renders this instrument inadmissible. This circumstance, coupled with the fact that it monopolises the hand necessary for operating, or for the application of remedies, undoubtedly accounts for the disparaging terms in which its employment is spoken of by most writers on the subject.

As a substitute for the palate-hook, possessing all its advantages with few of its drawbacks, and as a means admissible in numbers of cases where the use of this instrument is excluded, I am in the habit of adopting a plan, the simplicity of which would certainly lead one to infer its previous employment, whilst perhaps, at the same time, explaining its want of notoriety.

A glance at the chief obstacles to a successful rhinoscopic examination shows them to consist either in (a) insufficiency of the distance between the soft palate and the posterior wall of the pharynx, or (b) in an extension in a downward direction of the attachments of the lateral margins of the soft palate to the pharynx, thus unduly limiting the space between the free margin of the velum and the dorsum of the tongue necessary for the adequate illumination of the rhinal mirror; and, lastly, (c) excessive irritability, which may complicate one or both the previous conditions.

Bearing in mind the precise nature of these obstacles, and recognising the desirability of a hand at liberty for operating, application of remedies, etc., the following directions become intelligible.

Placing the patient in the usual position and illuminating in the ordinary manner, having depressed the tongue with a rectangular tongue-depressor, I instruct him to hold it in position. Taking advantage of the insensibility of the uvula as compared with the neighbouring structures, I pass around it a ligature, tying sufficiently tightly to hold and yet to allow removal (practice soon determines this tension). Since this ligaturing of the uvula is not always unattended with difficulty, I have had constructed the following "uvula-snare", which, as its use obviates any difficulty in this respect, I will shortly describe.

It consists, as seen from the woodcut, of an outer hollow ring, A B C, the upper half being movable on the hinge H, and open along its internal margin; the lower half consists of the two tubes, A and C, united to the stem at the shoulder E, and communicating with corresponding perforations in it. The portion D consists of a semicircular tube open along its internal margin. The instrument is represented with the upper segment partially open, to show the position of the ligature when ready for use.

In preparing the instrument for use, the upper portion B being widely opened, an end of the ligature is inserted in one of the apertures in E, and drawn through the corresponding tube to the extent of about fourteen inches; an ordinary undrawn knot is now tied, and the same end of the ligature inserted into the distal opening of the other tube, and drawn out through the corresponding aperture in E. The lower portion of the loop having been arranged so as to lie in D, the upper portion is protected by closing B, when the instrument is ready for use.

The instrument being introduced, so as to allow the uvula to hang within the ring A B C, the free ends of the ligature are drawn tight, allowed to hang free, and the instrument withdrawn. If the proper tension have been exercised, the uvula and soft palate may now, by means of the ligature, be drawn forwards and to either side, whilst the examination is conducted by means of the rhinal mirror. This completed, and

the most favourable position of the palate for the attainment of the object in view having been thus determined, the free ends of the ligature are secured by the attachment of a small weight, and both passed over either ear, or one end over each ear, according as a lateral or median traction is found the most suitable. The operating hand is thus set at liberty, and may be employed under more favourable conditions than by any other method with which I am acquainted.

The ligature is usually easily removed by passing a bent blunt probe between the loop and the uvula whilst employing gentle traction by the free ends. In some specially unfavourable cases, where a satisfactory examination is not attainable on the first attempt, the object may be gained by a daily ligaturing of the uvula *high up* and stretching of the parts, thus occasioning their temporary relaxation, and, at the same time, familiarising the patient with the procedure; a circumstance tending materially to facilitate operations in these sensitive regions.

HODGEN'S SPLINT, AS USED IN GUY'S HOSPITAL.

By J. FARRANT FRY, L.R.C.P. (late House Surgeon).

FOR some time past, fractures of the femur (whether of the neck or shaft) have been treated in Guy's Hospital with the Hodgen's splint. The results have been so uniformly satisfactory, that an account of the splint cannot but be of service, and will, in all probability, lead to its more frequent use.

A pole, about seven feet in length, is fastened to the foot of the bedstead, not at a right angle to it, but forming, with it, an angle of about 115 deg.; and, to make it more secure, it is better that the end of the pole should be fixed in the ground by a spike. To the upper end of this pole a pulley is attached. A piece of strapping (of which Leslie's brown holland is perhaps the best) is placed along each side of the limb, leaving a stirrup projecting beyond the foot, in which a piece of wood is placed, having some cord fastened to it. Thus vertically placed, strapping is now securely bound to the leg by horizontal pieces, extending from the ankle to as near the seat of fracture as possible, but, of course, omitting the knee.

The splint itself consists of an iron rod, extending on each side of the leg, from the groin on the inner and rather higher on the outer side, to a few inches beyond the foot, where the two rods are united by a transverse one; the two pieces are further fastened together by two or three rods arching across the limb. The cord fastened to the stirrup is now tied securely to the transverse piece, bringing these two almost close together.

To support the leg in the splint, something must pass between the two rods and beneath the limb. For this purpose, strips of bandage may be sewn to the rod on one side, and each separately carried beneath the limb and fastened to the rod on the other side, after being drawn sufficiently tight to fit the inequalities of the leg. A cord is now fastened by its ends to the outer and inner rods, rather above the knee, leaving a large loop, at the centre of which is a double-block pulley, round the lower wheel of which the cord runs. Another cord is fastened in a similar manner midway between the knee and ankle, and leaving, like the first, a large loop passing through another double pulley. The splint containing the limb has now to be raised from the bed by a third cord, which passes through the upper wheel of the two double-block pulleys, and thence round the pulley attached to the pole at the foot of the bed.

By this means, the limb can be raised to any height, the most convenient being an angle of about 135 deg. with the recumbent body. The lower end of the bed should be raised on blocks, to prevent the patient from being dragged down by the extension which is exerted.

Until this splint was introduced, the long outside-splint with weights was generally employed; but whether this plan, the perineal band, or double inclined plane, was adopted, the results were so bad that Mr. Cooper Forster, in the *Guy's Hospital Report* for 1875, says: "If an adult fractures his thigh, it is all but certain that there will be shortening of an inch; and that the method adopted to keep up extension does not matter, provided always that, whatever the plan may be, it is overlooked with care, the result will be about the same."

The advantages claimed for the Hodgen's splint over others are: 1. Less shortening of the limb; 2. Greater comfort to the patient, who is able to sit up in bed, to turn on either side, and conveniently to use the bed-pan; 3. Less liability to bed-sores in aged people. In fact, there is no one point in which (for an adult) any other treatment is to be preferred.

The results, as regards shortening of the limb, may best be shown by giving statistics of an equal number of cases. Out of seventeen unselected cases of fracture of the shaft of the femur, treated in 1874 by

the long outside splint and weights, varying from ten pounds to four-teen pounds, the average amount of shortening was more than an inch; in one case, it was two inches; in five, it was one and a half; in five, it was one; and in two only, was it less than an inch. No case is recorded in which there was no shortening. This exactly accords with eleven cases reported by Mr. Cooper Forster in the *Guy's Hospital Report* for 1875. Out of seventeen also unselected cases, treated with the Hodgen's splint, the average amount of shortening was considerably less than half an inch. In two cases, it was one inch, and in all the rest it was less than an inch; six cases being returned without any shortening.

HYDROBROMIC ACID.

By EDWARD WOAKES, M.D.,

Surgeon to the Throat Hospital.

THIS drug having established its claim to antagonise the ear-symptoms occasioned by large doses of quinine, there appears to be but one step between this fact and the inference that it should be equally efficacious in analogous states of the ear arising from other causes. Viewing certain forms of tinnitus as possessing marked analogy to the condition induced by quinine—one, that is, of congested labyrinthine circulation—I have prescribed certain remedies with a view to the relief of this most distressing symptom; amongst these codeia, with some advantage, but not in any degree comparable to the results attending the hydrobromic acid. It may be needless to remark that the cases should be selected with a view to their appositeness to the presumed physiological action of the drug; and the indication which should be regarded as most distinctly pointing in this direction is that the noises have more or less of a pulsating, or, as the patient will describe it, a "knocking" character. The existence of vertigo, if present, will rather confirm the indication for the exhibition of the acid. The subjoined cases are intended to illustrate these remarks, and are taken from a number of others under recent observation.

F. C., aged 24, was the subject of otorrhœa media, associated with tinnitus of a very distressing character. This latter symptom persisted long after the others had yielded to treatment. The patient, a fairly intelligent mechanic, described the noises as increased on lying down, when they became "like the knocking of his heart". He was ordered fifteen minims of hydrobromic acid in water every four hours. At his next visit, he stated that, after taking three doses, the noises had much diminished, an improvement which steadily continued, so that at the end of a week he considered himself well.

J. T., a chorister, aged 33, presented an acutely inflamed condition of the lining membrane of the middle ear, which projected through a large central perforation of the drum-head. The external meatus was red and tender in its deepest portion, and near the membrane were two granular polypoid growths. There was abundant otorrhœa of a very fetid description. After removal of the growths from the external canal, the subsidence of the inflammatory state of the tympanic cavity, together with the discharge, he still complained of pulsating noises in the head, increased by walking or stooping, headache and occasional giddiness. The hydrobromic acid was given, as in the previous case, with an equally rapid disappearance of all the symptoms associated with the tinnitus.

Two points appear important to secure the success of the drug. 1. The auditory apparatus must be clear of any well marked objective morbid process. 2. The tinnitus should present the characters of congested blood-supply, already alluded to. In mentioning the foregoing facts at a recent discussion at the Harveian Society, owing to the lateness of the hour, the distinctive indications for the successful administration of the drug were not insisted upon, an omission which, I trust, this communication will sufficiently rectify.

MARYLEBONE.—Dr. Whitmore states that in the quarter ending March 31st there were registered 1,240 births and 920 deaths, which gave an annual death-rate of 23.10 per 1,000, being 3.74 per 1,000 more than in the previous quarter. This excess was chiefly caused by an unusual mortality from pneumonia and bronchitis. There were four deaths of young children from small-pox, one of whom was successfully vaccinated seven days before the disease appeared. There were also nine deaths from this disease in the Metropolitan Asylum Hospitals. A meteorological summary is also given for the quarter, showing that the highest and lowest temperatures were observed in March, and that as much as 5.06 inches of rain were registered in January. The sanitary works carried out show reasonable activity for the time of year.

OBSTETRIC MEMORANDA.

PUERPERAL ERYSIPELAS.

MR. FORD'S Case of Erysipelas in connection with the Puerperal State reported in the *JOURNAL* of June 2nd, reminds me of a similar one which came under my care about a month ago. In my case, however, an attack of facial erysipelas came on three or four days after labour, and readily yielded in a few days to treatment by the internal use of tincture of sesquichloride of iron and the external application of thin gruel; nor was there any interference with either lochial or lacteal secretion. Unlike Mr. Ford's patient, mine was in very indigent circumstances.

J. B. WILLIAMS, M.R.C.S., L.S.A., Hull.

MIDWIFERY-FORCEPS.

THERE is no instrument used by the medical profession of which there are so many varieties as midwifery forceps. In the lists published by Maw, Son, and Thompson, and by Arnold and Son, there are forty-five. Each, no doubt, in the opinion of the inventor, has its peculiar advantages; but in all the long forceps there is a very serious defect: *i. e.*, it is impossible to use traction with them in the axis of the inlet of the pelvis, without using undue pressure on the perineum or os pubis of the mother. To illustrate what I mean, let us bear in mind the direction of the pelvic axis. A line, carried from the umbilicus to the middle of the coccyx, gives the axis of the inlet; a line, drawn from the upper part of the sacrum to the centre of the outlet, gives its axis. Let us take it for granted that the child's head is at the inlet, and we want to deliver; if we attempt it with straight forceps, we find the thing impossible (unless the sacrum be very slightly curved and the perineum short), because the instrument will occupy the axis of the outlet. With curved forceps, we may deliver—but how? The blades are in the axis of the inlet, the handles in the axis of the outlet, and, consequently, nearly all the force must be exerted against the os pubis. With these mechanical disadvantages, the pressure unavoidably employed is often sufficient to sacrifice the life of the child. It is said that, with "Tarnier's new forceps", or rather two forceps, the operator can *always* use traction in the axis of the pelvis, and I believe this to be the case; but the instrument is too complicated, and requires the use of both hands, one to each forceps. A far simpler instrument, about which I have been thinking for some time past, will do all that it is said to do. Let us take, for example, Knight's forceps (there is a picture of it in Maw and Son's illustrated list); it locks by a screw, the handles are of steel, with a blunt hook at the end of each. Now, let us bend the handles as much backwards as the blades are curved forwards, and let us fancy that this instrument is applied on the child's head, and that it is at the brim of the pelvis; we find that the blades are in the axis of the inlet, the perineum resting on the depression at the lock, and the ends of the handles on a line with the axis of the inlet of the pelvis; consequently, traction made by them must be in that line. As the labour advances, by letting the handles of the instrument go forward, one must be in the axis of the pelvis all the time. This instrument is very simple, and will require very little force, because it can always be used in the right direction; the lock will act as free as straight forceps, because the curve of the handle corrects the curve of the blade.

DAVID CHRISTIE, L.R.C.P.E., Carrigart, Co. Donegal.

GLASS SPECULA.

IT may not be known to all the readers of the *JOURNAL* that glass specula, not quite of the same kind as those mentioned by Dr. Murphy, have been used for many years in Germany. In 1866, I purchased, in Berlin, a case containing four specula of various sizes packed inside each other, and made of opalescent glass, which is very tough, and bears boiling water without cracking. I have used these constantly in my practice, and prefer them to any of the others in common use.

THOMAS FAIRBANK, M.D., Windsor.

I FULLY agree with Dr. Murphy as to the superiority of plain glass specula. I have tried them, and have proved them to possess all the advantages which he claims for them.

My reason for writing, however, is to point out that the toughened glass of which he and other correspondents are desirous of having them made has been known to "explode" suddenly and without any apparent cause. Should this occur during their introduction, or while *in situ*, it would be extremely awkward, if not absolutely dangerous.

H. F. C. EAGLE.