follows this kind of incision. Out of 21 of Dührssen's cases of deep incision of the cervix, 15 patients bore another child about a year and a half later. The labors, which included three miscarriages, were generally easy.—*Br. Med. Jour.*

ALLEGED VICARIOUS MENSTRUATION.—Windmüller (*Centralbl. f. Gynäk.*) aud others warmly debated this question in the course of a discussion on Grassow's paper on amenorrhœa at the Hamburg Obstetrical Society. Windmüller stated that a lady, aged 42, had never seen any vaginal "show" for thirteen years, when periodical hæmoptysis set in and occurred every four weeks, continuing till the present time. The lungs and larynx, as well as the sputum, had repeatedly been examined for organic disease with negative results. There was no hysteria. Seeligman had seen periodical hæmatemesis follow disappearance of the menses. Hot water vaginal injections were prescribed; the normal catamenia returned and the hæmatemesis ceased. He could find no evidence of gastric ulcer. Aly disputed this assertion, and Olshausen considered that amenorrhœa was simply caused by the anæmia which resulted from gastric ulcer. Schrader did not believe in vicarious menstruation. Women with amenorrhœa looked on any kind of hæmorrhage as vicarious menstruation; investigation often proved that the bleeding was merely a coincidence. He often saw amenorrhœa in pupil midwives; it lasted long, and was never accompanied by any vicarious hæmorrhage. Grassow said that such cases were due to altered conditions of life and to psychical impressions. He had seen vicarious menstruation in cases where local conditions had caused the suppression of hæmorrhage from the uterus. Ratgen stated that cases of this condition were chiefly recorded in French literature. He knew of three young girls who repeatedly had hæmoptysis at the menstrual period. Twenty years since a lady, aged 40, used to cough up cupfuls of blood at every period. The patient was still alive and free from any sign of pulmonary disease; she was very hysterical. Voigt had seen similar cases, and in one, still under treatment, there was no sign of any disorder of the lungs or larynx.—*Br. Med. Jour.*

TREATMENT OF SPRAINED ANKLE.—Dr. V. P. Gibney advocates (*The New York Polyclinic*) the treatment of sprained ankles by the use of strips of adhesive plaster. Dr. Gibney owes his indebtedness for the new method to a little book by Mr. Edward Cotterell, of the University College Hospital London. It was not until the end of 1888 that the treatment advocated in brochure was fully digested and put into use by Dr. Gibney. He had all through his previous surgical career looked upon a sprain as a kind of mystery "not always so bad as a fracture but sometimes more tedious," requiring fomentations for a little while, then a fixed dressing of plaster of Paris or silicate of sodium, crutches perhaps, and rest and massage afterward. He had never been attracted toward these methods, and he had come to expect a "stiff-ish" joint in nearly every case that came under his charge. His first case to be tried according to Cotterell's plan was that of a lady who had wrenched her right ankle severly. The usual external features of a sprain were present; no dislocation or fracture could made be out. Dr. Gibney first cut strips of rubber adhesive plaster about half an inch in width and long enough to completely encircle the foot. Then, with the foot well raised, he strapped it (the ankle) and the lower third of the leg with these strips, very much as if he had had an ulcer to treat. The first strip was carried over the outer side of the foot from near the base of the little toe. The second strip crossed the first, the third lapped over the first, and the fourth overlapped the second, and so on until at the conclusion he had practically constructed a Scultetus bandage of adhesive strips extending far enough to include the lower third of the limb. Over this he placed a cheesecloth bandage to help the plaster strips to adhere to one another and to make the dressing more tidy. The patient was told to put on her stocking and shoe and to walk about the room. The walking was accomplished with some diffidence, but with no real difficulty. She was made to walk the next day and went out shopping without any bad results. The recovery was without relapse, and the usefulness of the ankle joint was unimpaired—*Kansas Med. Jour.*

DIAGNOSIS AND TREATMENT OF GASTRIC ULCER.—J. Boas, of Berlin, Germany (*Medical Record*), uses the usual means of arriving at a diagnosis establishes it by the presence of localized pain in the epigastrium and upon the examination of the stomach contents. Pain, however, may be rarely absent and the hyperacidity may be present in carcinoma when the growth is on the base of an old ulcer. He has found after many observations that a dorsal point of tenderness exists almost as frequently as the epigastric point, and the point is so sharply circumscribed that for diagnostic purposes it has far more value than the point in the epigastrium. The point is found to the left of and on a level with the tenth to the twelfth dorsal vertebra rarely higher or lower. It lies usually directly against the vertebra, rarely some distance from it. In a few instances the point is on both sides. In no other disease, and especially no other disease of the stomach, is the point found with equal constancy. In cases of cholelithiasis there is a painful spot to the right of the twelfth dorsal vertebra. He uses an instrument called the "Ægesimeter," by which the pressure made can