rapidly "paid" by the finger and thumb into the cavity of the nostril. The solid mass thus formed should be forced along the floor of the nose, first with the little finger, and then with the dressing forceps or a pencil, until it is found to occupy the posterior nostril, and distinctly felt in it by the finger, hooked round the soft palate. This is far the most important part of the entire proceeding, being, as it were, the basis of operations. The second portion should now be paid into the nostril in the same way, and pressed by the finger and forceps into its position—the roof of the nose. The third and last portion should be pushed into the nostril, so as to occupy a position in front of and below the other two, and, being caught within the edge of the alar cartilage, will usually retain its position without trouble. I think it desirable that the material should not be cut, but retained as one continuous piece for the facility of subsequent removal; but too much care cannot be taken in disposing of the first portion. The nostril being thus perfectly and thoroughly packed, every portion of the lining membrane is steadily and firmly compressed, and the escape of blood is rendered physically impossible. In the course of about forty-eight hours, the plug begins to loosen, the end falling from the nostril. Directions should be given to the nurse or attendant on no account to pull it, but simply cut the projecting part on a level with the nostril, according as it drops, until the entire plug comes away. For some years past, I have adopted no other mode of plugging the nostrils; and many of my professional brethren in Dublin, who have practised it, have found it simple, effective, and satisfactory. There is little fear of the plug remaining too long, as, when the natural secretion is restored, it becomes quickly loosened and unpacked, and falls away through the anterior nostril.

CASE OF ULCER OF STOMACH, PENETRATING INTO THE LIVER.

By J. INGLEBY MACKENZIE, M.B. Cantab., Rugby.

THE subject of the following history was W. L., aged 56, ill-nourished and rather emaciated in appearance, with sharp pinched expression of face. His skin was dry; his pulse feeble, regular, 60; his tongue was covered with whitish fur. His appetite was small. The bowels acted but seldom—then with difficulty. He slept very badly. The abdomen was distended. He complained chiefly of pain in the right hypochondriac and epigastric regions, increased by pressure and followed by sickness. He had been subject, he said, to "sick attacks" for years. I had attended him in one of these, in the temporary absence of my predecessor, about four years since, but had lost sight of him professionally up to March 10th, 1879, at which date I was sent for to attend him, and these notes were taken. The treatment consisted in small doses of nitro-muriatic acid, which afforded some relief to his pain; also small doses of ipecacuanha wine to allay nausea, with an opium pill to give sleep, and a wet compress over the seat of pain. He improved on this plan so much that, on March 22nd, he was able to go out and superintend a small farm he occupied for amusement; and I heard nothing of him till, on April 10th, an indigestible supper reproduced all the old symptoms, but in an aggravated form. The former treatment was resorted to, but unsuccessfully. All solid food was strictly forbidden; his diet consisted chiefly of arrow-root and brandy, with occasionally mutton-broth, thickened with ground-rice, and an opium pill at night. The treatment was continued with varying success up to the middle of July, when, talking the case over with a medical friend who was staying with me, he suggested the treatment proposed by Dr. Balthazar Foster of Birmingham, in his *Clinical Lectures*, viz., giving the stomach perfect rest, and supplying nutriment *per rectum*. This plan was adopted for two days; but, on the morning of the 10th, I was hastily summoned to find him moribund—no change having taken place to warn his friends in the least.

Post mortem Examination, eight hours after death.—The body was very anæmic and emaciated. On opening the abdomen, a long distended stomach concealed all the other viscera; the walls were very thin—so much so that the scratch of a finger-nail inadvertently pressing on them instantly ruptured them, disclosing the contents to be a dark grumous, coffee-ground like fluid, in quantity about two and a half pints. On carefully raising the stomach, it was found to be attached to the left lobe of the liver. The stomach was emptied and opened along its greater curvature, and a large ragged ulcer, opening direct into the liver, was found near the pyloric end of the viscus. On passing the index-finger about three inches into the cavity in the liver, it was found to contain the same grumous fluid as did the stomach, the edges of the ulcer being firmly agglutinated round the orifice, forming a continuous structure. The cavity in the liver had no wall, but was apparently a "bur-row" caused by the action of the contents of the stomach. Just short

of the pylorus (the fibres of which were considerably thickened) was discovered a pouch or *cul-de-sac*, one inch in depth, apparently in the inferior wall of the stomach, and containing similar fluid to the stomach. The intestines were shrunken in calibre, and contained small bullet-like faeces. The walls of the heart were thin, and the muscular fibres pale and anæmic. There were some pleuritic adhesions of old standing.

REMARKS.—There can be no doubt that the ulceration into the liver was an effort of nature at repair. The rupture must have occurred at some considerable distance of time from the patient's death, as the edges of the ulcer were so firmly adherent to the structure of the liver. How long, it is impossible to define. The thickening of the fibres of the pylorus was not so great as to lead one to suppose that that alone was the cause of the vomiting. The *cul-de-sac* just short of the pylorus was also a special feature in the case, leading me to think it not unworthy of record.

SURGICAL MEMORANDA.

DECALCIFIED BONE-TUBES.

IN two cases in which drainage-tubes were inoperative, I have lately employed the newly introduced (Neuber's) decalcified bone-tubes; and I regret much to have to report that the hopes of finding an efficient drainage-tube, which would allow more unfrequent antiseptic dressings, have not been verified.

In the first case, amputation of the thigh for disease of knee-joint of nine years' standing, in a female aged 37, I employed three tubes: one, inside, of the usual India-rubber; two, one of them on the outer side and one midway of the flaps, of the new decalcified bone. For two days, all looked well; but, on the third and fourth day, I found the India-rubber tube acting perfectly, while the other two were partially eroded, absolutely flattened, collapsed, and blocked. Hence arose retention of serum between the flaps, suppuration excited by the tension so produced, and a tedious recovery, not yet quite complete. In the second case, a large bursa over the patella was punctured, with the usual antiseptic precautions, and a Neuber's tube, of the smaller size, employed. But here, again, in twenty-four hours the tube had ceased to be an efficient channel of exit, and the bursa was distended with serum—leading, as might be expected, to a slower repair. India-rubber drainage-tube, often very efficient, is sometimes, from position or pressure, flattened, and so is then of little value. I hope to make a trial shortly of some tubes made from gutta-percha.

WILLIAM NEWMAN, M.D. Lond., F.R.C.S. Eng., Stamford.

TWO CASES OF FRACTURE OF THE SCAPULA.

AS it is of importance on all occasions to add to surgical statistics, I am desirous of bringing before the notice of the profession the two following cases, the first of which is of rare occurrence, and of the second there are very few authentic instances.

CASE I.—On March 12th, David W., aged 42, carter, fell out of his spring-cart to the ground face downwards, the wheel passing over his shoulder. He complained of great pain about his shoulder, and of being unable to raise his arm. On being stripped, not much deformity was discernible, except some swelling at the back of the scapula. There was no injury to the shoulder-joint; but the scapula, it could distinctly be detected, was fractured transversely one inch below its spine. The treatment used was a gum and chalk shoulder-cap, extending from spine to sternum, with a pad in the axilla. This casing was removed on April 19th. Osseous union was found to be firm and complete, with no deformity beyond very slight angularity of union.

CASE II.—Mary Jane G., aged 16, on April 11th was swinging on the shaft of a hand-cart, and fell on her right shoulder. When stripped, but little swelling was discernible; the breadth of the shoulder, however, seemed increased, hanging a little forwards, outwards, and downwards. As she was a thin girl, the anatomical bearings could be very clearly defined. On manipulation, the head of the humerus could be made to perform all movements in the glenoid cavity, and, by fixing the scapula and firmly grasping the shoulder, crepitus could be obtained, most distinctly attributable to the fractured neck of the scapula—the fracture extending from the inner side of the base of the coracoid process to the glenoid cavity. The deformity was easily reducible by supporting the elbow and drawing the shoulder gently back, but it instantly returned when the support was relaxed. The treatment I adopted was somewhat similar to that in the former case. A good sized pad was placed in the axilla, the arm was bandaged to the side, and the whole fixed with a gum and chalk casing, which was also made to pass under the elbow and support it. By means of carefully applied padding, I succeeded in fixing and maintaining the shoulder in very fair position.