

young under 15 generally recover, while it is quite exceptional for a patient above 70 to do so. 8. The disarticulation of the shoulder-joint proved fatal at Erlangen in 50 per cent., at Helsingfors in 80 per cent., and at St. Petersburg in 40 per cent. That of the hip-joint did so in 4 out of the 8 cases at Erlangen, and in the 5 cases at the other hospitals, one of these, however, perishing from the cholera. The 7 cases of disarticulation of the knee all proved fatal. Of the 9 operations on the joints of the hand only 1 proved fatal; and of 20 tibio-tarsal operations all but 2 did well. Operations on the fingers and toes were nearly all successful.

To this statement Dr. Heyfelder adds another statistical abstract, derived, from cases observed (in private practice, we presume) in Finland and at St. Petersburg, during the years 1855-62. From this it appears that 234 amputations furnished 151 recoveries and 83 deaths, the mortality prevailing in the following proportions: amputation of the arm, 33.3 per cent.; forearm, *nil*; thigh, 77.3; leg, 53.2; shoulder-joint, 66.5; hip and knee, 100; the hand, 9.1; and tibio-tarsal, 25.1.—*Med.-Chir. Rev.*, April, 1868, from *Berliner Klinische Wochenschrift*, September, 23.

33. *Results of Ovariectomy.*—On the completion of 100 cases of ovariectomy in the Samaritan Hospital, Mr. SPENCER WELLS gave a short account of the progress of the operation in London Hospitals. When he performed his first operation in February, 1858, ovariectomy had only once been performed successfully in any of the large hospitals of the Metropolis, and that solitary case was in 1846, or twelve years before. For twelve years—or from 1846 to 1858—there had not been a single successful case of ovariectomy in any of the large hospitals of London; yet in less than ten years after 1858, he (Mr. Wells) had himself, in this small hospital, completed 100 cases, with a result of seventy recoveries and thirty deaths—a result which ten years ago would have been regarded as incredible, but which the experience of the past teaches us will become still more encouraging in the future.

After performing the first operation in the hospital this year, Mr. Wells again recurred to this subject, and exhibited the following table of his hospital cases, from the first in 1858 till the last in 1867:—

Year.	Cases.	Recoveries.	Deaths.	Year.	Cases.	Recoveries.	Deaths.
1858 . . .	3	3	0	1864 . . .	13	10	3
1859 . . .	7	4	3	1865 . . .	14	11	3
1860 . . .	2	1	1	1866 . . .	11	6	5
1861 . . .	6	3	3	1867 . . .	21	17	4
1862 . . .	13	10	3				
1863 . . .	16	11	5		106	76	30

He said this table proved that a much greater success has been attained in 1867 than in any preceding year; and if the cases are divided into two nearly equal series, by comparing the 47 cases up to 1863 with the 59 cases since, it will be seen that there were 15 deaths in each series—15 deaths and 32 recoveries in the 47 cases, 15 deaths and 44 recoveries in the 59 cases.

In reply to a question, last Wednesday, on the comparative success of ovariectomy in hospital and private practice, Mr. Wells said the experience of the Samaritan Hospital proves that it is possible to obtain as good, or nearly as good, results in a small hospital as in a private house; for his own success in hospital and in private practice has been almost the same. He has completed the operation in 250 cases, with a result of 180 recoveries and 70 deaths—a mortality of exactly 28 per cent. But the results of the later cases have been much more favourable, for of the last 50 cases only 8 have died and 42 have recovered—a mortality of only 16 per cent. He believes that even this mortality will be still further reduced.—*Med. Times and Gaz.*, February 22, 1868.

34. *Non-Uniting Fractures.*—Mr. GEO. W. CALLENDER read a paper (March 24, 1868) on this subject before the Royal Med. and Chirurg. Soc. After referring to the statements made by Amesbury and Hamilton respecting non-uniting fractures, the author relates a series of cases to show that the union of

a broken bone is never prevented, although it may be delayed, by constitutional causes. Instances are given of the repair of fractures in cases of recent and long-standing paralysis, and cases of non-union occurring during childhood are incidentally referred to. The results of the treatment of fractures at St. Bartholomew's Hospital during the past seven years are mentioned; also the history of a case of non-uniting fracture of the thigh, and cases of non-union from special local causes. It is concluded that three well-defined varieties must be enumerated of fractures which fail to unite: 1. Fractures, not inaptly termed spontaneous, which ensue from diseases of bone; in which it is evident that no union is likely to take place. 2. Fractures (*a*) with separation of the bone and periosteum to such an extent that there cannot be thrown out bone-material enough to fill up the gap between the fragments; (*b*) occurring through bones not provided with periosteum, when it is difficult to keep the broken ends together. 3. All fractures other than the preceding; and in these cases, although union may be delayed, it never ultimately fails, except as the result of bad management of the injury. Several cases are narrated to show the effect of non-uniting fracture upon joint movements, and the treatment of those injuries where the thigh is the bone involved is briefly referred to. Cases are cited in illustration of the great length of time after the lapse of which a fracture, if properly treated, may be repaired, and the occasional good results from mere fibrous union are illustrated by pathological observations. The question of joint-stiffness after fractures is considered, and the importance of not interfering with such stiffness until the fracture is firmly united is insisted upon, and reasons are given for the presumption that such premature interference by the use of passive movements is a frequent cause of non-union. The following are the conclusions arrived at: Non-union of an ordinary fracture should never occur. Under careful treatment, bones will unite two years or longer after the occurrence of the fracture. It is reasonable to suppose that such fractures would have united at an earlier period, if properly treated. Treatment of delayed union should consist—1st. In the improvement of the health, and in the avoidance of local obstructions to the circulation. 2d. In placing the broken bone in the best position attainable. 3d. In leaving it at rest until it unites, its doing so being simply a question of time. 4th. In avoiding all attempts to overcome the stiffness of joints adjacent to, but not involved in, a fracture, until the bone is firmly united; and this applies also to the management of fractures which unite in the usual time.—*Med. Times and Gaz.*, April 11, 1868.

35. *Dislocation of the Thigh into the Ischiatic Notch; Reduction by Manipulation.*—Mr. G. W. CALLENDER records (*Lancet*, March 14, 1868) a case of this in a robust labourer, æt. 35. A surgeon in the neighbourhood attempted to reduce the dislocation without success, and the next morning he was sent to St. Bartholomew's Hospital. In the afternoon the patient was put under the influence of chloroform, and Mr. C. attempted reduction but failed; and the following day another effort was made by manipulation, and also by extension by pulleys without success. Vexed by his failures, Mr. C. studied more carefully the causes of his failures, and after allowing the patient to rest for several days he adopted the following plan: "The thigh was bent upon the abdomen, and I slowly moved the limb into a straight line with the body, so that the head of the bone could be felt projecting in the buttock, outside the tuber ischii. The limb, in a straight line with the trunk, without allowing any rotation outwards, was then drawn forward from the abdomen, and forced downwards (extended), and the head of the bone at once slipped into the acetabulum. These movements were made slowly and steadily, and the limb was extended with care, remembering the great leverage which we were making use of, and the position of the head, which was being pressed up into the socket. In two recorded cases the neck of the femur has been broken under a somewhat similar strain.

"If these manœuvres are examined by the help of the skeleton, it will be found that by flexion, and by moving the thigh into a straight line with the body, the head is brought from the notch into the groove just above the outer side of the tuber ischii. Here it is opposite the least prominent part of the lower edge of the acetabulum, and if the femur is depressed whilst in this position the head