Years before this happened, in the address on surgery given at the Cork meeting of the British Medical Association, Sir William (then Mr) Savory had somewhat severely criticized the rigid exclusiveness of the members of the spray-and-gauze school: the sum and substance of the address was that every careful surgeon was an anti­septic surgeon, and that the success of the Listerian surgeon did not depend upon the spray or the gauze, or the two together, but upon *cleanliness—*that the surgeon’s fingers and instruments and the area operated on must be *surgically clean.* Though precise experiments show that it is impossible for the surgeon to remove every trace of septicity from his own hands and from the skin of his patient, still with nail-brush, soap and water, and alcohol or turpentine, with possibly the help of some mer­curic germicide, he can, for all practical purposes, render his hands safe. Recognizing this difficulty many surgeons prefer to operate in thin rubber gloves which can, for certain, by boiling, be rendered free of all germs; others, in addition, put on a mask, sterile overalls, and india-rubber shoes. But these excessive refinements do not seem to be generally acceptable, whilst the results of practice show that they are by no means necessary. The careful, the antiseptic surgeon of 1885 is to-day represented by the careful, the *aseptic* surgeon. The *antiseptic* surgeon was waging *a* constant warfare against germs which his creed told him were on his hands, in the wound, in the air, everywhere— and these he attacked with potent chemicals which beyond question often did real damage to the healthy tissues laid bare during the operation. If, as was frequently the case, his own hands became sore and rough from contact with the antiseptics he employed, it was not to be wondered at if a peritoneal surface or an incised tissue became more seriously affected. The surgeon of to-day has much less commerce with antiseptics: he operates with hands which, for all practical purposes, may be considered as gormless; he uses instruments which are certainly germless, for they have just been boiled for twenty minutes in water (to which a little common soda has been added to prevent tarnish­ing of the steel), and he operates on tissues which have been duly made clean in a surgical sense. If he were asked what he con­siders the chief essentials for securing success in his operative practice, he would probably reply, “ Soap and water and a nail­brush.” He uses no antiseptics during the operations, he keeps the wound dry by gently swabbing it with aseptic, absorbent cotton-wool, and he dresses it with a pad of aseptic gauze. This is the simple aseptic method which has been gradually evolved from the Listerian antiseptic system. But though the pendulum has swung so far in the direction of *aseptic* surgery, a very large proportion of operators still adhere to the *antiseptic* measures which had proved so highly beneficial. The judicious employment of weak solutions of carbolic acid, or of mercuric salts, and the application of unirritating dressings of an anti­septic nature cannot do any harm, and, on the other hand, they may be of great service in the case of there having been some flaw in the carrying out of what should have been an absolutely aseptic operation.

A great change has taken place in connexion with the use of soft india-rubber drainage-tubes. In former years most surgeons placed one or more of these in the dependent parts of the area of operation, so that the blood or serum oozing from the injured tissues might find a ready escape. But to-day, except in dealing with a large abscess or other septic cavity, many surgeons make no provision for drainage, but, bandaging the part beneath a pad of aseptic wool, put on so much pressure that any little leakage into the tissues is quickly absorbed. If a drainage-tube can be dispensed with, so much the better, for if it is not actually needed its presence keeps up irritation and delays prompt healing. But inasmuch as a tube if rightly placed in a deep wound is an insur­ance against the occurrence of “ tension,” and as it can easily be withdrawn at the end of twenty-four hours (even if it has served no useful purpose), it is improbable that the practice of drainage of freshly made cavities will ever be entirely given up. If the tube is removed after twenty-four hours its presence can have done no harm and sometimes the large amount of fluid which it has drained from the wound affords clear evidence that its use has saved the patient discomfort and has probably expedited his recovery. For septic cavities drainage-tubes are still used, but it must be remembered that the tube cannot remain long in position without causing and keeping up irrita­tion; hence, even in septic cases, the modem surgeon discards the tube at the earliest possible moment. If after he has taken it out septic fluids collect, and the patient’s temperature rises, it can easily be reinserted. But it is better to take out the tube too soon than to leave it in too long; this remark applies with special force to the treatment of abscess of the pleural cavity (empyema), in the treatment of which a drainage-tube has almost certainly to be employed.

Poultices are now never used: they were apt to be foul and offensive, and were certainly septic and dangerous. If moisture and warmth are needed for a wound they can be obtained by the use of a fold of clean lint, or by some aseptic wool which has been wrung out in a hot solution of boracic or carbolic acid, and applied under some waterproof material, which effectually pre­vents evaporation and chilling. There was no special virtue in poultices made of linseed meal or even of scraped carrot: they simply stored up the moisture and heat. They possessed no possible advantage over the modern fomentation under oil-silk.

Much less is heard now of so-called “ bloodless ” operations. The bloodlessness was secured by the part to be operated on— an arm, for instance—being raised and compressed from the fingers to the shoulder by successive turns of an india-rubber roller-bandage (Esmarch’s), the main artery of the limb being then compressed by the application of an elastic cord above the highest turn of the bandage. The bandage being removed, the operation was performed through bloodless tissues. But when it was completed and the elastic cord removed from around the upper part of the limb, a reac­tionary flow of blood took place into every small vessel which had been previously squeezed empty, so that though the operation itself had actually been bloodless, the wound could not be closed because of the occurrence of unusually free haemorrhage or troublesome oozing. A further objection to the application of such an elastic roller-bandage was that septic or tuberculous material might by chance be squeezed from the tissues in which it was perhaps harmlessly lying, forced into the blood vessels, and so widely disseminated through the body. Esmarch’s bandage is therefore but little used now in operative surgery. Instead, each bleeding point at an operation is promptly secured by a small pair of nickel-plated clip-forceps, which generally have the effect, after being left on for a few minutes, of completely and permanently arresting the bleeding. These clips were specially introduced into practice by Sir Spencer Wells, and it is no unusual thing for a surgeon to have twenty or thirty pairs of them at hand during an extensive operation. Seeing how convenient, not to say indispensable, they are in such circum­stances, the surgeon of to-day wonders how he formerly managed to get on at all without them.

Biers’s treatment by passive congestion is carried out by gently assisting the return of venous blood from a part of the body without in any way checking the arterial flow. In the case of tuberculous disease of the knee-joint, for instance, an elastic band is gently placed round the thigh for several hours a day, and in disease of the wrist or elbow the girth is applied round the arm. The skin below becomes flushed, and the arterial blood which, as shown by the pulse, is still flowing into the affected part, is compelled to linger in the affected tissues, giving the serum and the white corpuscles time to exert their beneficial influence upon the disease.

In the case of tuberculous, or septic, affections of the lymph­atic glands of the neck, or of other parts where the constriction cannot be conveniently obtained, effective congestion can be secured by the use of cupping glasses. And if so be that suppuration is taking place in the interior of an inflamed gland, the cupping-glasses can be applied after a small puncture has