advisable to put these on record that others may publish their cases, and thus some conclusion may be arrived at which might guide us in the treatment of these unfortunate cases.

To sum up, the points which my cases seem to illustrate are:

1. That the operation, if performed aseptically and the fluid drawn off slowly with the head well depressed, is not attended with the danger usually ascribed to it.

2. That improvement follows the operation as a rule.

3. That if operated on sufficiently early, there is some prospect of the child becoming a useful member of society.

Mr. ARBUTHNOT LANE congratulated Dr. Hern on the results which he had obtained. He had used interrupted and continuous drainage for these cases, the latter being obtained by the use of a fine hypodermic needle and hydraulic pressure, extending over a considerable period of time, but the result in every case was, though temporarily mitigating the patients' symptoms, yet to produce no permanent benefit. He could quite understand that cases occasionally occurred in which the mechanical conditions were so evenly balanced that the removal of some fluid on one or more occasions might determine the recovery of the patient. It had, however, never been his good fortune to meet with such a case. He considered that Dr. Hern had more than his share of good fortune.

Mr. R. J. GODLEE said that the congratulation must be qualified by the reflection that this case might have recovered spontaneously. He had tried this method of treatment, and had been much disappointed with the result. He had not only tried repeated tapping but continuous drainage, but had never met with a successful result. He had spoken to numerous surgeons at children's hospitals in London on the subject, and had always met with the same answer, namely, that they had tried the treatment in the earlier days of their practice, but had ultimately given it up.

Dr. DAVID NEWMAN asked Dr. Hern if he observed any difference in the percussion of the skull after tapping from what it was before the operation was performed. When the pathology of acquired hydrocephalus was considered he thought very little hope was held out of a complete or permanent cure by tapping. In most cases of hydrocephalus the veins of Galen were obstructed by pressure from without, and so the vessels of the choroid plexus became distended, and excessive exudation into the ventricles was the result. This led to increase in the intracranial pressure, to anæmia, and in some instances to atrophy of the brain. If they could remove the cause of obstruction then a cure might be effected, but simply to draw off the exudation could only give temporary relief, for it was certain to reaccumulate.

A NEW AND EASY METHOD OF PERFORMING INTESTINAL RESECTION.

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IN cases of intestinal growths complicated by obstruction, of irreducible intussusception and gangrenous herniæ, an operation to be successful must be rapidly performed, and should be complete. Resection of the intestine with immediate suture has been followed by some brilliant results, but the operation is long and difficult, requires special skill with trained assistants, and even then has a large mortality. With my instrument (Fig. 1), it is possible to complete such operations in from ten minutes to half an hour.

The principles of the operation I have devised are (1) to provide for the formation of a fæcal fistula primarily, and (2) that a large intestinal anastomosis shall follow the same operation. The advantages are that the distended intestine is drained by the most direct route, and that at one quickly and easily performed operation a radical cure is made possible. The operation will be easily understood by referring to the accompanying diagrams. The steps for an ordinary case are:

1. Draw out the diseased knuckle of bowel through a convenient opening in the abdominal wall (Fig. 3).

2. Pack round the abdominal opening, and make an incision $\frac{1}{2}$ inch long in either intestinal tube on the convex surface away from the mesentery (Fig. 3).

3. Introduce into the upper distended intestine the blade of the forceps with tube affixed.

4. Pass a thick silk ligature through the mesentery, and tie the intestine firmly to the blade and tube in the groove provided (Fig. 2). The most convenient method of passing the silk is to push a pair of sinus forceps through the mesentery, open them slightly on the other side, grasp the silk, and draw it back with the forceps closed.

5. Introduce the other blade of the forceps into the distal end of the intestine, turn the convex surfaces of intestine towards each other, lock and screw up the instrument.

6. Pass a thick silk ligature round the whole loop of intestine, mesentery, and instrument, embracing the ligature previously applied, and cut off mesentery and intestine beyond the ligature, cleanse the whole, then dust the cut surfaces and the ligatures with iodoform.

7. Introduce a continuous or a few interrupted sutures to fix the intestinal loops securely together on the convex surface and below (Fig. 4). On the opposite side the mesentery makes everything secure.

8. Put the intestine with the instrument back into the abdomen to within three-quarters of an inch from the ligature.

9. Suture the abdominal wall and fix the intestine to it.

Dress carefully with iodoform, and pack round tube with

Fig. 2.—Blade for distended upper bowel. Blade for empty lower bowel. (For the drawings I am indebted to Dr. Baigent.)

wool, applying a suitable bandage to support the instrument. In from three to five days the ligatured peritoneal coat sloughs, when the whole apparatus must be removed and the faecal fistula dressed.

In cases of gangrenous inguinal or femoral hernia the operation is modified thus:

Fig. 3.

1. The sac is opened, and the gangrenous intestine exposed, cleansed, and drawn down till a healthy portion is reached.

2. A thick silk ligature is tied round both tubes and mesentery, and the diseased part beyond cut off.

3. The stump is cleansed, covered with iodoform gauze, and seized through the gauze with strong long clamp forceps such as are used in ovariectomy.

4. The forceps with enclosed stump are passed through the ring into the abdomen and projected from within at a convenient spot against the anterior abdominal wall.

Fig. 4.

5. A small opening is made over the forceps, which with the enclosed intestinal stump is passed through the opening in the abdominal wall.

6. The intestine is released, drawn out through the abdominal opening, the forceps drawn back, and the stages of the previously described operation gone through.

7. The sac may be quickly removed and ligatured at its neck in the hope of obtaining a radical cure of the hernia.

THE FALLACY OF THE VERTICAL FOOTPIECE.

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It is curious that for such a number of years surgeons have thought fit to put up fractures of the lower extremity in splints with footpieces so placed in a vertical transverse plane that the inner margin of the foot, when attached to it, is vertical. I will now attempt to prove that nothing can be more unscientific or more fallacious than such treatment.

If one lies on one's back in an attitude of rest the thighs roll outwards and the hip-joints occupy the position of rest for this posture. It is, like all postures of rest, one in which the limb is retained in that position by ligamentous structures—in this case chiefly by the capsule of the hip-joint, no active contraction of muscles existing. It comes about very simply, since the weight of the leg bears such a relation to the hip-joint that when the muscles, by their active contraction, cease to retain the extended limb in any position, it at once rolls outwards until the movement of outward rotation is stopped, chiefly by the strain exerted by the oblique