sion, allow me to recapitulate. I have urged that many of the phenomena of syphilis usually counted as tertiary really occur, as a rule, in its early periods, and that there is no structure in the body which may not be attacked in the secondary stage. As instances of this fact, I have mentioned rupia, periostitis, and diseases of the viscera and of the nervous system. If my argument holds good, we must regard the terms secondary and tertiary as applicable to different periods of time, and not to different phenomena. At the same time, it has been fully admitted that syphilitic processes do display different tendencies in relation to the stage in which they occur. The position assigned to the tertiary symptoms has been that of late relapses of morbid processes, in tissues previously damaged. In this way it has been suggested that syphilis may occupy an important part in predisposing to such maladies as locomotor ataxy, without actually causing them. Lastly, the relation of mercury to the natural evolution of syphilis has been discussed, and I have tried to claim for it the position of an antidote to the virus, asserting that not only can it cause symptoms to disappear, but, if used early enough, will entirely prevent them.

"ON A CONDITION OF THE INNER SURFACE OF THE UTERUS, AFTER THE BIRTH OF THE FŒTUS, OF PRACTICAL IMPORTANCE."

By J. BRAXTON HICKS, M.D., F.R.S.,
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THE above was the title of a short paper of mine read at the meeting of the British Medical Association at Cardiff last year. It was published on October 10th, 1885. This heading is repeated by Mr. J. Stuart Nairne, of Glasgow, in the JOURNAL of January 16th. And then he says, "I am very glad this condition has attracted the notice of such an eminent physician, but I would have been still better pleased if he had given a little credit to some small observations of my own on the same subject."

In answer to this I would say at once that, to be thought capable of omitting knowingly to give a co-worker due credit, is a source of pain to me. My explanation of my omission is simple but twofold; 1, we are talking of different conditions; 2, I have never seen the remarks made by either Mr. Nairne, or Dr. Napier.

1. I am talking of a condition of the whole internal surface of the uterus, while Drs. Nairne and Napier are speaking of the area of placental insertion (serotina); this they describe after uterine contraction as now "about a couple of inches in length and breadth." In one of my cases, I specially observed that it was outside the area of the placenta before its removal. But, supposing we were describing actually the same condition, then the second part of my answer is, first, that I have to-day consulted the *Glasgow Medical Journal* of 1884, and can find no account of Mr. Nairne's paper, nor any discussion thereon in reference to this question, neither in the report of the Glasgow Southern Medical Society for March, 1884, nor in the April number of the Journal, nor in any other volume thereabouts, neither could I find any report in the Edinburgh journals of these meetings. The only allusion I can find in this remote south is one by Mr. Nairne on Dr. K. N. Macdonald's case in this JOURNAL. This came out in May, and was overlooked by me, doubtless because the heading was "How to Prevent Septicæmia in Cases of Morbidly Adherent Placenta." My paper had been projected long before, and I should have quickly noticed anything bearing on the subject; but, as I say above, the conditions are different, as can be seen by comparing the papers. I therefore must repeat the last paragraph of my short paper. "I am not aware of any one having noticed or pointed out the peculiarity before, though I can hardly think it could have escaped observation; but, in the excitement of the moment, the danger of mistaking the lining of the uterus for adherent placenta is undeniable, and this must be my excuse for occupying your time."

ROYAL EAR HOSPITAL.—It was stated in the report presented by Drs. Pritchard and Matheson at the annual general meeting of the Royal Ear Hospital, Frith Street, Soho, that during 1885 there were 7,796 out-patient attendances, at which 2,463 separate cases received careful treatment. Forty-four patients were admitted into the in-patient wards, all serious cases, and mostly children. This new department was reported to be a very great success, although it had considerably added to the expenditure. The financial condition of the hospital was shown to be far from satisfactory, as there was a considerable falling off in the donations and subscriptions. Funds are urgently needed to prevent a reduction in the number of beds.

ON THE SURGERY OF THE LATE EXPEDITION TO SUAKIN.

Read before the Surgical Section of the Academy of Medicine in Ireland.

By R. F. TOBIN, F.R.C.S.I.,

Assistant Surgeon, St. Vincent's Hospital, Dublin; late Assistant Professor of Surgery, Army Medical School, and Field-Surgeon to the Suakin Expeditionary Force.

DURING the late military operations at Suakin, it was my good fortune to occupy the position of Field-Surgeon; and, although I have nothing very new or important to communicate, it may be that it will interest you to hear from an eye-witness the surgical history of that brief campaign. The appointment, styled Field-Surgeon, is one new in our army, it is one that has not yet been recognised by the supreme authorities, and the duties of which are not defined in the army medical regulations. (The subject is treated of in Mr. Longmore's work on *Gun-shot Injuries*, pp. 438, 439.) Let me, therefore, say a few words about it. Perhaps I shall best convey to you the nature of the appointment, by pointing out the conditions that call for its existence. If I do so by uttering a truism in connection with an acknowledged fact, I hope I shall offend no one. That skill in the practice of operative surgery, especially of antiseptic surgery, can only be obtained by practice, is a truism. That in times of peace the ordinary duties of an army medical officer give few opportunities for such practice, is an acknowledged fact. When, therefore, on the breaking out of war, medical officers sent out from various stations are called upon to take charge of wounded, it seems right to put at their disposal, for the purpose of consultation, etc., some one whose hand, to use a familiar phrase, is "in" at surgery. Men skilled in surgery will be glad of such an assistant; men whose training has been limited to operating on the dead body, will be steadied and encouraged by the presence of such a one in their first operations on the living. Men, on the other hand, who from any cause are reluctant to operate, will ask him to undertake for them whatever operations fall to their lot.

The operating tent at Suakin was a large double pole tent, of a pattern in use in India. To the poles were hung irrigators, and to the walls all round were stitched calico bags, filled with ready-made Lister's dressings of various sizes, salicylic, boracic, and iodoform wool, lint, bandages, and other surgical appliances. The floor of the tent was kept sprinkled with carbolic acid solution.

There were carried into the base hospital at Suakin, 129 wounded non-commissioned officers and men. The officers were, as a rule, taken direct to the hospital-ships; and, as I did not see much of them, I do not include them in my statistics or remarks. The official returns classify the 129 wounds as follows.

Regions of the Body Wounded.	Admissions with Wounds.		
	Total Wounded.	Projectile or Weapon by which Wounds were Inflicted.	
		Rifle-Shot.	Sword or Spear.
Wounds of the Head	6	2	4
" " Face	6	4	2
" " Neck	5	3	2
" " Chest	11	8	3
" " Abdomen	3	2	1
" " Back and spine	13	9	4
" " Urinary organs	2	2	—
" " Upper extremity	32	20	12
" " Lower extremity	51	43	8
Total	129	93	36

N.B.—The Royal Marines are included in this return.

Of the 129 who were wounded, 124 recovered. The five deaths occurred as follows: one from a perforating wound of lung and liver, one from a similar wound of abdomen, with perforation of the intestines; three from wounds of the lower extremities. Two of these latter wounds were fractures of the femur in the neighbourhood of the hip-joint, a class of wound which has never, under the most favourable conditions, furnished a less mortality than 70 per cent., and one of the two was complicated with other injuries that