A third death occurred at the Leeds Infirmary a short time since under the influence of ether, though this would probably have occurred whatever anæsthetic had been given. The patient, a woman, aged 43, suffering from acute intestinal obstruction, was admitted for the purpose of having a colotomy performed. She was constantly vomiting liquid faecal matter. During the period of anæsthesia, some of this passed into the trachea, and, in spite of tracheotomy, she was asphyxiated.

In reviewing the cases of death from chloroform and ether respectively, one is struck by the difference in the character of the operations; the deaths from chloroform being mostly in comparatively healthy persons, during slight operations. The deaths from ether occurred, without exception, in persons severely debilitated by disease. It is doubtful how far such a case as No. 5 should be attributed to the anæsthetic; in a large hospital there are many chances of a patient taking cold during removal from the theatre to the ward.

Since January 1st in this year, one death from chloroform, and one from ether, have been recorded.

EXTRACT FROM A CLINICAL LECTURE ON A NEW OPERATION FOR NASO-PHARYNGEAL OR FIBROUS POLYPUS.

By FURNEAUX JORDAN, F.R.C.S.,

Surgeon to the Queen's Hospital, Birmingham, Professor of Surgery in Queen's College.

GENTLEMEN,—This is the second young woman from whose nose and pharynx I have removed a fibrous growth by a very simple operation. This growth comes in young adults of both sexes. It is often attended by severe hæmorrhage. It deforms the bones of the face. Ultimately, it interferes with the functions of breathing and swallowing.

Many methods have been used for its removal. Mr. Syme advised forcible avulsion by curved forceps carried through the mouth. Mr. Cooper Forster has shown the dangers of this method in a remarkable case, in which it gave rise to fracture of the base of the skull. Nélaton reached the growth by dividing the soft palate. The upper jaw has been excised for the purpose. More frequently, the upper jaw has been so loosened, that it could be turned upwards or downwards, according to the judgment of the operator.

The operation I now describe to you I have found to be efficient, simple, and followed by but little scarring. The leading principle of the operation is to thoroughly uncover the bony orifice of the nasal cavity. This is done by making a triangular flap out of the upper lip and the side of the nose. A curved bistoury is carried under the lip into the affected nostril, and made to cut its way out. Then the soft part of the nose is divided on one side of the middle line in a line

with the cut in the lip (the wood-cut shows the incision). A few touches of the knife permit the flap to be turned well outwards. The nasal cavity is found expanded, well defined, and open to any sort of manipulation. To-and-fro traction by one or two fingers in the pharynx, and one or two at the front, aided, perhaps, by snips of scissors or knife, readily detach the tumour, which falls into the hand in the mouth. If the bone-opening should be found too small, I would enlarge it with strong bone-forceps. I believe the need for such a step would rarely arise. Delicate adjustment and stitches leave scars so fine, that only resolute search can find them.

Probably similar incisions would be found very useful in cases where the nostril is filled with ordinary, but obstinate and crowded, polypi, and also in cases of malignant polypus, where it is deemed well to clear the nostril for a time.

VARICOSITY OF THE LINGUAL VEIN AS A DIAGNOSTIC SIGN.

By G. CECIL DICKSON, M.B., Carnoustie, N.B.

MUCH has been written on what the physician may learn from an inspection of the cavity of the mouth, but I have found no reference in works on diagnosis to the state of the lingual veins being indicative of other more important vascular changes.

Under certain conditions, and especially in elderly persons, the ranine and lingual veins are remarkably dilated and varicose; they are much enlarged, and present many bulgings, which extend in a racemose manner to the edge of the tongue. This is most easily observed by directing the patient to place the tip of his tongue against his upper incisor teeth; the main vessels will then be seen, but the branches will be better observed by its being turned somewhat to one side. In the following two cases, this condition was most marked.

D. T. had, in 1880, when aged 79, an attack of right-sided hemiplegia, with aphasia; and, since then, had been liable to frequent attacks of unconsciousness, accompanied with lividity of the face, twitching of the limbs, and great irregularity of respiration. He was stout and florid. The lingual veins were remarkably varicose, and so large as to project from the edge and be seen from the dorsum. The pulse was weak and irregular. In 1884, he had senile gangrene of the right leg, and died, six weeks afterwards, in one of his convulsive attacks.

G. M., aged 83, had an attack of aphasia in May 1884. He recovered, but since then his face frequently became much flushed, and his speech confused. The lingual veins were much dilated and varicose, especially on the left side. The heart's action was weak and irregular, and occasionally there was a mitral systolic murmur. In February 1885, he died in an apoplectic attack, accompanied with right-sided hemiplegia and cerebral breathing.

In these two cases, the condition was evident, and, although there was no necessity to indicate the exact lesion, yet death certainly resulted from vascular changes in the encephalon, probably either thrombosis or hæmorrhage; and they indicate to us, what theory would also suggest, the diseases that are liable to occur when this varicose state of the veins is present. The lingual vein being a branch of the internal jugular, will indicate the state of the blood-current in it, and so will approximate to the state of the brain-sinuses, the veins of Galen, and, indeed, the whole intracranial venous system. Distension and varicosity of the linguals will become associated with passive congestion in them, precisely the conditions in which thrombotic and hæmorrhagic lesions are apt to occur.

Its cause is indicated in these cases, as in several others I have observed, by the state of the heart, which was beating feebly and irregularly, just the condition which tends to produce venous congestion.

The appearance of the capillaries and veinlets in the nose, lips, and ears, gives us a clue to the state of the circulation of the head; but the lingual vein, from its large size, is specially manifest, while, from being covered only by mucous membrane, it is clearly seen, and, moreover, by being thus so fully supported externally, it will most readily yield and bulge from internal causes. It is difficult to see what local causes in the mouth could induce it, and it is thus contrasted with the saphena vein, varicosity of which more usually arises from some pressure either in the limb or in the abdomen, and, also, the latter, belonging to the inferior canal-system of veins, will not indicate the cerebral state as the lingual.

Just as varicosity of the hæmorrhoidal veins at the other end of the alimentary tract points out the state of the portal venous system, so a varicose condition of the lingual becomes indicative of a dilated state of the whole jugular system.

Like other diagnostic signs, there is a wide limit, varying at each age, within which this may occur in health. It is only an exaggerated varicosity that would seem to be prognostic. It does not always accompany the arcus senilis; that suggests rather arterial anæmia than venous hyperæmia.

DR. RICHARD FITZGERALD, of Tarbert, county Limerick, died last week, deeply regretted. The members of the Board of Guardians of the Glin Union have passed a resolution, expressive of the loss which the district has sustained by his untimely death.

INCREASED SALARIES.—The Northfleet Local Board have increased the salary of Dr. John E. Crook, the medical officer of health, from £30 to £50 *per annum*. The Biggleswade Guardians have increased the salary of Dr. Charles Burnett, one of the district medical officers, from £30 to £40 *per annum*.