sinus was soft and sloughy, there was no evidence of thrombosis. On pricking the sinus over this area, blood flowed freely. During that day the child had a rigor, and another on the following day, June 1st. I then determined to ligature the internal jugular vein, and open and plug the lateral sinus. On tying the vein the child became so collapsed that I did not dare to proceed to open the lateral sinus. I therefore proposed to postpone that portion of the operation till the child had recovered a little from the shock.

On June 2nd he had another rigor, and he was still very feeble.

On June 3rd I opened the wound, and found that the sinus was firm, and that it had evidently thrombosed very recently. I therefore determined to do nothing and watch the course of events. A slight erythematous rash appeared on the shoulders on the following day; but with the exception of a rise of temperature, due to a collection of pus about the ligature of the vein, the child had no marked rise of temperature up to the present date, namely, seventeen days after the ligature of the vein, and sixteen days after the thrombosis of the lateral sinus and the last rigor. There has been no indication of the thrombus in the sinus breaking down.

In this case we had a sequence of at least eleven rigors, the temperature rising each day to between 104° and 105° , then subsiding abruptly, not with the ligature of the internal jugular vein but with the thrombosis of the lateral sinus, on the following day. It seemed to me that the slowing of the venous circulation, consequent upon the ligature of the internal jugular vein *plus* a probable amount of irritation or of superficial thrombosis resulting from the inflamed condition of the outer wall of the sinus, determined its complete occlusion. There was no optic neuritis observed at any time.

FURTHER REMARKS ON THE SELF-RETAINING PALATE HOOK; INCLUDING ITS USE IN POST-NASAL CATHETERISM.

By E. CRESSWELL BABER, M.B.LOND.,

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IN the JOURNAL for January 12th, 1889, I described and recommended White's self-retaining palate hook for drawing forward the soft palate. Since that date a constant use of this instrument has continued to prove to me its great value both for examination and for operations in the nasopharyngeal cavity. As a larger experience has brought out some fresh details in its application, and in regard to the special cases in which it is of benefit, a few remarks supplementary to those I have already made may be of service to those using the instrument.

First, I now never use a weaker solution of cocaine than 10 per cent., and it almost always suffices to run a few drops into the nostrils with a syringe or medicine dropper (letting them run back over the palate), in order to allow the hook to be kept in position for several minutes at a time. If sufficient anæsthesia is not produced by these means, the cocaine is also painted up behind the soft palate.

Secondly, after the hook has been introduced behind the palate, I direct the patient to close his lips without biting the instrument. The nasal respiration thus induced, especially if the patient sniffs at the same time, causes the palate to relax, and allows it to be drawn freely forward with very little effort.

A mistake often made by those unused to the instrument is that they do not pull the palate forward sufficiently, and consequently obtain an imperfect view whilst producing more irritation. The hook when applied should hold itself firmly in position without the use of the screw. If it does not do so the instrument, if of right size for the case, is faulty. Either the arms of the sliding adjustment are not sufficiently bent towards the hook—which can easily be remedied with the fingers—or the sliding adjustment itself is not correctly fitted to the bar.

I sometimes use a hook of which the lower part of the loop is closed by means of a thin plate of metal. This modification has the advantage of not allowing the uvula to fall through; but it has the disadvantage of preventing the angle of the hook from being easily altered. I have also tried Dr. White's modification of the hook, in which the bar is provided with a joint, enabling

the handle to be turned laterally at right angles after introduction of the instrument, but have not found this of any special advantage.

Messrs. Down have made for me an electric palate hook—that is, one of these instruments which has attached close behind the convexity of the hook a small incandescent electric lamp, the wires carrying the current running in the stem of the hook. This gives a splendid illumination of the nasopharynx, but whether it has any special advantages over the ordinary hook I have not yet ascertained. With a view of using it to illuminate the nasal cavities by transmitted light, a little metallic reflector can be attached behind the lamp in order to throw the rays of light forward.

For simple inspection of the nasopharynx the hook is invaluable. By its use rhinoscopy is no longer in many cases a question of skill and perseverance, but can be thoroughly and easily performed, and is quite as simple as laryngoscopy. I agree with Tornwaldt that no inspection of the nasopharynx can be considered complete unless the palate is first drawn forward by this or some other method. For, on the one hand, the close proximity of the palate to the spinal column often renders it difficult to obtain a good view of the choanæ. On the other hand, the anatomical position of the vault and posterior wall of the nasopharynx necessarily renders a view of it obtained after the palate has been retracted much clearer and less foreshortened than it otherwise could be. Indeed, when the tubercle of the atlas is prominent, it is almost impossible to see the back wall of the nasopharynx at all without the retractor. A considerable portion of this wall can be seen by direct inspection in the following manner: The hook being placed in position, but for this purpose not drawn forward very tightly, the patient's mouth is opened wide and his head tilted back as far as possible without obscuring the pharynx with the lower teeth. The anterior end of the palate-hook is then depressed, tilting the distal end upwards. The posterior wall can thus be seen to a considerable distance above the tubercle of the atlas, sometimes even as high up as the opening into the pharyngeal bursa.

A class of cases in which the hook has proved very successful in my hands is those of deep syphilitic ulcers on the posterior wall of the nasopharynx. With the hook they can be treated and watched with the rhinoscopic mirror, and can be seen to a considerable extent by direct inspection in the manner just described. Painting with solution of sulphate of copper or of nitrate of silver, and a post-nasal spray of perchloride of mercury I have found the best local treatment for these cases. For the treatment of affections of the pharyngeal bursa and tonsil in the adult the hook is of equal value. Dr. Bronner prefers Voltolini's hook to this one, but surely when one requires both hands for holding the rhinoscopic mirror and operating in the nasopharynx, it is no small advantage to have an instrument which holds itself in position, can be easily adjusted to any tightness, and can be removed without the least difficulty.

There is another purpose for which I have found the hook of service, and that is in catheterism of the Eustachian tube through the mouth. The catheter which I have had constructed for this purpose is of metal; its size and shape are shown in the accompanying woodcut. The catheter measures nearly 18 centi-

mètres from the large curve to the end. Both curves are in the same plane, which enables the instrument to be used for either ear. It is well to have one or two catheters of slightly different curves.

The method of using this catheter is as follows:—The palate being drawn forward to its full extent, the patient holds down his tongue with an angular tongue depressor. The point of the

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.,
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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