fine black after five or six hours, and this mark lasted more than double as long as the iron-haematoxylin mark when exposed to the same conditions. Further, the mark was unaffected by iodine, acetone, ether soap, etc., and could, in fact, be scrubbed with a nail-brush and ether soap two days after it was made without being completely removed.

Experiments were next carried out in order to obtain the fluid in one solution, and it was found that a mixture of the two solutions was quite satisfactory and seemed to keep well, showing no great tendency to oxidize even when kept in an open test tube. This is possibly due to a small amount of acid in the liquor ferri perchlor. from which it was prepared. The next points to find out were a satisfactory concentration and the best proportion of the ingredients. The latter was determined by painting the skin with a mixed solution of known constitution, and then, when dry, painting marks on it of solutions of pyrogallie acid and ferric chloride respectively. If one or the other improved the result the mixture was amended accordingly. The former point was disclosed by a series of comparative marks with different strengths.

Different skins seem to vary in the degree to which they take stains and as to the durability of the resulting marks. Experiments with different solvents showed that acetone and methylated spirit gave little difference in result on my own skin, the latter, however, was better than rectified spirit. Owing to the greasiness of some skins it seems advisable to make the fluid, at any rate in part, with acetone, though if this is not obtainable, methylated spirit may be substituted.

The formula I finally arrived at was—

Acid, pyrogallie.	...	...	1 gram
Spirit, vini meth.	...	...	10 c.cm.
Liq. ferri perchlor. fort.	...	...	2 c.cm.
Acetone	...	...	ad 20 c.cm.

This gives a concentration of 5 per cent. pyrogallol and 2 per cent. Fe. The solution is best kept in a bottle with a camel's-hair brush attached to the cork so that it can easily be painted on. The mark is a brownish-grey at first, but after a few hours turns a brilliant black. It fulfils the conditions set forth above.

DRAINAGE v. SCRAPING IN THE OPERATION OF CURETTAGE OF THE UTERUS.

BY

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THE object of this paper is to protest against the recent modification of an old and good operation which is nothing but bad and is tending to bring a good operation into discredit. The new-fangled procedure is to dilate the cervical canal by a three-bladed dilator just sufficiently to allow the passage of a small curette, the dilatation being often to about the calibre of a lead pencil. In the original operation the canal was dilated as much as possible, and safe, to the size of the largest Hegar dilator. I shall give my reason for thinking that this is the proper procedure.

Any benefit derived from the so-called operation of "curettage" is not from the scraping, but the drainage which dilatation to introduce the curette involves. Apart from removal of soft breaking down and loose mucous membrano by gentle use of the curette, I suggest that the results of the "curettage" operation would be at least as good if no scraping were done. The persistency of leucorrhoea is due to the inadequacy of the lower opening of the uterine cavity to permit drainage of what is virtually an open abscess cavity. For the same reason it is absurd to treat whites with douches; the drainage of the uterus (without artificial interference) through the tightly-closed cervical canal into the vagina being inadequate, the discharge tends to find its way along the path of least resistance to tubes and ovaries. If the condition is analogous to the persistent discharge of an inadequately drained abscess cavity and a condition demanding prolonged drainage, it seems obvious that to dilate the vent to such a slight degree that it rapidly closes again is absurd. We must revert to the old Hegar method, amplify it and not worry too much, if at all, about scraping; drainage is the important thing, and dilatation

must therefore be thorough, must be maintained for an adequate time, and the surgical principle of making the drainage opening at the most dependent part must not be disregarded. The cervical tissues must be rendered soft or the operation commenced after preliminary use of a laminaria tent, or following the period. The cervical canal must then be dilated to the full Hegar size. If the curette be used, it must be gently. I have found that application of iodized phenol makes little difference; if it is of benefit, I imagine it acts not by destroying germs but by determining blood to the part, and thus favouring the flow of serum. The cavity of the uterus being wiped out, one of the tubes illustrated should be inserted to maintain the dilatation and be used for a few days or a week. A thiodine pessary is inserted in the vagina, and then a little gauze, and the patient put to bed; the top end of the bed is raised on blocks to facilitate drainage from the uterus. As soon as the patient is able she gets up and remains up, so as to place the drainage opening at the most dependent part. Using this operation for drainage instead of scraping I have had the most gratifying results. If the drainage tube tends to fall out, a small amount of iodoform gauze is placed at the top of the vagina. Every night for about two to three weeks, when the patient goes to bed, a thiodine pessary is placed in the vagina.

The tube is a modification of a tube for which I am indebted to a previous contributor to the JOURNAL. It is

A, Slot. B, Retention ring. C, Flange. D, Opening for silk. E, Interior tube.

about 2 inches long, slightly flanged at the vaginal end. At the upper third (uterine end) there is a slit to allow of the escape of exudation, and about three-eighths of an inch from the end around the tube is a ring to prevent the tube coming out of the cervical canal. At the flanged end is a small aperture for a silk thread to allow of easy extraction. Tubes have been made in five sizes, uterine diameters $\frac{3}{16}$, $\frac{4}{16}$, $\frac{5}{16}$, $\frac{6}{16}$, $\frac{7}{16}$ of an inch, by Messrs. Allen and Hanburys. The smaller tubes could be used for drainage in leucorrhoea without an operation after preliminary dilatation by a

laminaria tent. Many cases of whites can be cleared up or improved by such procedure if the drainage is maintained for a suitable time. Instead of curettage we might call this operation drainage of the uterus. It is a valuable prophylactic operation against damage of ovaries and tubes and the necessity for their mutilation and removal later. The tubes will also prove of value in maintaining dilatation for spasmodic dysmenorrhoea.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

MILK SUBSTITUTES FOR THE SICK.

IN view of the present scarcity of milk it seems urgent that we should reconsider our present custom of feeding sick adults on a diet more or less composed of milk. There are, of course, many for whom it is essential. On the other hand, there are great numbers for whom it is not necessary and some for whom it is not even desirable. Indeed, there are not a few to whom it is repugnant.

In a hospital dietary before me the diet of every patient contains 1 to 3 pints of milk daily, unless specially ordered otherwise. Now, is there any real difficulty in giving a digestible and sufficient diet without milk to a large proportion of these invalids—let us say, to many surgical, cardiac, and mild febrile cases? The fashion is to a great extent only of recent origin, and a peculiarly British one. We have not, indeed, the advantage our Continental friends possess in their light and harmless bouillons, potages, and ptisanes, nor are our patients (unfortunately) accustomed to them, nor have they the mild non-intoxicating breakfast beers of our forefathers, but the chief reason for the popular use of milk as a staple food for the sick, apart from its harmlessness and digestibility, is the ease of preparing it, which saves so much work to friends and purses in a sick house. In many cases