catheter is next introduced into the Eustachian orifice under guidance of the rhinoscopic mirror. The handle of the catheter is then moved towards the opposite angle of the mouth, and perhaps slightly depressed, the beak of the instrument being introduced well into the tube by a slight onward and upward movement of the whole instrument. Inflation can now be made with the bag in the ordinary way. The opposite tube can of course be catheterised without removing the instrument from the nasopharynx. My catheter, being only curved in one plane, differs from that of Cutter, of Boston, in which the terminal portion of the instrument is movable, and also from those suggested by Störk and Kessel, who, according to Politzer, recommend that the instrument should be bent to one side as well as somewhat backwards. I agree with Politzer that without fixation of the palate post-nasal catheterism is often difficult or impossible, but with the use of the hook it becomes a simple and sure procedure.

How far in cases of obstruction of one nasal cavity this method of catheterism will supersede that through the opposite nostril remains to be seen, but certain it is that the Eustachian tubes can be easily catheterised in this manner, and with but little inconvenience to the patient.

A SUCCESSFUL CASE OF CÆSAREAN SECTION.

By F. ALBERT MOUILLOT, M.B.,
Gorey.

ON Friday, May 16th, I was sent for by Dr. Acheson to see with him a Mrs. L., who was in labour. On my arrival at 9 P.M., I found that Mrs. L. had been suffering from pains for thirty-six hours, and had had strong pains for eight hours. She was 30 years of age, and married nine months.

When I examined her, I found a large portion of the uterus low down in the pelvis, and the os sufficiently dilated to admit my finger. The presentation could not be felt, and the brim of the pelvis was certainly not more than two inches in its conjugate diameter.

After consultation, Dr. Acheson and I were of opinion that delivery was impossible except by abdominal section. This procedure was accordingly decided upon, but some delay took place owing to the reluctance of the patient's friends to allow the operation. The patient herself was in such dreadful agony that she was willing to submit to anything—indeed, she repeatedly asked us to poison her or allow her to throw herself into the river. Dr. Pounson's assistance was obtained to give chloroform. All this time the patient repeatedly said she could feel the child coming into the world, but examination showed that this sensation was caused by the pressure of the cervix on the perineum as more and more of the uterus was forced down by the violence of the uterine contractions.

At midnight Dr. Pounson put the patient well under chloroform, and a catheter having been passed, I made the abdominal incision in the usual manner. No vessel required ligaturing. The uterus, when incised, bled, but not profusely. The focus was found to be placed with its bræch downwards and dorsal surface anterior. I removed it by the breech without difficulty, and following the cord found the placenta at the fundus. The child was vigorous and well developed. The uterine wound looked so very formidable that, contrary to my original intention, I made up my mind to suture it, but was prevented by a firm contraction coming on when I placed my hand on the fundus; and in consequence, I suppose, of so much of the cervical portion of the womb being in the vagina, only the fundus was to be seen after the contraction. A coil of intestine escaped through the wound, and had to be replaced.

The abdominal wound was then united by ordinary silk sutures, and the patient was allowed to recover from the chloroform. She was given a dose of ergot, and the wound was dressed with dry lint.

Dr. Acheson, who gave the case unremitting attention, tells me that on the fourth day the temperature rose to 100° F., and there was some sickness, which yielded to his treatment. After this recovery was uninterrupted. The sutures were removed on the ninth day, and the wound, which had been dressed with Gamgee's gauze tissue dusted with iodoform, was healed. The bowels acted the same day from a dose of pulv. glycyrrhizæ co.

I visited her on May 30th, and then found that her height was

4 feet 11 inches, and the distance between the anterior superior spines was only 8 inches.

The operation was done by candle-light in a peasant farmer's house, and the satisfactory result can only be attributed to the fact that, though the patient's sufferings were terrible to witness, she had not become exhausted when the operation was done, and consequently a good uterine contraction followed the removal of the child. Had I been prepared I would have preferred doing Porro's operation, but I only had an ordinary pocket case at hand.

ON THE RADICAL CURE OF HERNIA.

By ERNEST KINGSCOTE, M.B.,
Honorary Surgeon to Salisbury Infirmary.

THE utilisation of the sac as an internal pad in the radical cure of hernia has, since the introduction of antiseptics, become of such absorbing interest to the surgical world that any remarks bearing on the subject and substantiated by facts carry their apology with them. Mr. Stanmore Bishop's interesting paper has induced me to give a short description of the operation I am in the habit of performing.

The incision is transverse and well above the internal ring. With the aid of retractors this gives plenty of room for manipulation, and after the final stitches are secured the wound is carried high up on the abdominal wall, and thus the danger of septicism from the pubic hairs, etc., is minimised. This was suggested to me by my friend, Mr. Wainwright, of Charing Cross Hospital. The operation is then conducted, up to the point where the treatment of the stump commences, on similar lines to those of Macewen, Barker, and Bishop, the fingers and handle of the scalpel being used where possible instead of the knife. The sac is then carefully dissected out, as in Macewen's operation, for about half an inch round the abdominal aspect of the internal ring, and two stout absorbable catgut sutures are inserted diagonally through the stump, as far inwards as its separation from the abdominal wall will allow, and carried on loosely through the pillars of the ring (Fig. 1). One or more fine absorbable catgut stitches (stout

Fig. 1.

ones are unnecessary owing to the quickly uniting properties of the applied peritoneal surfaces) obliterate the opening into the peritoneal cavity.

The stump is then pushed a little inwards, and three—or more if necessary—very stout catgut sutures are introduced through the transversalis fascia, etc. (the point of the needle impinging on