comprised under the term of Pott's fracture. The broken bone is of small calibre, it is readily exposed, and it is dense in structure, holding securely the wire or other means used to retain the broken surfaces in apposition should any be found necessary after their replacement by the elevator or forceps. The results obtained under the methods at present in use are, in my experience, often most unsatisfactory. If on the dead body one divides the fibula in the seat of fracture and displaces the lower fragment it is often possible by manipulating the foot to bring the fragments into tolerable apposition, and I should imagine that the recognised methods of treatment are based upon such a study as this; but in the living subject a considerable amount of hæmorrhage and effusion very often takes place, and this alters the mechanical conditions so thoroughly that it is probable that in many cases the forcing the foot into a position of adduction not only does not bring the fragments into apposition but by traction on the bruised and inflamed peronei and upon the skin, made tense by the effusion beneath and into its substance, the displacement is exaggerated rather than lessened.

One cannot but feel that the perpetuation of methods of treatment which have been in use up to the present time must depend on the fact that surgeons have not taken such trouble to inquire into the subsequent life-history of these patients as they have done in other departments of surgery.

It is very possible that I may be accused of exaggerating the evil results of the treatment of fractures in the present day and that many may not be inclined to agree with the mechanical principles upon which my statements are based. It is, however, quite open to anyone to prove the former by publishing an account of a series of fractures sustained at the same period of life which show better results, and the latter are obviously capable of absolute demonstration.

A NOTE ON THE TECHNIQUE OF REMOVAL OF THE VERMIFORM APPENDIX.

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THE last six or seven cases in which I have quite recently been called upon to remove a diseased vermiform appendix for various reasons have given me the opportunity of perfecting a method of dealing with the stump which I had put in practice some years ago in a modified form, and which appears likely to simplify the procedure considerably and save much time. It is possible that it has been adopted by others before this, but, if so, I am not aware of its having been published. I note, too, that in an interesting series of cases recently published by Mr. Treves he still adheres to the older practice of stitching the serous coat over the stump of the appendix after removal, and I think that, had he been aware of the advantages of the method I am about to propose for further trial, he would have adopted it, if only to reduce the duration of his operation.

This saving of time appears to me to be a matter of prime importance in this class of cases, as in all abdominal operations, and any surgeon who has done many of them will admit that where time is lost it is in the preparation for and carrying out of stitching, which, to be efficient, has to be neatly done, and often under great difficulties, at some depth in the abdomen in the cases alluded to.

Some years ago I noticed in removing the appendix that the greatly thickened and sclerosed mucous and submucous coats were comparatively loose within the other outer coats of the process close to the cæcum, and that after circular division of the latter could be drawn out of them to the extent of an inch or so in an unbroken tube. Noting this, I at once put in practice in a modified form the measure now to be briefly described.

In any case in which the appendix has been separated from its surroundings its mesentery is first transfixed and tied in one or two parts with fine silk. The little mesentery is then cut with scissors up to the base of the appendix, close to the cæcum. Then at about three-fourths of an inch from the latter the serous and muscular coats are divided by a circular sweep of a sharp knife, leaving the mucous tube intact. The

latter is now gently drawn out, and the two outer coats are stripped back towards the cæcum with a director, and turned over like the sleeve of a coat. In this way the tube of mucous membrane can be reached at its point of exit from the cæcum, and is tied with a fine silk ligature, and so closed. Then it is cut across an eighth of an inch beyond the ligature, and immediately retracts. The outer tube of serous and muscular tissue is now turned down over the stump of the mucous coats, which has retracted towards the cæcum on being divided. This tube formed of the outer coats is then, instead of being stitched, simply surrounded with a fine silk or gut ligature, and closed over the mucous stump. Of course the serous surfaces are not by this means brought together, but this is not necessary, and perhaps not even desirable, as no firmer barrier to the prolapse of the mucous membrane could be made than by bringing the raw, inner, non-serous surfaces of the tube into contact.

The simplicity and rapidity of this little manoeuvre are great, and my colleague Professor Heath, who was looking on at one of my cases lately, was much struck by its superiority to the method of stitching the serous coat over the stump.

As all these six or seven cases in which I have proceeded as above have recovered, I cannot show any specimen to illustrate the state of the stump after operation; but Fig. 1,

Fig. 1

a, Tube of mucous membrane drawn out of stump; b, divided edge of two outer coats; c, swollen end of appendix. Natural size from a photograph.

from a photograph taken from an appendix recently removed in this way, shows to what extent the inner mucous tube can be drawn out and separated, and consequently how much of a tube of the outer coats there is when they are drawn forward again for the circular closing ligature. Fig. 2 is a dia-

LIGATURE ROUND THE TUBE FORMED OF OUTER COATS.

Fig. 2.

gram to illustrate the relation of parts while applying the latter.