the contrary, increased. The patient now objects to the experiment, apprehending that a time might come when we should be no longer able to master the induced contraction, and naturally not desiring to return to her own locality with a contracture of the right arm, after having come here with contracture of the left. That certainly would not be worth travelling to Paris for. However, for your instruction and the good of science, she consents to another experiment, and you can observe the change I have described taking place before your eyes. The right arm has now become contracted and rigid, so that it is difficult to stir it; this state, however, will disappear after half an hour's faradisation; but it would be obviously inadvisable to persist with such experiments, lest her apprehension should be justified. Her treatment in hospital has had this effect: that contracture has almost completely disappeared from the left arm, where we find now a certain degree of paresis; still, on placing your hand in hers, you find that she can press it with some little strength.

For this case, then, we have a parallel in that of the previous patient, and the fact of identical phenomena supervening under the condition of induced lethargy gives us a clue to their mode of causation. Here, however, it is not necessary for us to have recourse to faradisation to put an end to the contracture. Let her be now awakened, and the contracture will persist for a considerable time; but we shall throw her into her first state of induced lethargy; then stimulate the antagonistic muscles exactly as we stimulated the flexors, and now you observe that the tension relaxes, and the whole arm becomes free and flexible.

The state of catalepsy can be immediately induced by causing the patient to fix her attention on some object, such as a bright light. Thus, if she gaze for a moment at the electric light, she passes, and now has passed, into a cataleptic condition, when her limbs remain in any position in which you choose to place them. The patient can now be made to assume any posture, however inconvenient, and will retain it as long as you please. In this condition, you can study the influence of attitudes on the expression of the physiognomy. Thus, if we bring her arms and hands together, a smile appears, raising the corners of the mouth; on the contrary, if you place them in an attitude indicative of horror or denunciation, the physiognomy becomes solemn. (At this moment, the assistant unexpectedly stopped the electric light, and the patient suddenly fell back into her chair in a fit of lethargy.) The extinction of the light has sufficed (continued Professor Charcot) to cause her to pass at once from catalepsy into lethargy, which is not, as I have already remarked, a state of sleep, but rather a somnambulistic condition. She is now, in fact, in that state of suggestion or subjection which causes her to follow and obey. This is the condition into which animal magnetisers plunge hysterical persons, and, during its persistence, they cause them to perform mystical acts, such as working in the dark, describing absent persons, distant places, and the like. From this condition our patient can be brought round by one of two methods: by pressure on the ovary, for instance, or by blowing suddenly upon the ophthalmic region. She does not immediately resume complete consciousness and freedom, but may remain in a benumbed state for a quarter of an hour or more; this, however, soon disappears, especially in the open air, and the patient recovers her normal condition.

[Professor Charcot then concluded his lecture amid well merited applause. A singular incident then occurred. As the crowded audience, composed of physicians and students of different nationalities, separated, one of them seized the occasion, whilst close behind a patient whose case has been described above, to press with his hand upon the sensitive area in her back. Possibly, he was sceptical of the fact related; but, if so, the result must have convinced him of its reality. The patient fell immediately upon the tiled floor of the corridor in a state of lethargy. The reckless culprit escaped in the confusion; but his act, which naturally caused great annoyance in an institution where every care is taken to guard against accidents, remains to prove the reality of the phenomenon he appears to have disbelieved. —G. S.]

PROFESSOR VON LANGENBECK of Berlin completed his sixty-eighth year on November 9th. His pupils crowned his portrait with laurel on the occasion, and a deputation waited on him to express their good wishes. It is now thirty years since he succeeded the celebrated Dieffenbach; he still, we are glad to learn, preserves his vigour.—Professor Du Bois-Reymond entered on his sixty-first year on November 7th, on which occasion he was presented with a richly bound photographic album, containing the portraits of those who had worked in his laboratory.—The Order of the Iron Crown of the third class has been conferred on Professor Späth of Vienna.

EXCISION OF THE RIGHT ANKLE-JOINT FOR CARIES.

By J. H. PORTER, L.R.C.S.I., Surgeon-Major,
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AS a contribution to the statistics of articular excisions, I trust the following case, as an unit, will prove of sufficient interest and importance to justify the publication of its history, progress, and result.

Private R. H., 2nd Battalion, 13th Regiment, aged 20; service $1\frac{1}{2}$ years, of which 7 months were spent at Malta; an extremely strumous-looking lad, whose family history appeared to be good, and he stated that he had always been healthy. His illness dated from the 10th of November, 1877, at which time he was stationed at Malta, where he was admitted with acute inflammation of the right ankle-joint. He first noticed a dull pain, which came on gradually and was followed after a few days by swelling. There was a history of slight rheumatic pains in the arms on three or four occasions, but no history of injury. A few days after admission to hospital, the inflammation became so severe that he was unable to stand or walk; and there being no prospect of his being benefited by remaining at Malta, he was invalided to Netley, where he arrived on March 3rd, 1878. He was then in a pale anæmic condition; his ankle was very much swollen, but not to say painful on pressure, and there was no appearance of suppuration having taken place in the joint. Rest for the joint was at once enforced by means of a plaster-of-Paris bandage, which enabled him to move about with ease; and from being able to enjoy fresh air, and with the use of tonics, he appeared to improve.

On the 28th of March, there was considerable pain in the joint, when it was found necessary to remove the plaster-of-Paris bandage. Suppuration had taken place in the soft parts over the lower end of the fibula; and, on examination, it was found that a probe could be passed through a sinus under the soft parts at the back of the ankle anterior to the tendo Achillis, and be felt on the back of the joint, but no exposed bone could be detected. Free incisions were made on each side of the joint, which were kept open by means of drainage-tubes, and the limb was well supported. After this, he again appeared to improve greatly, but, about the beginning of May, the ankle-joint became much swollen and painful. It is remarkable, however, that there was no increase of pain when the articulating surfaces of the joint were forcibly pressed together. This may have been due to the fact of the bones (especially the astragalus) being denuded of cartilage, as was observed when the joint was opened at the operation. A probe could now be passed under the fibula, but still no exposed bone could be detected; it was, however, apparent that the joint was extensively implicated, and that some operative measures were necessary. It was decided to excise the ankle, the man's youth giving to the operation every prospect of success.

On the 13th of May, I performed the operation by two lateral incisions, as recommended and practised by Mr. Hancock, the limb being rendered bloodless and the patient under the influence of ether. After the operation, the wound was freely irrigated with iced water, and then sponged with a solution of chloride of zinc, thirty grains to the ounce of glycerine. When Esmarch's elastic bandage was removed, there was not a single vessel that required any interference, and, by exposure of the wound to the air, all active oozing was checked. Several horsehairs were placed in the back of the wound for the purpose of establishing drainage; and both lateral wounds, except at their depending angles, were closed with sutures of silver wire.

The limb was put on a light wooden back-splint, with a foot-piece; and in front a strong wire anterior (Smith's) splint, the whole enclosed in cotton-wool, and secured with a plaster-of-Paris bandage, so arranged that the wounds could be dressed; when dry, it could be suspended from a parallel bar placed over the patient's bed. There was slight oozing from the wounds for about twelve hours, but he progressed most satisfactorily, there being very slight increase of temperature or surgical fever, all functions remaining normal.

On the 28th of May, I removed the splint for the purpose of cleaning it, when the wounds were found to be healing steadily, and no inconvenience had occurred from the long-continued pressure on the heel, the back splint having been hollowed out to receive it.

On the 5th of June, I removed the horse-hair drainage, as it appeared to be causing considerable irritation, and replaced it by a fine tube, which was more comfortable.

The plaster-of-Paris splint was removed on the 15th of June, and a light wooden side-splint substituted, which gratified the patient very much, as it enabled him to shift his position in bed and to be moved into the open air.

Towards the end of July, he was able to place his foot on the ground, perfect bony union having taken place between the tibia and astragalus. From time to time several superficial sinuses formed, which were duly laid open, and healed from the bottom with salicylic acid lotion.

On the 27th of September, he was able to put on a soft leather boot, with a cork heel about an inch and a half higher than that of the sound one. By great caution he gradually brought himself to bear his full weight on the foot, and now, a little over five months since the date of operation, he is in the following condition. His general appearance and health are vastly improved; from being listless, pale, and anæmic, he has become bright and intelligent. There is perfect union between the tibia and astragalus. There is no pain when the foot is pressed or struck. The swelling in the neighbourhood of the joint is gradually subsiding. The wounds of operation are perfectly healed, and, with one exception, so are the original sinuses. He can flex and extend his toes; he has regained the power of flexing and extending the knee, which at one time was contracted from carrying the leg in a bent position. He is able, with the aid of a crutch, to walk up and down stairs, and, with a soft leather boot which has a raised heel, is able to get about on level ground with great facility.

The illustrations represent the portions of bone (natural size) removed in this case. No. 1, the lower end of the fibula, was firmly adherent to

the tibia, and required considerable force before it could be removed. No. 2 is a thin slice of the tibia, and No. 3 the upper surface of the astragalus, so thin and brittle that it accidentally broke in two on removal.

With regard to the operation which was performed on this patient, much difficulty is generally experienced (at least I have found it so) in removing the upper articulating surface of the astragalus, as, unless great caution be observed, the articulation between the astragalus and scaphoid may be opened; or, if the saw be not held at a proper angle, the articulation between the astragalus and os calcis may be interfered with, either of which might compromise the ultimate results of the operation. There is difficulty in fixing the foot to saw the bone. To obviate this, I hold the heel of the foot in the left hand, and press the upper surface of the astragalus against the cut end of the tibia, so as to fix it, an assistant holding the leg firmly on and a little over the edge of the table. By this means, and with a long firm narrow-bladed saw, the surgeon has it in his power to regulate the amount of bone he wishes to remove, and to do so without injury to the other parts.

REMARKS ON OVARIOTOMY.

By THOMAS WHITESIDE HIME, B.A., M.B.,

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THE practical and suggestive remarks of my old teacher and friend Professor von Nussbaum on this subject have brought vividly before my own mind difficulties and dangers which I have met with in connection with ovariectomy, some remarks on which may be of service.

Firstly, with regard to preparatory treatment, it is very desirable that for some time, not only the regular, but also the complete, evacuation of the bowels be attended to. A patient may have her bowels moved every day for months, and still have scybala retained high up in the intestine to be a source of trouble and danger afterwards. A patient on whom I performed ovariectomy a month ago illustrates this. Previously to the operation, her bowels had always been regular. After her admission to the hospital, she had purgatives and enemata preparatory to the operation. On the fourth day after the operation, she was doing as well as any patient could; but in the night she was attacked by rigors and vomiting, her pulse and temperature ran up, and she became excessively weak. After taking five grains of calomel and an ounce and a half of castor-oil, she had thirty-nine copious fluid motions in twenty-four hours; and after all this had come away, she parted with a scybalum as large as a hen's egg, hard, dry, and smooth, and all the bad symptoms at once disappeared.

Her subsequent history is noteworthy. After three weeks, she exhibited all the symptoms of intestinal obstruction, with great debility, flatulent distension, and evacuation of nothing but bloody mucus from the rectum. The anus was gaping and the rectum distended and empty, and enemata were returned immediately after injection. An obstruction could be plainly felt high up in the rectum, above which it was impossible to pass a bougie. Ultimately, eructated flatus smelled stercoraceous. Purgatives were useless. Within a few days she took, at various times, fifteen grains of calomel, three ounces and a half of castor-oil, six minims of croton-oil, in pill, with aloes, one ounce of sulphate of magnesia, in addition to cataplasms, inunctions, etc., but without producing a motion, though there was violent straining. Having succeeded in passing an O'Beirne's tube beyond the obstruction, I allowed a quart of warm water and one ounce of castor-oil to gravitate into the bowel, through three feet of elastic tube and funnel (fig. 1). This plan, which I have frequently adopted with success, also was ineffectual, neither the water injected nor faeces escaping. Subsequently, I attached six feet of elastic tube to the O'Beirne's tube, and by this means introduced two quarts of water, with one ounce of sulphate of magnesia, in solution, into the bowel, letting it gravitate slowly in from a height of six feet. I then withdrew the O'Beirne's tube, passed a wire through it, fastened a small piece of sponge to one end of the wire (fig. 2), and connected the other with one pole of a faradaic machine. After some time, I passed this tube fourteen inches up the rectum, as one pole of the battery, and the other pole I applied to the abdominal wall. Violent straining and working of the bowels began as soon as the battery was set in action; but no other result followed for twenty minutes, after which time fluid faeces began to flow in large quantity through the tube (not through the rectum). The patient subsequently did well.

The simple apparatus (fig. 1) will be found very useful for giving enemata, washing the bladder, and, indeed, any cavity, etc.; but care must be taken to prevent air from being passed with the fluid into the bowel. Some air adheres to the tube.

Fig. 1.

Fig. 2.

I have been in the habit of giving all my cases for some time before the operation sulphocarbonates in considerable quantity, including the salts of iron, quinine, sodium, calcium, etc. Being a strong believer in the efficacy of the antiseptic treatment of wounds, which I first employed in ovariectomy in 1876, it has seemed to me desirable to administer internally such drugs as present at least the probability of checking, i