

possibly, some may not have come to my knowledge. But relapses, improperly so called, or, rather, exacerbations of the disease, occur often, when patients discontinue the treatment prematurely.

The prognosis in the individual case, as regards the duration of treatment, is very uncertain. I know of no definite landmarks. Neither the previous duration of the disease and the character of the discharge, nor the size of the perforation and amount of destruction seem to determine the persistence of the purulent inflammation under antiseptic treatment. Even the presence of complications, like polypous growths or granulating erosions, does not necessarily prolong the time of treatment.

Of other antiseptic agents, iodoform has been much lauded by American authors, but much less so by European otologists. As long as I contented myself with simply filling the meatus with this powder, I found it quite unreliable, and never as prompt as boracic acid; but since I distribute the powder in such a state of fine subdivision over the entire surface, by means of the powder blower, its value has become more apparent to me. Yet its action is generally not as prompt as that of boracic acid, although in some few cases I have found it beneficial to substitute iodoform for other applications, when the latter had ceased to influence the disease very markedly. On the whole, I have not found the value of iodoform in otorrhœa sufficient to compensate for its odor.

The enthusiastic praise by Kocher of subnitrate of bismuth, as a substitute for iodoform in antiseptic surgery, has led me to use it in otorrhœa. Although it does not destroy the odor of the discharge as promptly as boracic acid, it lessens the secretion in a very marked manner. I have, however, employed pure bismuth but very few times, because I have found it so much more efficacious, when triturated with a one per cent. of corrosive sublimate. The addition of this powerful antiseptic does not give rise to any pain, while its quantity is too slight to endanger the patient's health. I have used this mixture now in some fifteen instances, with the most gratifying results. In three cases the cure was accomplished by a single application, while in others, still under treatment, the influence was manifested by an immediate improvement, as compared with the previous effect of boracic acid or iodoform.

The cloud of dust which can be obtained with this powder is so much more penetrating than that of boracic acid, that this explains in part its superiority over the latter agent. Besides, bismuth it is claimed by Kocher and other surgeons, diminishes directly the secretion of even aseptic wounds, which I can confirm from a limited surgical use of the bismuth and mercuric chloride mixture. While it might be difficult to prove the superiority of this antiseptic powder by my limited figures, the prompt effects which I have seen of lessening and deodorizing the discharge, and of allaying the pain in the more acute instances, have led me to discard all other insufflations but those of subnitrate of bismuth, with the addition of 1 per cent. of mercuric chloride.

I have tried insufflations of calomel a few times and found them nearly as efficient as the bismuth

mixture, but have feared applying it too often on account of the personal danger in inhaling the fine mercurial dust.

Not the least advantage of the antiseptic treatment of otorrhœa is its effect on polypi. Unless these are very large, so as to fill up the cavity and prevent the entrance of the powder, or so constricted at the pedicle as to render their removal very easy, there is not much object in operating upon them. Twice have I been able to check the otorrhœa by one or several applications of boracic acid, although polypous growths were present. The latter atrophied gradually afterwards. In another case boracic acid failed to accomplish this. The bismuth and corrosive sublimate mixture I have found more efficacious in this respect in the two cases which have lately come under my treatment.

Finally, I claim for the antiseptic treatment this decided advantage, that the painful, and, indeed, dangerous, inflammatory exacerbations and complications, which under other treatment, so often annoy patient and physician, are never observed with rigid antiseptic medication.

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RESTORATION OF A LOST CHEEK BY A FLAP FROM THE SHOULDER.

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This operation, so far as I know, is new; at least, I find no example of it among the works of reference at present accessible to me, and it is of importance as showing that for plastic operations on the side of the face one may use the shoulder freely as a source of flaps.

Case 11,707, *Andrew's Surgical Record*, May 18, 1882.—The patient was a young woman about twenty-two years of age. During the previous year she had received the discharge of a shot-gun close to her face, passing obliquely from the front backward and outward. The right cheek, from the angle of the mouth backward nearly to the ear, was torn away, stripping the jaws down to the periosteum. The teeth were not injured, but a few scales of bone afterwards exfoliated from the side of the body of the lower jaw. The masseter muscle was injured, but not torn away. At the time of the operation the parts were cicatrized, the lips were separated widely at the commissure, the upper one being adherent to the upper jaw near the ala of the nose, and the lower one to the lower maxilla an inch below, changing the mouth to a triangular opening. The molar teeth were exposed in the cavity where the cheek should have been.

I examined the forearm and the neck with the view of transplanting a flap from one of these places, but the patient was thin, and it was evident that there was not fat enough in either of these locations to supply the thick cushion torn from the cheek by the gun. Fortunately, the patient had a long and flexible neck, and the shoulder was very movable. By experiment, I found there was no difficulty in placing the wounded spot fairly against the top of the deltoid region by

flexing the neck to one side, and raising the shoulder to meet the spot where the cheek should be; at the same time, there was a tolerably thick cushion of fat covering the deltoid muscle.

I therefore made the first operation by anæsthetizing the patient, and raising a thick oval flap from the front of the deltoid two inches wide and two and a half inches long, leaving it attached by its upper end near the outer extremity of the clavicle. This flap was washed in carbolized water, and wrapped in gutta-percha tissue, and left about a week to recover the vigor of its circulation. The patient was again anæsthetized, and the circumference of the cicatrized vacuity in the face and of the flap were well refreshed with the scalpel. Bending the neck towards the flap and raising the shoulder to meet it, the flap was turned up, and without much difficulty stitched into its place, with the free end backward toward the ear. The head and shoulder were now firmly plastered together by long and broad adhesive straps, passing around the head and face and under the axilla, reinforced by bandages crossed and fastened in proper places. At the end of another week the union was established, and I separated the flap from the shoulder and released the head from its confinement. Most of the transplanted tissue retained its vitality, but a portion nearest the mouth sloughed, and eventually came away, leaving the flap deficient in size at that part. Three weeks after the final separation of the flap from the shoulder, I separated the external angles of the lips from their abnormal adhesions, placed them together so as to make a good commissure, and filled the gap between them and the flap by sliding in other tissues from above and below.

A salivary fistula from the duct of Steno still remained near the ear, which was cured by making a free route for the saliva into the mouth, and sliding a small flap over the external orifice.

The result of these tedious labors was most excellent, and the patient recovered a reasonably full and rounded cheek, and a comparative comeliness of countenance.

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MEDICAL PROGRESS.

MEDICAL NOTES ON JAPAN. Prof. Ch. Remy (*Archives Générales de Médecine*. Paris: March, 1883) gives an interesting account, the results of his observations in Japan, in which he details, first, the mode of nourishing and raising children. They are nursed by the mother to the age of five and six years—artificial nursing is unknown—but in the second year they are given also rice, boiled in meat juice, fish and eggs. The women bear this prolonged lactation exceedingly well. They are small in figure, and their breasts before pregnancy present nothing peculiar; after pregnancy they are capable of producing an incredible amount of milk, and pathological galactorrhœa is quite common. In one case, which he saw in hospital, a young woman gave from her breasts over twelve and a half pints of milk in a

day. Their diet during lactation consists of a considerable quantity of rice, herbaceous and farinaceous vegetables, fish, a great deal of tea, and certain popular drugs; forty or fifty times a day is tea made in a Japanese household.

This prolonged lactation may be the cause of the small degree of fecundity noticeable in the statistics; the women remain fifteen and seventeen months without menstruating. There are seldom more than three or four children from one mother in the family. The children are very healthy looking, and escape the gastronomical disorders. Nevertheless the mortality is very great, and they succumb principally to chest and head troubles. Hydrocephalus is very common, but rachitis does not exist in Japan.

The new-born child is not placed in swaddling-clothes; its only bandage is that around the umbilicus, and the children of the poor are frequently almost naked summer and winter. When they are dressed they wear robes with very large sleeves, open in front, and gathered around the waist by a belt, leaving naked the upper part of the body and thorax, and uncovering the legs in many instances. This is a very insufficient protection against the cold, for which the houses are poorly provided. The child's head is sometimes covered by a little red bonnet, but most generally remains uncovered, and is close shaven. It is carried on the back of the mother, between the folds of her garments, and held in place by a band, so that while the lower part of the body receives the maternal warmth, the head and superior portion of the trunk remain exposed nearly naked to the changes of the temperature. It lives in this way, on the back of a carrier, almost until it is large enough to in turn take a younger child upon its own back. This mode of carrying children sometimes produces deformities, and is, therefore, described. The women wear a large sash over their clothing which, after four or five turns around the body, is tied in voluminous knot over the loins; over the shoulder is placed a loose garment, with sleeves, and open in front. The child is placed within the folds of this latter; is seated just above the knot of the sash, its legs about the body of the mother, and its belly against her back; then she folds this garment across her chest. The band which retains the child in position is made of thick stuff in folds, and so arranged as to pass under the buttocks of the child, then diagonally across the chest of the mother to the left shoulder, then across the back, and under the two arms of the child, to pass over the right shoulder of the mother, the two extremities being knotted together and forming a figure 8 over her chest. This frequently results in a lateral depression of the sides and a corresponding projection forwards of the sternum, which is frequently bent at one of its articulations, not at all resembling rachitis, but due to the pressure of that part of the bandage which passes under the arms and compresses the sides; in most cases, as pressure is relieved and age advances, the deformity disappears.

The mode of shaving the head, which is gradually allowed to grow hair as a tonsure, exposes the uncovered part to the rays of the sun, which are very powerful in their heat even in winter. It certainly