favourable influence in initiating collateral circulation before actual deligation was done—an inference which the total absence of oedema, together with the very trifling amount of pain or inconvenience experienced after ligature, seemed to justify.

Closure of the wound by first intention and the total disappearance of ligature and sutures may also be worthy of note.

ON THE ANTISEPTIC AFTER-TREATMENT OF VACCINATION.

By JOHN BARK, M.R.C.S.ENG.,

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DURING some five years' experience in a large public vaccination district, with a mixed population of over 100,000, and a yearly average of over 2,000 primary vaccinations, I have noticed that the most common mischief one has to dread is the occasional occurrence of erysipelas, which, of course, as in the case of any ordinary wound, may, under conditions favourable for its development, end fatally through septic absorption.

It is a noteworthy coincidence that all the cases that have come under my observation have been in children in whom cleanliness was almost entirely neglected, or who were living in houses where the hygienic surroundings were bad. There is no doubt that all attacks of blood-poisoning which follow vaccination are due to one or other of these causes, and that they are not the direct result of the operation, as anti-vaccinationists so confidently and unjustifiably assert.

In my practice as surgeon to a general hospital, having been for many years profoundly convinced of the value of antiseptic treatment in surgical affections, I have long felt that the same principle might be employed with advantage to prevent the incidence of erysipelas or blood-poisoning after vaccination. Acting on this idea, I have for over a year employed an antiseptic pad for the protection of the vaccinated arms of infants, applying it after the opening of the vesicle on the eighth day, before which date (in my experience) septic absorption does not take place.

The pad is composed either of boracic or eucalyptus absorbent cotton wool, or of Hartmann's perchloride wood wool wadding (the latter being the most absorbent, and therefore answering best), and covered at the back and edges by antiseptic gauze, and is applied in the manner shown in the woodcut.

Note.—The pad has been represented in the woodcut very much too large.

b and c are two straps of soft half-inch tape, which fasten the pad to the arm; while a a is a similar tape, which passes from its upper border to the opposite axilla, and prevents the pad from slipping down. The mother must be warned not to disturb this arrangement for at least six days. I have tried this protective dressing in about 100 cases, some of them specially selected on account of their large inflammatory areola, and have found that on removal of the pad on the sixth or seventh day after its application the inflammatory infiltration has entirely disappeared, and in most cases a firm, hard scab has already replaced the vesicles, so that the arm can safely be left uncovered.

The following are the advantages claimed for this form of protector:

1. It protects the arm from external violence.
2. It absorbs all discharge.
3. Most important of all, it reduces the risk of septic absorption.

4. It cannot be used a second time like ordinary shields, which it is too often the dangerous practice to use again and again.

5. Lastly, and not its least advantage, is its extreme cheapness. As the result of the practical experience gained in this matter, my conviction is that this antiseptic absorbent covering effectually minimises the risks of erysipelas and blood-poisoning, those *bêtes noires* of all vaccinators, and is well worthy of a thorough trial.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.,

TRANSIENT RECURRENT ATTACKS OF LATERAL HEMIANOPSIA.

A. B., a well-nourished and healthy-looking man, aged 65, stated that when 20 years of age he had his first attack. At that time he was working as a miner underground, and having finished his work had just returned home, when he noticed that he could only see half or part of anything he fixed his eyes upon; thus in looking at two objects placed side by side, only one was visible, or on looking at a bystander only the left half of his face could be seen. At the same time, an indescribable anxiety seized him, quite out of proportion to his concern at losing half his field of vision, and at the same time he felt a fulness at the epigastrium, as though, to use his words, he "had wind in his stomach." This having lasted a few minutes, there commenced a sort of vibratory movement over that part of his sight which was obscured of vision. This he described as appearing like rapidly passing the hand, with fingers outspread, backwards and forwards close by the side of the eye. This vibratory phenomenon gradually increased in intensity, and then gradually faded, and at the same time seemed to clear off the field of obscured sight, till in about fifteen minutes sight was again restored to its normal condition. He says that he had a slight headache afterwards, but nothing of importance.

Now the attack above described he says he has had at pretty regular intervals during the last forty-five years, though he says they are not so intense of late years as in earlier life. The intervals between the attacks vary, sometimes one every few days, at others every few months; he states also that the attacks vary in intensity, sometimes lasting about an hour, and sometimes only a few minutes. There is no history of any nervous complaint, as epilepsy or asthma (if this is a nervous affection), and no history of phthisis. During the last nine months he has lost the sight of his left eye from acute glaucoma, as he describes it. At the present time the right eye is perfectly sound.

Now this sort of attack has been described to me by another, who is quite independent of the gentleman spoken of above. This latter says his was first produced by a severe mental effort when a student, the onset being characterised by great irritability of temper and great inaptitude for reading, the attack in the two cases being exactly similar. In the latter case, after his first attack he had no more for four years, when they returned again at intervals of a few days. He now says that he has had none for some months.

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RIGIDITY OF OS UTERI: INCISIONS: RECOVERY.

ON December 5th, 8 P.M., I attended A. L., primipara, aged 30, married two years, good medical history.

Pains were strong and frequent, the nurse stated the waters had broken on December 3rd, and that the pains had left till now. The os was dilated to the size of half-a-crown, the parts moist. After waiting two hours without any change I left.

December 6th, 7 A.M., dilatation had increased, but pains slight and few; 8 P.M. pains returned, and I gave antimonial wine every half hour till nauseated, then administered chloroform, but without result.

December 7th, 10 A.M. As the pains were strong and the parts hot and dry, I decided to terminate the labour by incising the os, and consulted my partner Mr. F. Bennett, who agreed that it was absolutely necessary, and kindly rendered valuable assistance.

I first applied the forceps to steady the uterus, then made incisions anteriorly and posteriorly to the extent of about half an inch;