(thicknesses of towel); and I seized the tongue with a pair of forceps, and transfixed the tip of it with a needle carrying a stout double thread, which was afterwards looped and given to an assistant, by which he pulled the tongue well out of the mouth. I then laterally transfixed the tongue with a blanket-pin, beginning at the right angle of the mouth and bringing it out at the left, and by this means carried the pin immediately in front of the epiglottis. I then placed a single loop of very stout whipcord around the tongue behind the pin, giving it one turn of a knot, ready to be tightened. Next, I divided the attachments of the tongue to the floor of the mouth by means of a pair of scissors, while it was being dragged well out by the looped thread—taking care to hold the face well sideways and close as possible to the pillow. Then I quickly severed the tongue with the whipcord, which cut it much as it would cut hardened butter in frosty weather.

There was very smart hæmorrhage during the time the scissors were being used, and the patient lost, as near as I could tell, about three ounces of blood. There was no further hæmorrhage after the tongue was removed—never a drop from the surface traversed by the whipcord; and no ligature, or even mopping of parts with styptic, was required. The patient remained in bed three days, and went home—on foot, I believe—on the eighth day, a distance of eleven miles.

She had eight months of comparative health, when the cancer returned, this time in the larynx, and ended her life thirteen months after the operation.

I saw, during my student-days, the late Mr. Nunneley of Leeds remove tongues by his method; and afterwards, as an Edinburgh student, I saw the procedure of the late Mr. Syme carried out. In using the *lévaseur*, surgeons use the quite unnecessary precaution of waiting each time, after giving the handle a turn, half a minute or more, thinking thereby to prevent hæmorrhage. After a thirteen years' experience of the application of torsion among the so-called lower animals, I am in a position to state that no more blood is lost after the most speedy severance of actively vascular parts by the most rapid strangulation than is lost by the measured torsion at present resorted to. Further, I have not seen, even by Mr. Syme's operation, the tongue and its attachments more completely removed than was quickly effected by my simple proceeding.

MORPHIA AND A TELL-TALE AS AIDS TO COMPRESSION IN ANEURISM.

By C. F. MAUNDER, F.R.C.S.,
Surgeon to the London Hospital.

In my Lettsonian Lectures of 1875,* I drew attention to the value of morphia as an aid to compression, as a substitute for chloroform and its attendant risks. I illustrated its use in the case of a gentleman who "dozed, took his meals, smoked his pipe, and submitted to continuous digital compression for twenty-three hours, with scarcely a complaint; and, at the expiration of this time, expressed himself as capable of enduring treatment many hours longer". The following is another example of the value of the drug.

In February 1877, Mr. —, who is now forty-two years of age, was advised that he was the subject of an aneurism of the popliteal artery. He was put to bed and treated for the first ten days with a bag of shot weighing eight pounds placed over the common femoral artery. During the next month, a tourniquet was substituted, and worn during eighteen hours out of the twenty-four over the superficial femoral artery. His health now began to fail; treatment was discontinued; and he went to his business, the tumour being smaller and pulsation less marked. During the last three months, the swelling and the pulsation had both increased, associated with pain and general discomfort about the knee.

March 29th, 1878. I found Mr. — with an aneurism of the size of a large orange occupying the upper half of the popliteal region, and bulging somewhat to the inner side of it. Continuous digital compression with a weight of ten pounds was advised, aided by morphia, if necessary.

March 30th. Mr. W. R. T. Hawkins and Mr. Albert E. Jones of the London Hospital commenced the compression treatment at 11.45 A.M., the common femoral being the artery selected; and they maintained complete occlusion of this vessel for the space of half an hour alternately. At 4 P.M., the patient suddenly complained of severe pain (distal occlusion?), commencing in the calf of the leg, and running up along the aneurism and femoral artery. A quarter of a grain of

morpha was now hypodermically injected, and relief afforded. From this time, when the gentleman compressing was relieved by his colleague, and the pressure for the moment somewhat relaxed, the force of the pulsation in the aneurism was observed to be gradually diminishing. At 8 P.M., an assistant was recruited, in order to help in the continuation of the compression through the night.

March 31st. At 2 A.M., another paroxysm of pain occurred, after which pulsation was scarcely, if at all, perceptible; and a firm swelling occupied the seat of the aneurism, the disease being practically cured. At 10 A.M., no pulsation could either be felt or seen. One or two arteries could be detected meandering the knee. Compression was continued during the day as a precautionary measure. Throughout the whole time (thirty hours), the patient lay on his back, with the thigh rotated outwards, and the leg flexed at a right angle on this. An indicator (which consisted of a penholder with a piece of paper like a flag placed between the ribs, and which marked the presence or absence of pulsation in the aneurism) was lodged like a finger-post in the flexure of the knee, and acted like a tell-tale to the compressor. Mr. — took food at intervals, and was cheerful and chatty, except when asleep. An injection of morphia was resorted to four times.

The skin over the seat of compression, which had been protected by the occasional application of French chalk, was slightly reddened only, and was the source of the least possible discomfort to the patient, who said he could have borne the treatment many hours longer.

CASE OF PARALYSIS AFTER APPLICATION OF A PLASTER BY AN UNQUALIFIED PERSON TO THE NAPE OF THE NECK.*

By E. RICE MORGAN, M.R.C.S. Eng., Morriston.

X. M., AGED 25, living at Landore, workman in a tinworks, had been suffering for about six years from a skin-affection located at the back of the neck; whether sycosis—an unusual situation I admit—or some other cutaneous disease, I am unable to say, for I did not see the man in the early stage; in fact, not until the skin-affection had been effectually got rid of. His previous history was good; he had never had paralysis of any kind before, nor could I find any traces of a specific history; and I have grounds for saying that up to October 1877 he was a strong healthy man.

When I first saw the patient in October 1877, he was in a very dangerous state. His face was very swollen and painful; his eyes were suffused; his tongue was very foul; pulse quick and compressible; throat dry and sore, accompanied by cold clammy sweats; and I came to the conclusion that he was suffering from blood-poisoning, and thought it was probably due to arsenic. At the back of the neck was a large deep slough as large as the palm of one's hand, and I then elicited that, about nine days previously, a certain unqualified practitioner had applied a plaster to the nape of his neck to cure, as he said, the skin-disease. For a few days, the prognosis was very doubtful, and, though I treated him for blood-poisoning from some metal, I was unable to obtain any portion of the said plaster to find out by analysis its ingredients.

These bad symptoms gradually gave way, but, about the tenth day, I found he had lost all motor power in the arms and legs. Sensation, however, was unimpaired; nor did he lose power of speech or consciousness, and he had control over all the sphincters. The spinal cord being, as I judged, implicated high up, I was afraid that possibly the muscles of respiration would become affected; but, fortunately for the man, this did not occur.

After careful treatment, specially with sulphate of magnesia, iodide of potassium, and cinchona, the man quickly improved. The large wound left by the plaster gradually healed; the appetite returned, and with it strength. The return of power to the muscles, however, was very gradual; and it was nearly four months before he could place his hand upon his head; but this improvement has been going on uninterruptedly. His legs, of course, have been much slower in recovering.

March 29th, 1878.—He now looks quite fat, as compared to what he was four months ago. He can take a spoon in his hands, and carry food in it to his mouth, and can give a very fair grip to one's hand. The extensors are less powerful than the flexors. The muscles of the legs during the past month have also made rapid progress; for he is now able, when sitting, to lift them up and keep them out straight for a second. When once put up to stand and allowed to lean against something, he is able to remain thus unaided. Six weeks ago,

* *Surgery of the Arteries*, pp. 25. London: Churchill.

* Read before the South Wales and Monmouthshire Branch.

he could not do this. For the past fortnight, he has been amusing himself with one of Maw's galvano-electric machines under my tuition. Latterly he has been taking iron and cod-liver oil with a nourishing diet; and I have now every reason for thinking he will make a good and complete recovery.

What was the pathological condition of the spinal cord in this case? What was the poison? Did this plaster, of whatever it was composed, placed over the cervical region, and producing such a deep slough, implicate that portion alone of the spinal cord, causing myelitis or some other condition, or did the poisoning effect of it range over a larger portion of ground, and set up a subacute inflammation of the whole tract of the cord?

I ought to state that the unqualified person, frightened, I presume, at the serious effects of his nostrums, did not claim any payment for his valued advice.

In conclusion, I would beg to suggest that such a case as this ought to be published and widely circulated to warn the ignorant against placing themselves in the hands of quacks; for though, as a rule, their nostrums are harmless, yet we have grounds for knowing, as in this case, that they sometimes use drugs, of the dangerous effects of which they are not aware, but for which they are morally liable.

CLINICAL MEMORANDA.

ASPHYXIA SUCCESSFULLY TREATED BY DR. HOWARD'S METHOD OF ARTIFICIAL RESPIRATION.

A SHORT time since, I had an opportunity of testing, in two cases of asphyxia, the value of Dr. Howard's method of artificial respiration.

CASE I.—This was one of diphtheritic croup in which tracheotomy had been performed, and apparently the child had died during the operation; she was pulseless, had ceased to breathe, and the heart-sounds were inaudible. There being no time to lose, I applied the method vigorously, and, in about five minutes, she drew a short breath, which was soon followed by regular breathing. She lived for seven days, eventually dying from the disease for which the operation had been performed.

CASE II.—In another case of asphyxia occurring while a patient was under chloroform—though not arising from that anæsthetic—it was thought advisable also to empty the stomach of its contents. Dr. Howard's method was employed with excellent result, the stomach and even the rectum being emptied almost immediately. The respiration also returned, and the patient, who was about fifty, eventually made a good recovery.

W. C. JAMES, House-Surgeon, Guy's Hospital.

DIPHTHERIA: CROUP: TRACHEOTOMY.

DR. SEMPLE, in his kindly criticisms on my paper (May 4th), assumes that, in the first two cases related, *because* I saw patches of false membrane *therefore* they were cases of diphtheria; and, in the third case, notwithstanding my statement that I saw false membrane flapping through the wound, he assumes, because the other evidences were unfavourable to the diphtheritic theory, that I was in error, and that the case was one of ordinary laryngitis with œdema glottidis, "and that in the worst of them, as is shown in Dr. Bowles's third case, the operation of tracheotomy has a much greater chance of success".

This simply leaves the question where it was; given false membrane, therefore diphtheria. Dr. Moxon and others have demonstrated that false membrane is often present in burns and other traumatic cases; and, in my paper, I adduced positive evidence of a similar kind.

Lastly, Dr. George Johnson, in a contemporary, so far changed his front as to state that bad strains as well as diphtheria are responsible for false membranes. This, from so eminent a physician, is at least an important breach in the walls of the argument; which, if once gained, decides the point that false membrane does not *always* imply diphtheria, and we shall have idiosyncrasy, and local and other, at present, unknown causes rushing in and crying aloud in the moment of victory for their share in the etiology.

Whether it was really false membrane or the lining membrane of the trachea which we saw flapping through the wound I confess I cannot *prove*, but the probability is at least strongly in favour of the former; both Dr. Lewis (not Jervis) and myself are certain it was *within* the trachea, and have no doubt whatever but that the child in its awful struggle for life coughed up and swallowed, as children do, the dangerous if not false membrane which had so nearly cost the little thing its life.

ROBERT L. BOWLES, Folkestone.

OBSTETRIC MEMORANDA.

RETENTION OF THE PLACENTA.

ABOUT sixteen years ago, Mrs. G. arrived in London, and was seized with pains and threatened premature birth at about six months. I ordered perfect rest, etc., and matters went on comfortably for a few days, when the foetus was expelled. The funis was torn off short at the os, which was rigidly contracted; and I determined not to interfere. During the whole time of retention, I was kept in constant anxiety, as periodical flooding came on; and, on one occasion, I took the late Dr. Cape of Curzon Street, Mayfair, with me in consultation. After examination, we agreed nothing could be done but wait patiently. On the nineteenth day, the placenta was expelled in a perfectly healthy condition without a sign of putrefaction.

HUGH DAVIES, Surgeon, 42, Dorset Street, Portman Square.

RUPTURE OF THE UTERUS.

ON May 29th, 1875, under "Obstetric Memoranda", I published in the JOURNAL notes of a case of rupture of the uterus, which occurred in the year 1853. In that case, the rent was near the fundus, and the symptoms more definite and protracted than in the following one, which has features entitling it to be also recorded.

M. T., aged 37, mother of three living children, and said to have had good confinements, was taken in labour on February 25th, 1878. I visited her at 10.20 A.M. She had had pains since 8 A.M., which seemed natural and frequent. The passages were spacious and lubricous; the os about the size of a shilling, thin but dilatable. The waters had not escaped, and there had not been any show. The head was at the brim, presenting in the first position. The abdomen was more than ordinarily pendulous. Labour did not progress much, although the pains appeared to be strong and at short intervals. She had some warm tea. The os enlarged to about half-a-crown, and, a little before 12 A.M., the membranes were broken, with a view to relieve distension and change the character of the labour. The head advanced into the brim, and the patient remarked that she "could feel it getting lower". There was not any complaint of fixed pain in the abdomen. The progress being slow, which I attributed to the size of the head (the patient stated that she was a month over her time), I left at 1.55 P.M., as I resided within two hundred yards, and promised to return in half or three-quarters of an hour, with direction to send if I were required. I returned at 2.45 P.M., and, directly I entered the house, the nurse told me the pains had ceased, and she thought the woman was dying. I made a rapid examination: the os was well dilated, and there was no hæmorrhage into the vagina. The upper part of the head was firmly wedged in the pelvis. The patient said, "Lift me up; give me some brandy", and directed me to a cabinet. I immediately gave her some port-wine, which she swallowed. She was pulseless, evidently moribund from shock (syncope), not from asphyxia or coma. I next gave her a teaspoonful or two of whiskey, meanwhile slapping her face with a wet towel; but she died, with slight convulsive twitches about the mouth, at 3 P.M., a quarter of an hour after my return. Myself and the nurse were the only persons in the house at the time of death; hence I did not feel justified in performing gastrostomy, or in attempting to effect delivery *per vias naturales*. The death surprised myself as much as others. In public practice, an endeavour would, of course, have been made to rescue the child.

A *post mortem* examination was obtained twenty-one hours afterwards. The examination was made in a dark inconvenient room, on a low bed, in the presence of Drs. Byerley and Craigmile. Only the abdomen was investigated, which was extremely prominent. Section was made from the mid-thorax to the pubes. The abdominal parietes were very thin and free from fat. The uterus was exposed, and above the pubes a triangular effusion presented itself under the visceral peritoneum, which membrane was unruptured. About one pound of dark clots was removed, and much fluid blood with a sponge, when a rent was discovered just above the os pubis, anteriorly, extending to about one-third of the circumference of the lower segment of the uterus, through which the fingers could be introduced against the foetal head. The muscular tissue of the womb was torn in a ragged manner, similar to (allowing for difference of structure) laceration of the corpus striatum in cerebral hæmorrhage. The rupture had evidently happened at the thinnest part of the uterine wall, about opposite to the greatest diameter of the cranium of the foetus. An incision was made from the fundus to the cervix, and the child, a girl, seen *in situ* in the first cranial position. The upper part of the head was wedged into the brim, requiring force for its extraction. The child was large, especially its head, and the placenta implanted at the fundus posteriorly. The uterine tissue