Medical Matters.

A DANGER OF THE CLINICAL THERMOMETER.

MOST people have heard the story of the nurse who, to make sure of the perfect asepsis of her clinical thermometer, boiled that instrument, but possibly few of us appreciate the capabilities of the clinical thermometer as a germ carrier. In our contemporary, the *Buffalo Medical Journal*, a note of warning is sounded anent this subject by Dr. W. L. Conklin. He remarks that the thermometer as well as the scalpel may be a germ carrier, and the mouth furnishes as favourable a medium for the development and growth of bacteria as the open wound. The ordinary methods of cleaning a thermometer by holding under a tap and wiping it with a cloth are not sufficient to rid it of bacteria. Measurements, carefully made, show that the length and breadth of a degree mark, will furnish room for the lodgment of 280,000 tubercle bacilli.

Conklin himself carries his thermometer in an ordinary rubber case, filled with 1 in 500 or 1 in 250 mercury bichloride solution, for he considers that the instrument should be at all times sterile. The solution requires renewal about once in every three or four days. Whilst experimenting for the purpose of proving that a thermometer cleaned in the ordinary way was not necessary sterile, Conklin at the same time sought for proof that one kept constantly immersed in a strong bichloride of mercury solution was entirely free from micro-organisms. The results of bacteriological examination of six thermometers were as follows:—Four had been washed, but not sterilized. Micro-organisms of one or another variety were found upon each of the four. Two had been washed, and then placed in a case containing bichloride solution. No micro-organisms were found on either. He thinks these experiments furnish conclusive proof that the clinical thermometer may be a germ carrier, and that by means of a very simple and inexpensive device it may be rendered sterile after each use. It will at once occur to all practical minds that it would be much better in all cases to take the temperature in the axilla instead of placing a possibly septic thermometer in a patient's mouth; and that a few drops of a poisonous fluid might be as harmful there as a few germs.

FOUND, STRAYED AND LOST.

Abdominal surgery involves special anxieties, says the *Indian Medical Record*, and one of the worst is the fear that a forceps, sponge, or other foreign body has been left behind in the peritoneum after closure of the abdominal wound. Dr. Neugebauer, of Warsaw, has published a monograph on this terrible accident which will not reassure us. He classifies 101 cases, so that many operators are laudably candid, whilst necropsies tell terrible tales. In 38 cases the foreign body was only found at the post-mortem examination. In this grim list it is not surprising to find that in 19, or precisely half the cases, the object left behind was a sponge. In 14 cases the foreign body was spontaneously discharged through the anus. This occurrence must imply grave risk to the patient. In 12 cases the body was discharged through an abscess opening through the parietes or into the vagina. In 3 cases the body was missed, searched for and found just before closure of the abdominal wound. In 7 it was missed just after the closure of the wound, the wound was opened and the body removed. There is reason to believe that such an accident is so frequent that to these 10 cases several hundred might be added. The remaining cases include later operations for the removal of foreign bodies, also one in which several years after laparotomy Douglas's pouch was opened through the vagina and the body—a signet ring—removed, and two in which the missing body was left in the peritoneum in the hopes it would be discharged through an abscess. These three cases were not treated according to the generally accepted rules of surgical practice. To calculate the proportion of fatal cases in which the body was detected or came away before a necropsy would be of no value, so different were circumstances in different cases. The operator should remember that sponges seem very deadly, forceps nearly as dangerous, whilst gauze pads more readily tend to come away by the bowel. But the success or failure of secondary operations must depend in part on the severity of the laparotomy itself. Neugebauer notes two cases where the abdomen was reopened on the false alarm, nothing having been left behind. Such an occurrence might turn the scale against a severe case; still it is obvious that in every case in which a foreign body is reasonably believed to have been left behind, the cavity must be re-opened.