solution hourly by the rectum as long as the patient continued to retain it; (3) pituitrin $\frac{1}{2}$ c.cm. every four hours until the pulse settled down. In practice this amounts to three or four injections.

Appearances of the Spleens Removed.

With one exception all the spleens were enlarged. The largest weighed 19 oz., 20 oz., and 28 oz. respectively. The tears were multiple in all, and varied in severity from nearly complete division of the organ to mere rents in the capsule. Extravasations of blood into the spleen pulp were also numerous. The spleen tissue was soft and friable.

Effects of Removal of the Spleen.

(a) No ill effect was noticed while any of the patients were in the casualty clearing station, and news of two patients some months after operation was entirely satisfactory. No information about the remaining four has been obtained. (b) A very high leucocytosis occurs rapidly after splenectomy, which is not apparently to be accounted for except as a consequence of the loss of the organ. No series of observations was made, but the following figures from four cases are illustrative:

(a)	42 days after operation	...	...	22,300
(b)	16 "	"	...	20,000
(c)	5 "	"	...	45,000
(d)	2 "	"	...	16,000
	12 "	"	...	12,000

White counts on two cases of nephrectomy for injury showed no excess. (c) Any operation in a malarial subject is likely to determine a relapse. A case of splenectomy is no exception, and the relapse does not differ clinically from those occurring in patients with spleens. (d) Late haemorrhage occurs sometimes after splenectomy. This event occurred in one case. About ten days after the operation there was a sudden severe haemorrhage from vessels in the abdominal wound. A considerable amount of blood had managed to find its way into the peritoneal cavity, but its origin was entirely extraperitoneal; it was arrested by ordinary methods and did not recur. There was no history of haemophilia and to a rough test the coagulation time appeared quite short.

I am indebted to Colonel Kelly, A.M.S., for permission to publish this series of cases.

SOME POINTS CONCERNING THE OPERATION FOR VARICOSE VEINS.

BY

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I RECENTLY witnessed an operation for varicose veins performed by another surgeon; it was needlessly tedious and bloody. As the operation is much simplified by the method that I have adopted for some time, I have thought that an account of it might be helpful to others.

I have tried the various new implements that have been devised for the operation, such as strippers and extractors, but they have not given satisfactory results in my hands, so I have returned to the simpler method of excision, which I perform as follows:

The night before operation the limb is dry shaved, rubbed with ether, painted with iodine, the veins marked with an indelible pencil, and then wrapped in a sterile dressing. The patient having been anaesthetized, the limb is held in the vertical position for a couple of minutes and emptied of blood as thoroughly as possible by firm upward kneading, and a tourniquet applied to the thigh as high up as necessary.

Suitable incisions are then made and the veins removed, the cut ends of the main veins and the larger tributaries being ligatured with fine catgut. The incisions are then closed by means of Michel's clips, the limb wrapped in large sterile pads, and a bandage applied evenly and firmly, but not too tightly, from the foot upwards. The tourniquet is then removed.

As the limb is bloodless the operation can be performed very rapidly, for the thickened veins are quite easily recognized and dealt with. Time need not be wasted in tying small tributaries, for the firm bandage effectually prevents subsequent oozing with the formation of those haematomata

which so delay healing. The use of Michel's clips has many advantages over ordinary interrupted or continuous sutures—they are far more rapidly applied, the necessary eversion of the skin edges is ensured, and the wounds consequently heal soundly with the formation of firm linear scars. The edges of the wounds are so thin that the use of any other form of suture is almost bound to result in more or less inversion of the skin edges, so that gaping of the incisions takes place after the sutures are removed, and results in slow and tedious healing, leaving thin wide scars that are often tender.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

AN ASPIRATOR FOR PARACENTESIS THORACIS.

I HAVE found the apparatus here described and figured very convenient for tapping haemothorax. Others may be using a similar arrangement, but, as I have not seen it described, a short note on it may be useful. It is quite simple and inexpensive, and can be put together from easily obtained materials. In most hospitals there is only one aspirator, but in a ward where chest cases are dealt with a second, not in general use, is a considerable convenience.

The apparatus, as shown in the figure, consists of two bottles connected by pressure tubing. The larger bottle, B, holds anything up to two quarts of water, and has an outlet at the bottom, D, to which is attached about a yard of indiarubber tubing furnished with a pinchcock (not shown in the figure). The bottle A holds fifteen to twenty ounces, and is connected by the tube C to some form of aspirating trocar and cannula. It is convenient to graduate it in ounces. The whole apparatus must be airtight at all joints. When in use the bottle B is filled with water, and the long tube D is allowed to hang vertically, its lower end dipping below the surface of some water in a large jar. The pinchcock is placed near the lower end of the tube, and a little water run out to remove any air bubbles. The trocar and cannula having been inserted in the pleura the pinchcock is opened, and negative pressure set up in the bottle A by the fall of level in the water in the bottle B.

I have found an aspirating needle known as Hodder's convenient to use, as it provides a good attachment for the indiarubber tube. The side tube of the ordinary Potain's trocar is too short to allow of an airtight joint. When the bottle A is full, the pinchcock is closed, the indiarubber cork removed and the bottle emptied; B can similarly be refilled with water if required. The stream of blood or serous fluid is watched as it runs into A, and its volume regulated by partially opening or closing the pinchcock, and thus altering the rate at which the water escapes from B.

The advantages of the apparatus seem to me to be: (1) It is cheap and easily made; (2) it is easily cleaned; (3) a continuous negative pressure is maintained; (4) there is no arm-aching exercise of pumping necessary; (5) there is no pump to get out of order.

It might be elaborated by introducing a manometer through the cork in the bottle B, or a funnel for filling it, but in practice I do not think these are required.

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BLOOD PRESSURE IN WAR TRAUMATISMS.

IN THE BRITISH MEDICAL JOURNAL of August 10th (p. 132) Dr. E. F. Cyriax states that in certain cases of unilateral traumas the blood pressure readings taken with the Riva-Rocci apparatus were different in the two arms, but that this difference tended to disappear as recovery took