover this with a strip of oil silk (to prevent adherence of the wool), and then over all place a pad of boracic cotton. This is kept in place by an accurately adjusted gauze bandage, which must be evenly and firmly applied, so as to get the amount of elastic pressure required. If necessary, as in a limb, a paste-board or other light splint (well padded) is applied. If the parts can be accurately adjusted by pressure, drainage is not required. The wound, if the patient complains of no discomfort, should not be disturbed for a week or more. When the dressing is taken down, the wound is generally found to be nearly or quite healed. In foul ulcers, this method I have found superior to every other. In some cases of accident, where the tissue is lost, or so much injured as to be beyond repair, I have generally employed the moist form of dressing till the slough has separated. Of late I have been using a solution of boroglyceride, as recommended by Mr.

Barwell. This antiseptic, as far as my experience goes, is superior to carbolic acid. It has no odour, and is perfectly innocuous.

With regard to *Inflammation*, and its connection with septic organisms. The theory that you are no doubt most familiar with is that inflammation is due to the introduction of atmospheric germs into damaged tissue, and that if this introduction be prevented, the wound heals without inflammation. Prof. Hueter, Mr. Lister, Mr. Watson Cheyne, and others, have been the most able and efficient advocates of this view. There is, however, another, and I think a more probable explanation of the origin and spread of inflammation, of which Dr. Burdon Sanderson has lately in his Lumsdalen Lectures given a clear and convincing account, viz., that "inflammation is the physiological effect of traumatism"; that the exudates of a normal inflammation are not infective; that no inflammation-producing organisms exist in the atmosphere; that whenever inflammation becomes infective it owes that property to chemical change in the exudation liquid which, in absence of any other better explanation, we attribute to the presence of septic organisms or bacteria or, in other words, exudative fluids which are infective owe that property to the exudative soil in which the germs grow, and that atmospheric germs are not *per se* a source of danger. Dr. Sanderson says these germs are not so much mischief-makers as mischief-spreaders—they have the power of developing what he calls a phlogogenic infection, and of conveying it to all parts of the body. I do not propose to discuss this question, but merely place it before you as a subject for discussion, in its bearing on antiseptic surgery. Before passing on to another subject, I should like to draw your attention to some recent experiments by Dr. D. J. Hamilton on *Sponge Grafting*, and their bearing on surgery. Dr. Hamilton some years ago showed that the vessels of a granulating surface are not newly formed, but are simply the superficial capillaries of the part that have become displaced: that the granulation loops are thrown up by the propelling action of the heart. Whilst pursuing these investigations, Mr. Hamilton was struck with the similarity