moist, and he took nourishment freely. Urine still faintly alkaline. The ill effects of this second change were, however, quite unmistakable, and constitute the strongest argument in favour of perineal drainage. In the night the patient became restless, complaining of pain about the wound; and next morning there was the highest temperature reached—103.6° F.—with headache, pain in the wound, drowsiness, absolutely dry tongue, and almost complete suppression of urine. The patient died in the evening (tenth day). The feeble granulation tissue was evidently unable to resist the absorption of poisonous matter from the septic urine.

Shortly after this I removed a mass of six phosphatic calculi, weighing nearly 4 ounces when dry, by this method, with the perineal puncture, from a man about 40 years of age. The smaller of these calculi were deeply embedded in the prostate and neighbouring part of the trigone, and the pits left could not be perfectly drained. The urine coming down from the renal pelvis was very foul, and was slow in becoming sweet. Thus there was a high temperature for five days, but the large wound being kept perfectly clean rapidly contracted, and the patient did well.

Shortly after this again I performed suprapubic lithotomy on a man 55 to 60 years old. Though the urine was stinking, specific gravity 1007, average 44 ounces daily, the stone was little more than one ounce in weight, and had but a thin coating of phosphates upon it, and was very easily and quickly removed. Thinking this such a favourable case as not to need special drainage, it was simply treated in the ordinary way by frequent washing out from above and no perineal opening. But the wound became sloughy, and after a week collapse with hiccough and a falling temperature gradually set in, and the man died on the eleventh day with a temperature of 96° F. After death a small retropubic abscess was found shut off from the sloughy wound, and the kidneys extensively sacculated.

I feel certain that perineal drainage would have saved this patient, and am persuaded that the two chief causes of death after suprapubic cystotomies, suppurative nephritis, and retropubic abscess, as illustrated in these cases, should be generally eliminated by this measure properly carried out. These are the only "high operations" I have done in adults with foul alkaline urine and disorganised kidneys. In children special drainage is perhaps never needed, and in adults the probable state of the kidneys, as far as can be judged from the urine, the size and character of the stone, and from general conditions, seems to be the main consideration in its employment, though it is quite questionable whether it might not prove an advantage in all cases where the urine is stinking and alkaline.

A SIMPLE METHOD OF DRESSING OPERATION WOUNDS.

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HAVING, with the concurrence of the surgical staff of Addenbrooke's Hospital, employed the following plan of dressing wounds during the last eighteen months, I now venture to make it public on account of its efficiency, economy, and simplicity.

When practicable the patient is given a bath, and after the part to be operated on has been shaved, it is thoroughly scrubbed with soft soap; the soap is then carefully washed off with clean water, and the surface sponged with a strong solution of corrosive sublimate. A piece of towelling soaked in sublimate solution is then bandaged on to the prepared surface, and not removed until immediately before the operation. I first used soft soap about two years ago, after having heard of some exhaustive experiments made in Germany with the object of testing its properties. These appeared to prove satisfactorily that it was remarkably effective for cleansing the skin, and simply invaluable for cleaning instruments.

Constant use has more than confirmed the claims made for it. If it is thoroughly and carefully used, it is more reliable than either ether or turpentine; the dark green semi-transparent variety is the best.

I believe many surgeons think that, provided an operation

has been carefully performed with perfect antiseptic precautions, it is desirable to place next to the wound a soft unirritating aseptic material unimpregnated with antiseptics. With that object I have prepared such a material by keeping soft unmedicated gauze (costing 1d. a yard for 1,000 yards) in covered earthenware jars containing a solution of 1 in 500 of corrosive sublimate. A gallon jar holds about 100 yards, and, provided the solution is changed once a fortnight, the gauze will keep for an indefinite period, becoming, if anything, softer and whiter with time. A sufficient quantity of this gauze is cut off immediately before it is required and wrung as dry as possible. It is then put into a sterilised basin containing either boiling water or water that has been boiled. It is taken out by the operator and again wrung dry, shaken out loosely, and placed on the wound. The gauze is kept in the solution in order that it may be absolutely aseptic, and wrung out after soaking in boiling water to remove the corrosive sublimate, which might cause irritation of the healing surfaces. I believe it to be an essential and important detail to wring out the gauze as dry as possible, as mere excess of moisture is often as irritating as corrosive sublimate itself.

It then becomes necessary to cause all air that has access to the wound to undergo filtration through a medium such as cotton wool. If wool is used it should be put on in thin uniform layers and in large quantities. When a large quantity is used it secures the double advantage of absorbing and drying up the discharge and of maintaining a uniform elastic pressure. The wool should be unirritating and aseptic. Salicylic wool best fulfils these requirements, but Mr. Hankin suggested that the most efficient material would be absorbent cotton wool sterilised by superheated steam, and kept in stoppered glass bottles, to be opened only by sterilised hands at the time of operation.

The practice of Addenbrooke's Hospital is, as far as possible, not to use drainage tubes in operation wounds, and to apply firm pressure with the bandage. I have used this method in all the out-patient practice of the hospital, and it is rarely that we find a wound suppurate.

It will be obvious that such a mode of dressing as I have described would very considerably diminish the expenditure of a hospital. The gauze is of a good width and the cheapest that can be obtained; the corrosive sublimate has an almost nominal cost, and provided sterilised cotton wool be used, I feel sure that there can hardly be a more economical method for general use.

MEMORANDA:

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

EPITHELIOMA OF THE LIP IN WOMEN.

EPITHELIOMA of the lip is undoubtedly rare in the female compared with that affection in the male, but cases of the former do occasionally come under observation, although possibly they are not recorded. There were three cases of such admitted into the Cancer Hospital, Brompton, during the last three years, compared with 65 cases of epithelioma of the male lip. But there is another point of interest, for whereas in the male the lip affected was the lower in every case, in two out of the three in the female it occurred in the upper lip. Epithelioma of the upper lip in a man is extremely rare; I have never seen a case. In face of these facts can it be doubted that cancer, in this situation at least, owes its origin to irritation, and that it results in the great majority of cases from smoking?

The following are the notes of the cases:

CASE I.—A woman, aged 64, married, with no family history of cancer. She noticed a little pimple on the upper lip four years ago. This broke and has since been continually discharging. The last six months there has been distinct hardness. Present state (June, 1889): Epitheliomatous ulcer of upper lip, which was excised by Mr. Elam.

CASE II.—A woman, aged 49, married, and has nine healthy children, with no family history of cancer. History: She thinks there has always been a hardness on the left side of the upper lip; about six months ago this was scratched, since which there has been a sore which does not heal but scabs over from time to time. It has increased in size the last two months. Present state (January, 1890): On the upper lip, towards the angle of the mouth on the left side there is a thickening of the lip with a