thick, pupils unequal, tongue tremulous; there was loss of smell for pepper, and defective memory. After some months of this condition he became quieter, and appeared to be getting weak minded, and then in May, 1885, he was seized with a series of convulsive seizures affecting principally his left side, and leaving a temporary paralysis and anesthesia, and attended with a rise of temperature to 104° F. There was considered to be no doubt as to the nature of the case, he having had all one could want to make a diagnosis of general paralysis. The sequel is, however, interesting. From the time when he had these seizures, he has had no more symptoms. He had to be discharged "recovered" after an interval, and understanding that he probably had a progressive disease, and that the outside world would probably be too great a strain for him, he decided to remain here as a voluntary boarder, so he is still under observation. He is perfectly intelligent, has no loss of memory, manages his own affairs, and has no affection of speech, lips, or tongue, or other physical signs of general paralysis.

This case may, with some probability, be looked upon as a cure, but the patient being still under observation the details have not yet been published, there being, of course, the chance of the condition being merely a long remission. Mickle¹ quotes many recorded instances of long periods of remission and of real or supposed recovery, and gives some of his own cases. He adds: "It is noteworthy that several of the above-mentioned instances of recovery or of very prolonged remission have supervened on accidents, violent injuries or diseases of such a kind as to produce so-called 'revulsive effects.'"

In face of these facts I do not feel disposed to admit Dr. Claye Shaw's claim that "the operation has been justified by success." By his own admission the patient still has prominent bulbar symptoms in contrast to some of the cases I have given above, and I doubt whether the trephining has had more to do with the relief of the other symptoms than any other injury might have had.

It is surprising to me that Dr. Claye Shaw should not have referred to the fact of remissions occurring thus in general paralysis; this, I think, is a most important omission. Nothing is said as to the presence or absence of a history of syphilis.

Everyone must admire the boldness Dr. Claye Shaw has shown in resorting to trephining in an attempt to arrest this terrible disease, in which the physician, as a rule, stands powerless to do anything but guide the patient as gently as possible to the almost inevitable fatal termination, but I think few will care to resort to it from reading the case as it stands at present.

I have not touched on Dr. Claye Shaw's view of the pathology of the case, which has been discussed by Dr. Revington in your issue of November 23rd. I have failed to find in Dr. Claye Shaw's paper the expression "fluid in the convolutions," which Dr. Revington states is there, and I think it is a matter of regret that the latter should have used the expression "mechanical nonsense" in his criticism. With the exception, however, of these points, and the remark that I do not think it a universal custom to incise freely simply cedematous subcutaneous tissue, I agree with his letter.

Everyone will anxiously await for a further history of this case, which I hope will not be lost sight of. Though the patient may not be insane at present, I think there is little doubt he is merely in a period of remission, and that he will not remain long out of an asylum.

AMPUTATION AT THE HIP-JOINT, WITH THE SKEWER METHOD OF SECURING THE VESSELS.

By ROBERT JOHN GARDEN, M.D.,

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I HAVE read with interest the account in the JOURNAL of November 9th by Mr. Thomas Myles of a proposed new method of performing amputation at the hip-joint. The following notes of a case in which I performed this operation will show that the method adopted by me was almost the same as that proposed by Mr. Myles.

A. A., aged 21. Leg began to give trouble in June, 1887, pain being referred both to the hip-joint and the knee. The pain increasing, patient, who was a marine, was sent to Portsmouth Hospital, and was treated for sciatica. Morbus coxae being diagnosed, a stiff bandage was applied for six weeks, followed by a ten-pound weight extension for three months. In July, 1888, he was invalided, came to Aberdeen, and was admitted into the Royal Infirmary. Extension was tried. A Thomas's splint was applied afterwards, and the patient was allowed to go home. In the beginning of 1889 an abscess formed and burst on the inner side of the thigh, and he was readmitted to the infirmary in February. For a time he did well, but towards the end of March his temperature, which had been about normal, suddenly rose to 102° F., and continued hectic. On April 18th a large abscess in anterior aspect of the thigh was opened from end to end. This was not followed by any marked improvement, and about the beginning of May patient expressed a wish that something radical should be done. It was resolved, considering his age and the extent of the disease, to remove the limb at the hip-joint, and on May 28th this was done.

Since the unhealed wound which remained after the operation for opening the abscess in April would have been in the centre of an anterior flap, I resolved to amputate by lateral flaps. My operation differed from that suggested by Mr. Myles, inasmuch as I first cut the outer flap with a small knife, cutting from skin inwards. The bleeding vessels were secured by ligatures. By cutting the outer flap in this way it can be formed of better shape than by transfixion, owing to the prominence of the trochanter major. Further, a thorough examination can be made of the joint and upper part of the bone, in the event of its being deemed desirable, after the real state of the parts has been observed, to give the patient a chance of retaining his limb by excision. I then introduced a skewer from before backwards, exactly as proposed by Mr. Myles, the parts with the vessels being compressed by an elastic band. A long amputation knife was now introduced by the side of, but below, the skewer, and a large internal flap cut by transfixion. The head of the femur was then disarticulated—an easy process, for it was much wasted and softened by disease. The arrest of the bleeding was most complete, not more than a tablespoonful of blood having been lost.

Satisfactory progress was made after the operation, and the skin wound healed almost by first intention. A little discharge from the deeper parts continued for some time; but this is not to be wondered at considering the nature and extent of the disease.

I have had considerable experience of amputation at the hip-joint. The result has been uniformly successful, as in my fourteen cases I have had no death due to the operation. All my cases recovered except a child aged 9 months (whose leg was removed for a large sarcoma of the thigh) who died of measles contracted after the operation. So far as cutting the flaps is concerned, I pretty much followed the plan recommended by Furneaux Jordan, combined with the skewer securing of the vessels as suggested by Spence.

My experience does not lead me to regard the risk from shock as very great. The operation as described above removes the wound well away from the anus; and by the skewer method, both when antero-posterior and lateral flaps are formed, all danger from bleeding is effectually removed.

A CASE OF ELEPHANTIASIS TELANGIECTODES AND MOLLUSCUM FIBROSUM.

By WILLIAM CALWELL, M.A., M.D.,

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THE patient is a little, good-natured young man, aged 28, somewhat deficient, however, in the higher mental faculties. His father and sister, according to his own statement, suffered from small subcutaneous tumours, resembling the molluscum fibrosum of himself. Over his own body, except on hands and feet, are these sessile tumours, more or less subcutaneously movable, varying in size and elevation, frequently with large comedones, and some having the skin a dusky bluish-red. The left lower extremity is $5\frac{1}{2}$ inches longer than the right, hence he suffers from lateral curvature; the left thigh is 18, the right 14 inches long, and there is great irre-

¹ *General Paralysis of the Insane*, second edition, pp. 269 and 387.