the retention of a perineal opening generally renders the surgeon master of the situation, as he can at any moment place the patient in a condition of collapse, and by this means arrest the hæmorrhage.

From what I have stated, it may be gathered that, although what I advocate is only, perhaps, a small advance in the direction of what has been practised before, nevertheless, small as it is, it is sufficient to secure advantages which have never been hitherto within the resource of surgery, as it affords freedom from pain and irritation, immunity from relapses, and an escape from the miseries of an incontinent bladder in cases of enlarged prostate.

In conclusion, I wish to emphasise the chief features of this treatment: First, that the operation is undertaken with the design to establish and permanently maintain a fistula, in the closest possible proximity to the bladder, but in front of the prostate. Secondly, that the fistula can be utilised at pleasure for the dual purpose of removing the contents of the bladder, and of minimising the inconveniences attending regular, systematic, and thorough irrigation.

I am under the impression that the cases I have cited are the first on record where the bladder has been approached through the perineum with the deliberate intention of keeping the opening permanent for the purpose of relieving the pain and misery of an enlarged prostate.

HISTORICAL NOTE ON OVARIOTOMY IN SPAIN.

By SIR SPENCER WELLS, BART.,

Surgeon to Her Majesty's Household.

In the chapter, in successive editions of my books on *Ovarian and Abdominal Tumours*, on the History and Progress of Ovariectomy, I could not give any details as to the number of cases of the operation in Spain, nor of the results. I am now able, through the kindness of Dr. Kispert, a German surgeon who has practised in Madrid during the last fifteen years, and is physician to the English Embassy there, to supply all the information he has been able to obtain up to the end of 1855.

On my return from a short spring holiday in the South of Spain I passed through Madrid, and had the pleasure of renewing my acquaintance with Dr. Kispert, who had followed my practice at the Samaritan Hospital about twenty years ago, and has since had six cases of ovariectomy in Madrid, all successful. The operator who has had the largest number of cases is Dr. Rubio, of Madrid, formerly of Seville, who, up to 1855, had had sixteen cases, with seven recoveries and nine deaths. Dr. Cardenal, of Barcelona, has had seven cases, with five recoveries and two deaths. No other operator has had more than five cases. One of these surgeons lost all five patients; another had two recoveries and three deaths. In all there were sixty-one cases among twenty-eight operators, with a total result of thirty-one recoveries to thirty-eight deaths—a mortality of 55 per cent. Such a death-rate now appears enormous, but it is smaller than it was in England thirty years ago, and probably not much larger than it would be anywhere if operations were done by men of very small experience, some of them, as in Spain, not having operated more than once or twice.

Dr. Kispert believes that ovarian disease must be very much rarer in Spain than in Germany or England. In a large clinic he does not see more than two cases in a year. But he thinks that since 1885 ovariectomy has been performed more frequently, more generally, and with better results than before that year; and he hopes to be able to collect reliable statistics of the results during the past three years. My own case in 1887 in Tenerife will appear among the successful cases in Spain in the later tables.

I should like to refer those specially interested in the diagnosis and treatment of abdominal tumours to one case of extirpation of a floating kidney, published by Dr. Kispert in the volume of the *Deutsche Medicinische Wochenschrift* for 1886; and to a case of wandering liver—hepar migrans—which may be found with illustrative diagrams in the volume of the *Berliner Klinische Wochenschrift* for 1884.

PRESENTATION.—Dr. R. G. Loverock has been presented with an illuminated address accompanied by a cheque on the occasion of his leaving Ballyjamesduff.

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CLINICAL MEMORANDA.

RATIONAL TREATMENT OF PERICARDIAL ADHESIONS.

I LATELY met with a patient who gave the following history. A man, 28 years of age, when a boy of 15 suffered in England from an attack of rheumatic fever. He had a contemporaneous attack of pericarditis. After the acute symptoms subsided he was taken by his medical adviser to a well-known physician. The result of this consultation was that a very grave prognosis was arrived at, and the boy's parents were informed that his only chance of life was extreme care. He was sent to France to school, the conditions obtaining there being believed to be more favourable to the maintenance of health than by his staying in England. Being away from parental supervision, he, boy-like, neglected care and went in for gymnastics and sports of all kinds, commencing immediately upon his arrival—that is, within five months after his attack. He returned to England, and, after medical inspection, was pronounced much better. He was again cautioned to conserve his energy, but he disobeyed instruction in the most reckless manner, going in for running, cricket, football, and volunteering enthusiastically. He afterwards became an engineer and went to China, where I met him. He told me his history, and—not because he was ill—I examined his heart. No valvular disease was present, and the only condition found to be abnormal was a slight increase in the pericardial area of dulness. The case has set me thinking as to the rational treatment of pericardial lesions generally. If adhesions the result of inflammation take place in a joint, early movement of it is the A B C of treatment; if neglected, a stiff joint is the result. When recently-formed pericardial adhesions take place, why should the opposite condition be insisted on? Prolonged rest will allow of the adhesions firming up into fibrous patches of adhesion, rendering it impossible for the heart to execute more than a limited amount of movement; whereas early cardiac excitation will bring more movement to bear on the recently-formed adhesion tissue, and pull it out into strands of tissue, in place of allowing it to heal as it chooses in patches. In fact, a filamentous in place of a membranous adhesion will be more likely to be induced, thereby allowing more freedom of cardiac movement. When valvular trouble is present in conjunction with pericardial adhesion, encouragement to take exercise will, no doubt, cause trouble; but with pericardial adhesions pure and simple it seems only rational that benefit may ensue from gradually increased exertion at a reasonably early period during convalescence.

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Hong Kong.

SURGICAL MEMORANDA.

THE TREATMENT OF INGROWING TOE-NAIL.

INGROWING toe-nail is, no doubt, most rapidly and effectually cured by avulsion of the nail. The operation demands general or local anaesthesia, and is not lightly undertaken in private practice. I venture to suggest a plan of treatment which is rational though not rapid, free from risk, and almost painless. In my hands the results have been excellent, and the cure, so far as I have been able to ascertain, permanent.

Removal of the offending nail, entirely or in part, from the raw flesh or tender granulations is the essence of the radical, and the chief aim in all treatment. In the following method of treatment the aim is rather to remove the granulations from the nail.

Supposing the patient's left great toe is affected, and on its inner side. I first wash and dry the parts, and then thoroughly rub the granulations with solid nitrate of silver. Since the introduction of cocaine this proceeding can be rendered practically painless. I next cut small pieces of fine Turkey sponge, and press them well down between the nail and the granulations, inserting a small piece beneath the inner free edge of the nail. Pressing this sponge pad downwards and inwards, I fix it in place by winding a long narrow strip of plaster round and round the toe, commencing from the outer side, my aim being to compress the granulations, and draw them as far as possible from the nail. Turkey sponge is by far the best material for this purpose, being soft, absorbent, and elastic. A soft easy shoe should now be worn, and patients can pursue their ordinary avocations without risk. Some aching pain often follows, but this is soon succeeded by a considerable feeling of relief.