the patient has already been using his hand freely for two or three weeks no further treatment is required.

I have been treating Colles's fractures by this method for the past three or four years with uniformly good results and with considerable saving in the cost of treatment.

HYPERSPLENISM AND HYPOSPLENISM AND SPLENECTOMY.

BY

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APART from the results of traumatism and the exceedingly rare primary malignant neoplasms and some of the primary (or "predominant") tuberculous and other chronic infectious (parasitic) conditions of the spleen, the indications and counterindications for splenectomy will doubtless be more definitely formulated when more is known about the various functions of the organ in question. In regard to the functional activity of the spleen it will probably become more and more convenient to speak of "hypersplenism" and "hyposplenism"—by analogy with the terms "hyperthyroidism" and "hypothyroidism," "hyperpituitarism" and "hypopituitarism." It will probably also be found that there are various forms of hypersplenism and hyposplenism corresponding to involvement of the various functions of the spleen (and reticulo-endothelial system), apart from the now well-recognized function of the spleen as a blood reservoir (Barcroft, etc.).

In cases of harmful (not compensatory) hypersplenism splenectomy or some effective depressor of splenic function (radium, x rays, and other as yet undiscovered means) will be indicated. At present splenectomy is not rarely (sometimes with excellent result) performed for conditions, such as congenital haemolytic jaundice, thrombocytopenic purpura haemorrhagica, and the Gaucher type of splenomegaly, where there is more or less clinical evidence of hypersplenism. For cases of hyposplenism some effective activator of the spleen and reticulo-endothelial system will have to be searched out.

In regard to splenic infections it should be remembered that, though one of the functions of the spleen, as of the tonsils, is to resist and "hold up" infections, the spleen sometimes, like the tonsils, may become so overwhelmed as itself to constitute a harmful focus of infection—a state of affairs for which splenectomy may constitute a rational part of the treatment. In some such cases the bulk and altered consistence of the enlarged spleen may themselves become a source of danger for the individual (possibility of rupture from relatively slight traumata).

Under infectious and parasitic splenomegalies, besides the relatively transitory enlargements due to the ordinary acute febrile infections, one would place the more chronic ones due to malaria, syphilis, tuberculosis, hydatid cysts, kala-azar, schistosomiasis (one form of "Egyptian splenomegaly"), the problematic splenic "mycoses," and perhaps certain other cases that have been clinically labelled as "Banti's disease."

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE ANATOMICAL METHOD OF OPENING QUINCY.

Not everyone has been satisfied with the old method of opening quincy by cutting into the soft palate. The oedema present often makes it difficult to find the pus, and more than one cut may be necessary. On the other hand, immediate enucleation is so drastic a form of treatment as to appear unnecessary as well as risky. Both of these extremes can be avoided by opening the abscess in the right way.

A quincy is a collection of pus in the supratonsillar fossa. It forms because of inflammatory adhesions at the normal

orifice of the fossa. As pus accumulates the palate bulges and is further swollen by oedema. In order to evacuate the pus it is only necessary to break down the adhesions by introducing a pair of sinus forceps with closed blades into the supratonsillar fossa in the direction shown by the arrow in the diagram. The point of insertion is immediately

under the arch formed by the anterior and posterior faucial pillars on the same side. A slight push is needed. As soon as they have penetrated the abscess the blades are widely opened, the adhesions are broken down, and pus pours out.

There are many advantages in this method:

1. It is simple, certain, easy, and only one instrument is required.
2. Trismus is no obstacle.
3. There is no pain beyond pressure from the forceps points.
4. There is hardly any bleeding because nothing is cut.
5. The abscess is freely drained by its natural outlet.
6. The tonsils can be enucleated without risk at a later date.
7. There is no unnecessary mutilation of mobile parts.
8. No anaesthetic is necessary, either local or general.

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HEREDITARY ANGIO-NEUROTIC OEDEMA.

THAT heredity plays an important part in the causation of Quinke's disease is well established, and numerous authors have reported genealogies. The hereditary form would seem to be of a much more severe type than the comparatively common acquired cases, and this is illustrated by the cases of Griffith,¹ where both father and daughter died of acute oedema of the larynx. J. R. and T. R. Crowder² report five generations of a family, and of 63 known descendants 27 inherited it; of these, 14 died as a direct result. Although a number of cases are on record, the hereditary form would appear to be of sufficient rarity in the individual experience to justify a case report.

A woman, aged 55, was referred to me on account of angio-neurotic oedema of lifelong duration; the disease was of the cutaneous type, and there was a complete absence of any of the puzzling attacks of abdominal colic due to intestinal oedema. The attacks occurred every two or three weeks, and the reason that advice was sought was the alarming increase in severity and frequency of the laryngeal involvement; the areas of oedema were peculiar in the absence of itching. Physical examination revealed little apart from a slight degree of dermatographism—much less than is usually seen in the common variety of case.

The patient was considerably apprehensive as to the outcome of the disease, as her mother and her only two brothers died of it; in an effort to avert the family tragedy the patient was desensitized by a course of peptone in small doses, and she was instructed to ingest half a grain of ephedrine sulphate at the first warning of an attack. Up to the time of writing the results have been most happy.

The following is the genealogical tree.

An asterisk indicates that the individual was affected. D = Death from oedema of the larynx. M = Male. F = Female.

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¹ Griffith: *British Medical Journal*, 1902, i, 1470.

² Crowder, J. R. and T. R.: *Arch. Int. Med.*, 1917, 20, 840.