

tained a fracture of the base of the skull, which resulted in aphasia. At the post mortem there was found a blood clot situated upon the third left frontal convolution. Intra-cerebral hemorrhage I regard as entirely outside the province of the surgeon. In hemorrhage into the ganglia, in the neighborhood of the insula, or within the ventricle, I see no possibility of removing all the blood-clot or of doing any permanent good. Nor do I think it feasible (as has been suggested) to reach the internal capsule (the common region of cerebral hemorrhage) through the fissure of Sylvius. A ventricular hemorrhage of any size soon passes through the foramen of Monro to the opposite side, and to make an orifice through which a large blood-clot could be removed, would cause too serious a destruction of the brain tissue.

One of the most interesting aspects of modern surgery relates to the treatment of *epilepsy*, Jacksonian and idiopathic. In the former there is usually a localized growth, a source of irritation upon the cortex, causing the discharging lesion. The signal symptom is usually constant, and the march of the spasms follows in orderly sequence, occurring in the same way at successive attacks. In such cases the list of successful operations is already long, and the field here is wide and free. It, however, has limitations. In the Jacksonian epilepsy of children (in whom this condition is most common) the lesion is often due to sclerosis and to porencephalus, in which not much can be expected from operative interference. There is usually hemiplegia, the lesion is large, and descending degeneration is established. Two cases of this kind have been operated upon, one at the Infirmary, by Dr. Morton, with relief so far as the frequency of attacks was concerned, and the other by Dr. Bradford, of Boston, which proved fatal.

In idiopathic epilepsy, when the signal symptom is distinct, as in cases when the fit begins in the toe, in the hand, the face, or even if it is initiated by auditory or visual aura, it has been suggested that the centre from which the irritation has started should be removed. This has been carried out in several instances, and the fits have not returned after an interval of six or eight months. Time alone will determine how far this procedure is justifiable, and whether

the cortical scar left after removal of the centre may not itself prove, as it so often does in traumatism, a source of irritation.

Lastly, surgical interference has been urged in certain cases of distension of the ventricles—*hydrocephalus*. For the chronic condition, tapping has been occasionally resorted to for years. And in a number of cases drainage followed by pressure seems to have been of benefit. The majority of cases, however, die. I see no reason why slow drainage, with pressure, particularly if applied early, in case of simple hydrocephalus, should not be followed by good results. In acute hydrocephalus, due as it is in a great many instances to tubercular disease, tapping the ventricle cannot, in my opinion, be of the slightest benefit. Here the ventricular affection is but a part, and not a chief part, of the cerebral mischief. The lesion is in the basilar meninges, and in the arteries of the perforated spaces, the affection of which could not be benefited by the removal of the ventricular effusion.

A DESCRIPTION OF A CUFF-SPLINT FOR COLLES' FRACTURE.

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(To be presented with cases at the next meeting of the
Ontario Medical Association.)

THERE is no fracture so commonly met with as the one known as Colles' fracture of the lower end of the radius, with its frequent rupture of the ligamentous attachments, and occasional considerable comminution of the bone on the line of fracture where the violence has been severe and the bone friable. A description of the fracture is familiar to all, but there are two points which I wish to emphasize in addition to those on which is based the departure in the treatment introduced by Prof. Moore, and followed up by Packard, Pilcher, and others, as upon a clear understanding of their import depend satisfactory results.

First, the direction of the breaking force is from the front, and, like the passage of a bullet, it makes a clean fracture of the bone cells on the front, and a *raged, irregular, crushing* and grinding of the bone on the *posterior line* of the fracture, loosening up the periosteum more or less, destroying more or less of the bone tissue on both portions of the