The following method may obviate or lessen some of the above difficulties: After the tourniquet has been applied figure-of-eight fashion round the tumour and round the patient's loins, and the shallow skin incision marking the line of separation of the tumour has been carried across the base of the tumour at the back so far each way that when the tumour is let fall forward on the patient's legs

both ends of this cut may be seen, the tunnel leading to the penis should be slit up as far as the tip of the gland. This tunnel should be held open by an assistant using broad retractors, and the condition of the skin should be carefully inspected. It not unfrequently happens that some healthy skin is to be found close to the penis. This skin, which was formerly the inner surface of the prepuce (in the uncircumcised), may be separated by a circular cut across the base of the tunnel, the knife being held almost perpendicular. A thin cuff may then be dissected up and left adherent to the corona of the penis. The ends of the primary incision of separation of the tumour are now brought forward, forming, as far as healthy skin will allow, a U-shaped flap. The testes and penis having been shelled out in

the recognized way, this U-shaped flap under favourable circumstances may be sutured round the penis and the cuff at the end adherent to the corona turned back and sutured to it.

It is not always possible to carry this plan into execution, but when it is done it has the following marked advantages: 1. It helps to bridge the gap between the lower end of the flap and the end of the penis. 2. It leaves some natural penile skin at the end of the penis, and not the thick, hairy skin of the pubes, or insensitive cicatricial tissue. 3. When the patient is standing up the penis will hang in a more natural position.

In the patient of whom a photograph is reproduced the tumour when detached weighed 22½ lbs. I found quite half an inch of healthy skin wherewith to form the cuff. The tunnel leading to the penis was 5 in. long.

THE INTESTINAL STITCH.

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METHODS of intestinal suturing have been with us for about a quarter of a century, and the sutures of Dupuytren, Lembert, and Cushing have been handed down to us in the succession of textbooks, and so carefully described and fully illustrated by the various famous teachers, that it may seem sacrilegious to criticize them at this hour, whilst to add another method should be the height of absurdity. However, I shall take the risk of defaming the gods and do both.

First, let us ask what we aim at in the ideal stitch; and, in answer to this, let me lay down four fundamental principles which must be carried out in every method of stitching which aims at the ideal.

1. The stitches must not tear through.
2. Broad surfaces of union must be brought together evenly.
3. The stitches must be buried.
4. The application must be simple.

The ideal will be the stitch which carries out these principles in the best way. In regard to this we must remember that the internal muscular coat of the intestine

has its fibres arranged circularly—the external longitudinally. We must remember also that stitches which are inserted into muscle must, if they are to hold, run transverse to the fibres, and therefore the inner portion of a stitch taking up both muscular coats should run across the circular fibres. As to 2, the broader the surface of union, the stronger and more reliable the union—that goes without saying; but it needs just a little inspection to see which are broad surfaces and which are narrow; 3 and 4 need no comment.

Now let us take from the latest edition of one of our most popular textbooks three standard methods described and figured therein:

Continuous Lembert:

Here we have a simple method giving a broad surface of union, but principles 1 and 3 are not fulfilled, for the inner or deep part of the stitch does not cross the circular fibres, and so cannot hold them; and again, we either have an exposed stitch or a puckered surface of union, because the point B has to be drawn over either to A or to C. If the stitch be drawn tight, then B goes to A, and we have a puckered union; whereas if B goes to C, then the portion of the stitch A B will lie exposed between A C, and the union will be loose.

Cushing's:

Here principle 2 is not fulfilled, because on tightening the stitch there is only a narrow line of union, the line B being rolled over upon the line A.

Halstead's:

Here every principle is violated; the stitches ought to cut through, the surface of union is only a line, the stitches are exposed, and the application is complicated.

The conclusion, therefore, is that *theoretically* these three standard methods are at fault. Experience teaches that they will each make a good union, but that is not the point. Our textbooks ought to be theoretically correct, and therefore these faulty methods should be banished from them or else put quietly into the background, and some stitch more nearly approaching the ideal given the place of honour. And I submit the following stitch as one worthy to hold the place of honour until supplanted by a better. Here all four principles are complied with.

This stitch may be as old as the hills, and may have been described and figured before, but that should in no way discount the fact that it is the only theoretically correct stitch of the four, and therefore the one that should be given the place of honour in the textbooks.

At a meeting of the Berwick Board of Guardians, held on February 14th, Dr. MacLagan requested the guardians to take over the cost of the medicines, which at the present time he had to supply out of his own pocket. After some discussion it was agreed by a majority to grant the request of the medical officer.