During an epileptic attack the patient should be placed in a recumbent position, the clothing loosened about the neck and waist. The tongue of the patient should be protected by placing rubber or cork between the teeth. If status epilepticus is feared, it may be wise to prevent exaggerated convulsions by administering a small amount of chloroform. In petit mal, nitroglycerin is frequently of great service, producing, as it does, a moderate hyperemia of the brain, if the doses are not too liberal, grain 1/100 to 1/50 (.0006-.0012).

The attempt to prevent or check an attack at the appearance of the aura, either by constricting or rubbing the part from which the aura emanates, is sometimes successful.

The following combination, which is recommended by Dr. Daniel R. Brower, seems to be the ideal combination in the treatment of epilepsy:

℞.	Sodii bromidi	3x	40
	Ext. solani carolinense flu.	ʒii	60
	Aq. camphoræ q. s. ad.	ʒiv	120

M. Sig.: One teaspoonful three times a day in water.

To prevent the acne which may be caused by large doses of the bromids small doses of arsenic may be added in the form of Fowler's solution or Pearson's solution, two or three drops of either. If a heart tonic is indicated four or five drops of the tincture of adonis vernalis may be added to each dose of the bromid.

The following combination containing chloral is sometimes of service in nocturnal epilepsy:

℞.	Chloralis	gr. lxxx	5 | 30
	Pot. bromidi	3ii	8
	Syr. aurantii	3iv	15
	Aq. menth. verid. q. s. ad.	ʒii	60

M. Sig.: One dessertspoonful at bedtime in water.

Strontium bromid is said to contain a greater amount of bromin than the other salts. It may be given as follows:

℞.	Strontii brom.	3v	20
	Sodii brom.	3iiss	10
	Aq. feniculi q. s. ad.	ʒiv	120

M. Sig.: One teaspoonful after meals and at bedtime in water.

Medicolegal.

Dying Declarations.—The Supreme Court of Louisiana holds, in the case of State vs. Brown, that declarations properly considered at the time to be dying declarations do not lose their character as such by the fact that the party making them lives some time afterward.

Permitting Expert Witnesses to Remain in Courtroom.—The Supreme Court of Louisiana holds, in the homicide case of State vs. Forbes, that a ruling of the court permitting expert witnesses to remain in the courtroom during the trial is not ground to set aside the verdict. The rule, it says, is largely left to the discretion of the trial judge.

Liability for Care of Smallpox Patients in Iowa.—The Supreme Court of Iowa says, in the case of Walker vs. Boone County, brought by a physician, to recover for services rendered in taking charge of a pest-house and caring for smallpox patients, after a city board of health had approved his claim, that the mayor and city council of each city in that state constitute a local board of health. And where it is made to appear that smallpox or other disease dangerous to the public health exists, the board has power to make provision for the care of patients, and may remove the same to a separate house, or to a detention camp or hospital. It may provide nurses, needful assistance and supplies, which shall be charged to the patient, or those liable for his support, if able; if unable, it shall be done at the expense of the county. Code, Section 2570. By Code, Section 2571, it is further provided, among other things, that all expenses incurred in the enforcement of the provisions of the Code relating to the public health, when not otherwise provided, shall be paid by the city. The expression "when not otherwise provided," as used in this section, can have relation only to the provision made in Section 2570 for charging matters of expense to the county, as the matter of the expense incident to the enforcement of the laws relating to public health is nowhere else referred to. Now, the reading of the provision in Section 2570 is plain, and the meaning unmistakable. If the patient is unable to pay, and those liable for his support are unable to pay, then the county must bear the expense. The corollary follows that the county can not be made to pay except that the conditions on which its liability depends are made to appear. In this case the record did not disclose that the physician suing made proof that the patients attended by him and those liable for their support were unable to pay. Such being the condition of the record, it followed that the trial court did not err in sustaining a motion for a verdict in favor of the county and entering a judgment against the party suing for costs.

Waiver of Privilege Extends to Future Trials.—The Second Appellate Division of the Supreme Court of New York, in considering, in the case of Schlotterer vs. the Brooklyn and New York Ferry Co., the effect of the provision of the statute that the express waiver of privilege required must be "on the trial or examination," says that the purpose of the statute is to cover the relation of physician and patient with the cloak of confidence. The purpose is to save the patient from possible humiliation or distress, not to enable him to win a lawsuit. If the patient once permit the physician to testify, there is no longer any reason at any time for excluding competent testimony under the plea of public policy. If the patient once voluntarily renounce the protection of the statute, his waiver is everlasting and irrevocable. So it thinks that the purpose of the provision referred to was not to limit the continuous force of a waiver, and thus to permit the patient to use the statute once as a shield and anon as a sword, but by way of further assurance that the waiver had been formally, clearly, and certainly made. Nor does it think that the language of the statute, in the further provision that the waiver "must be made in open court on the trial of the action or proceeding," authorizes a construction which affords the privilege, notwithstanding the reason for its continuance has ceased to exist. it says that it simply means that, when the waiver is made, it must be made in open court on a trial of the action. It thus affords a safeguard that the waiver was duly made, but not a shift of the waiver, once made. And the court holds that a trial was a trial of the action, within the purview of the statute, where it appeared that, after trying her case after a nonsuit, the party suing began anew, but proceeded on the same cause of action against the same defendant.

Impotence and Marriage and Divorce.—The Court of Chancery of New Jersey says, in what is entitled the case of "G—— vs. G——," that cases of impotence are so rare that the rules governing the action of the courts in such cases are not thoroughly settled. In England the notion seems to have been entertained formerly that complete impotence rendered a marriage void from the beginning, precisely the same as would the existence in life at the time of the marriage of an undivorced spouse of one or the other of the parties, or the fact that the parties were related within the prohibited degrees of consanguinity. This is evidenced by the mode in which suits were framed. The English judicial reports show that suits for a declaration of nullity on account of impotence were framed in this wise: A., falsely called B., vs. B. This was the form in suits for nullity for the other two causes mentioned. But the later cases establish clearly the doctrine that contracts of marriage between parties, one of whom is impotent, are voidable, merely. In New Jersey, the legislature, in the revision of the divorce act of 1902, has provided for decrees from the bond of matrimony in cases of adultery, desertion, and incurable impotence, using the following language: "In case the parties, or either of them was at the time of the marriage physically and incurably impotent, or was incapable of consenting thereto, and the marriage has not been subsequently ratified." In a case of impotency the parties have the power to contract, and the marriage is binding for all purposes, unless it is dissolved by a decree of court at the instance of the party having the right to make the complaint. Thus it seems

clear that the widow of an impotent husband would be entitled to dower in his estate, in the absence of a decree of dissolution. The ground on which the decree of dissolution is based is not an original incapacity to contract, but the entire and complete failure of the consideration of the marriage contract. Hence the better doctrine is that the contract of marriage is voidable merely, and not void from the beginning. The statute quoted assumes that it may be ratified. But be that as it may, the clear trend of authority, as stated, is that the marriage is not void from the beginning, but merely voidable at the instance of the disappointed party. If that is so, then the correct doctrine is that such party may ratify it. It is suggested with much force that such ratification may result from a long-continued acceptance and enjoyment of the benefits of a merely platonic marriage, so that the disappointed party will not be permitted, after such long enjoyment, to repudiate the contract.

Current Medical Literature.

AMERICAN.

Titles marked with an asterisk (*) are abstracted below.

American Medicine, Philadelphia.

February 27.

1 *Diagnosis and Treatment of Thoracic Aneurism. Stephen S. Burt.
2 *Retroperitoneal Infection a Result of Appendicitis. I. S. Stone.
3 *"Urethral Labia," or "Urethral Hymen." Pathologic Structures, Due to Repeated Traction. Robert L. Dickinson.
4 *A New Technic in Operations for Appendicitis. W. Easterly Ashton.
5 Pathology of Leukemia. Edward T. Williams.
6 *Treatment of Cervical Adenitis. F. S. Bulkeley.
7 Report of Hemorrhagic Septicemia in Animals in the Philippine Islands. Paul G. Woolley and J. W. Jobling.

1. Thoracic Aneurism.—Burt's article is very detailed as regards diagnosis—too much so to be easily abstracted. He notices the leading characteristic symptoms, such as tracheal tugging, physical signs, pain extending down the right arm and dyspnea, and discusses in particular the characteristic differences between aneurism and malignant growths. For treatment he recommends absolute rest, mental as well as physical, and restriction in the amount of food, especially fluid, and iodid medication. All these expedients are intended to favor the deposition of fibrin in the sac. Sacculated aneurisms with relatively small openings are most benefited by treatment. He does not speak well of the use of the introduction of foreign bodies into the sac as a satisfactory method. Three cases are reported, one with recovery, under the potassium iodid treatment.

2. Appendicitis.—Stone calls particular attention to the dangers of retroperitoneal abscess, especially in cases where the appendix points to the left and downward. The symptoms are mainly those of septicemia in addition to appendicitis. Persistent high temperature and quick pulse after appendectomy should always suggest posterior complications, especially when one or two weeks have elapsed before operation. Such symptoms may disappear, but not as a rule, and it is important that we should check what may become systemic infection. He sums up the indications as follows:

1. We should consider every "delayed case" with anxiety, lest there should be retroperitoneal infection.
2. We should be careful to give a guarded prognosis in every case of appendicitis ushered in by, or complicated by chills or any symptoms of sepsis.
3. If operating in such cases, we should consider retroperitoneal infection as already started and act accordingly. The discovery and proper treatment of such infection is quite as important as the usual intraperitoneal technic.

In view of the possibilities of retroperitoneal infection, we assume a great responsibility by advising non-intervention in appendicitis, and while we often advise delay when we believe the lesions strictly intraperitoneal, yet it would appear that such a course is very unsafe and it should be condemned when we have reason to fear the complications described.

3. Urethral Labia.—Dickinson notices the recent paper by Howard Kelly in *American Medicine*, Sept. 12 and 19, 1903, noticed in THE JOURNAL of Sept. 26 and Oct. 3, 1903, pp. 805 and 878, and remarks that he described the same condition in *American Gynecology*, September, 1902. (See THE JOURNAL, Oct. 25, 1902, p. 1073.) The so-called urethral labia are not normal protective organs, as Kelly supposed, but are always artificial and pathologic. They occur only when there are hypertrophies at the labia minora and clear-cut evidence of traction, pressure and friction. He considers that they are an enlargement of the anterior portion of the hymen. They have no protective function, but are connected with special sense. The only certain method of cure is section with the cautery wire.

4. Appendicitis.—The new operation described by Ashton consists in pulling out the head of the cecum from the wound, keeping the appendix taut with control ligatures, then packing with gauze and severing the appendix at its origin and closing with a purse-string suture, supplemented by a Lembert suture to prevent leakage. The article is very fully illustrated. The steps of the operation are given as follows:

1. After the appendix has been located and freed from adhesions, the head of the colon is brought within the abdominal incision. A No. 7 braided silk ligature is then tied around the tip of the appendix, the free ends knotted and the loop, which should be about 6 inches long, is held taut by the assistant.
2. A ligature of the same material is now passed through all the coats of the colon, except the mucous, about three-quarters of an inch beyond each side of the base of the appendix. The free ends of the ligatures are then tied, leaving two loops, each 6 inches long, which are used to control the head of the bowel. A purse-string suture is now passed through all the coats of the bowel, except the mucous, about a half inch from the base of the appendix.
3. The appendix and head of the colon are now completely under the control of the operator, who keeps the appendix taut by traction on the ligature, which is tied around its tip. At the same time the assistant grasps the loop on each side of the base of the appendix, and by making traction on them holds the head of the colon well within the abdominal incision.
4. The seat of operation is now shut off from the surrounding parts by packing a strip of plain gauze around the head of the colon.
5. The mesoappendix having been previously ligated and severed, a circular incision is made through the serous coat of the appendix about a half inch above its base.
6. The peritoneum is then stripped back beyond the base of the appendix with the scalpel.
7. The appendix is now amputated below its base with scissors curved on the flat.
8. The opening in the bowel is now closed by inverting its edges with forceps as the purse-string suture is tied, and subsequently introducing a mattress suture to guard against leakage.
9. The operator now douches the seat of the operation with warm normal salt solution, and dries the parts with a gauze sponge. The gauze packing is then removed; the control ligatures cut and withdrawn from the bowel; and the head of the colon allowed to sink into the abdominal cavity.

Special Directions.—The control ligatures which pass through the walls of the colon on either side of the base of the appendix must penetrate only the submucous or fibrous coat, because if they enter the lumen of the gut, infection may result from capillary attraction.

From the time the appendix is amputated until the opening in the colon is sutured and the field of operation douched and dried, the assistant must keep the control ligatures taut to prevent the bowel from becoming displaced and infecting the surrounding intestines.

The serous coat of the appendix must be stripped off well below its base so that when it is amputated a portion of the wall of the colon is also removed. This not only thoroughly eradicates all the diseased structures, but it also leaves no redundant tissue to interfere with the close approximation of the edges of the wound. As a matter of fact, under these circumstances, the serous coat usually retracts and partially closes the opening before the purse-string suture is drawn taut. The antiseptic precautions employed during the operation must be thoroughly carried out, as we are necessarily dealing with an open wound of the intestine. Therefore all instruments which come in contact with the seat of operation must be thrown aside at once, and not used again. Thus the knife which is employed to make the circular incision through the serous coat, and the scissors used to amputate the appendix, naturally become infected, and must be discarded at once. A serious mistake is often made from an antiseptic standpoint in operations of this character by using the same sponge several times on the seat of operation. This habit undoubtedly spreads infection and often causes post-operative complications which can easily be avoided. A sponge which has been pressed once against the tissues should be discarded and not used again. If this is not done the pathogenic germs which adhere to the sponge will be scattered over the uninfected areas surrounding the field of operation. In an aseptic field this precaution is, of course, unnecessary, but when as in an appendicectomy the sponge comes in contact with the contents of the intestinal canal, it is obviously a dangerous practice, and one which must result in jeopardy to the life of the patient.

Variation in the Technic.—If for any reason a purse-string suture can not be used to close the opening in the colon, a Lembert or a Cushing suture may be substituted. The first six steps of the operation are the same as described above, and after amputating the appendix the surgeon then grasps the upper control ligature about an inch from the bowel with the fingers of his left hand to steady the field of operation while the wound is being closed. The sutures are introduced with a small, full curved intestinal needle, which must be held in the grasp of a needle-holder or a hemostatic forceps.

6. Cervical Adenitis.—Bulkeley points out that many cases of cervical adenitis occur in which the importance of avoiding