example, scarlet fever, diphtheria, etc.—and this explains why it is seen in more than one member of the same family. As to the factor, he says, just as cavities in the mastoid, lung, etc., have their odour, so have cavities of the nose, and is due to saprophagous parasites, which produce the gases formed from the products of bone necrosis.

As regards treatment, where there is ethmoidal disease he scrapes away the granulation tissue, diseased bone, etc., and opens the ethmoidal cells to give exit to pus.

Noebel's plan of opening the sphenoidal sinuses is worth noting. Previous to operation he applies a 20 per cent. solution of cocaine, in nervous cases partially anæsthetises, but prefers cocaine.

Armamentarium.

In addition to Grünwald's forceps and sharp spoons, he has three modifications of Bechmann's scissors; one pair of scissors curved on the flat to the right to cut through the left middle turbinate; another pair curved to the left to cut through the right middle turbinate; thirdly, a pair curved on the edge down towards the fingers; lastly, a pair of punch forceps to punch out as large an opening as possible in the anterior wall of the sphenoidal sinus. The dressings are sterilised and the nose well douched out.

First Step.

Separate the posterior half of the middle turbinate with the curved scissors cutting transversely through the middle turbinate. Cut away the posterior half with the scissors curved on the edge, then haul it away with snares or forceps and plug the nostril. A few days after this, having first found the ostium of the sphenoidal sinus with a probe, we enlarge it with a sharp spoon so wide that a blade of the punch forceps passes into the cavity. Now snip away the bony anterior wall of the sinus until a large opening is got.

If by now caries is demonstrated, we remove the granular degenerated mucous membrane with a sharp spoon, taking great care at the roof where is the brain, and at the outer side where is the optic nerve and the carotid artery. If the mucous membrane is not seriously diseased leave alone, but make the opening as large as possible, for it has a tendency to diminish in size as shown by Moritz Schmidt.

After cleansing the nose introduce iodoform gauze into the cavity, and into the nostril a tampon saturated with eucalypti oil, then send the patient to bed. Plug afresh daily. After the fourth day douche with astringents. Two effects of the operation manifest themselves—namely, cessation of headache and disappearance of factor. Both are explained by the free exit of the discharge. Naturally suppuration cannot cease until the cavity is healed.

Finally, Noebel says all attempts to solve the disease (ozæna) from the point of view of the turbinate theory, has proved unfruitful.

The focal theory has cleared up the essence of the disease from all points of view. That theory teaches us that the nasal suppurations—ozæna and others—depend chiefly on disease of the ethmoidal and sphenoidal sinuses, and to obtain cure or relief the treatment required is surgical, or it is without success. Grünwald and Schäfer have been in the habit of using a trocar to puncture the sphenoidal sinuses. Their plan is described along with Case I. Spiess employs a trephine.

COMPLETE PROLAPSE OF THE RECTUM SUCCESSFULLY TREATED BY INTRA- ABDOMINAL FIXATION.

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THIS operation is suggested in several of our recent British textbooks, but as there are not many recorded cases the following one may be of interest. In May last, a male child, aged 12 months, was brought to the out-patient department of the Belfast Royal Hospital suffering from an extensive complete prolapse of the rectum. The protruding mass measured 4 inches in length; it was very congested, and the mucous membrane was marked with a number of small ulcers. The

bowel could only be reduced under chloroform, and when reduced the sphincter was completely relaxed and offered no support at all.

The patient had been under Dr. Clokey's treatment for three months before coming to hospital, and had been given various astringent injections, had had the buttocks strapped together, and had worn a pad and T bandage at different times without the slightest benefit, and was finally sent to hospital for operative treatment.

On admission the bowel was reduced under chloroform and the buttocks carefully strapped together; the child was also circumcised. During the following twenty-four hours the bowel came down six times, and each time reduction was more difficult on account of the increasing congestion of the bowel, so I decided to open the abdomen and fix the rectum in its place. This was done through an oblique wound over the left iliac fossa, the abdominal wall being opened by splitting the muscles and aponeuroses parallel to the direction of their fibres. The small intestines were pulled over to the right and the rectum pulled upwards as far as possible. The peritoneum was then stripped off a part of the iliac fossa so as to expose the iliac fascia, and then the bowel was stitched with a continuous fine silk suture to the exposed area of iliac fascia. The suture was put in in an oval manner, so as to bring a large area of bowel into contact with the fascia. The portion of bowel so bound down was quite close to the attachment of the mesocolon, in order to prevent an aperture being left in which intestine might later become strangulated. The operation was simple, and easily performed. Next day the child seemed none the worse, and it made a rapid recovery, and has not shown the slightest sign of any relapse, although it had an attack of diarrhoea in August. The laparotomy scar is now quite firm, and has not stretched at all.

This was the first case of complete prolapse of the rectum on which I have operated, and I decided on this operation in preference to that which is, I believe, commonly performed in these severe cases—namely, complete removal of the prolapsed portion of bowel—on account of the success attending the similar operation of ventrifixation of the uterus, and on account of a dislike to mutilate the lower part of the rectum for fear of giving rise to stricture or want of control of the bowel, and also because I believe that the operation I performed is less risky as regards immediate recovery than that of removal of a part of the bowel.

The only objection I see to this apparently ideal operation is the risk of a subsequent ventral hernia, and this can be minimised to a great extent by splitting the muscles and aponeuroses as far as possible, and not cutting them.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL, THERA- PEUTICAL, PATHOLOGICAL, Etc.

THE USE OF TUBERCULIN IN THE TREATMENT OF LUPUS VULGARIS.

IT is with the hope that tuberculin may be useful in similar cases that I publish the following notes of a case in which surgical measures had been adopted previously at varying intervals over a period of three years, but without any material improvement: J. R., aged 40, a cook, was admitted into the Sussex County Hospital on May 1st, 1899, for lupus of the nose of three years' standing. The part had been scraped under an anæsthetic eight or nine times, the scraped surface having been touched with acid nitrate of mercury or fuming nitric acid on different occasions, and on no one occasion had the surface continued healed for more than a few weeks. Latterly the septum had become affected, and had been scraped, but the gelatinous-looking nodules had reappeared, and the disease was evidently advancing and infiltrating previously healthy tissue. There was no definite pain in the nose, but there was a smarting sensation which was more appreciable in cold weather. The patient had been in Guy's Hospital seven years previously for tuberculous disease of the left elbow-joint; the joint was excised, and she made a good recovery.