My method of prescribing the drug was sometimes pure terebene alone—10 drops on sugar three times a day. In other cases, I combined it with cod-liver oil, as follows: pure terebene, two drachms; cod-liver oil, to four ounces; two drachms three times daily. I could not say, however, that the effects produced were any better in the one case than the other. If there were any difference, pure terebene alone had the preference.

Some of the patients complained that the medicine made them sick; others that their appetite was improved by it. In a few of the cases, it appeared to have a laxative effect. In a very large proportion, drowsiness was complained of; while in some giddiness, or even a slight transient intoxication, was observed.

SEVERE LACERATED WOUND OF RIGHT LEG: TOTAL LOSS OF EXTENSOR POWER: SUCCESSFUL OPERATION.

By JAMES T. RUDALL, F.R.C.S. ENG.,
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Miss Z., aged 16, was sent for my advice by Dr. Cutts on May 11th, 1885. Nine weeks ago, while tending some plants in a conservatory, she fell through a skylight and cut the front part of her right leg deeply, about two inches above the ankle-joint. She was placed under the care of a local medical practitioner, who, besides other treatment, applied sutures to the skin-wound; but, when the dressings were taken off and she left her bed, she was quite incapable of stepping or standing, except with the help of crutches.

Upon examination, I found in the situation before described a transverse depressed and adherent scar, about two inches long. She was unable to extend the foot, but could just perceptibly move the four smaller toes—doubtless by the action of the extensor brevis digitorum pedis. The scar was rather tender, but she had otherwise no pain. The tibialis anticus, extensor proprius hallucis, and extensor longus digitorum pedis, were quite without action, and it was evident that their tendons had been completely divided. The muscles of the calf were much wasted.

Although not quite without misgivings as to ultimate success, I strongly advised her parents to allow me to try what could be done, rather than let her continue permanently in such an unfortunate helpless condition.

The patient, having been taken to lodgings in Melbourne, on May 14th, was anaesthetised by Dr. Cutts; and, being otherwise assisted by Dr. F. Godfrey, I operated. Esmarch's bandage was applied, and the parts having been washed and bathed with the antiseptic fluid, which I have found very reliable (sublimatè $\frac{3}{10}$, sodium chloride $\frac{1}{2}$ per cent.), an incision about four and a half inches long was made in the front of the leg, just on the outer side of the tibia, crossing the cicatrix of the injury at right angles. The fascia was then divided for the same distance. The cicatrix was dissected up, and the tendons were sought for. The upper end of the distal portion of the tibialis anticus was densely matted in with the cicatrix. The lower end of the upper portion of the tibialis eluded discovery for some time, and it was reached only after lengthening upwards the incisions in the skin and fascia. The ends of the extensor proprius hallucis tendon were about two and a half inches apart, but were slightly joined by intervening connective tissue.

After separating the surrounding adhesions, and dissecting out the tendons, it was found impossible to bring down the upper part of the tibialis anticus to meet the lower portion. I therefore freshened the side of the lower portion of the extensor hallucis, and the upper end of the lower portion of the tibialis anticus, and united them by fine strong carbolised silk sutures, and then cut out about an inch of the connective tissue medium of the extensor hallucis, and joined the ends by silk sutures. The ends of the extensor longus digitorum pedis, after a small bit had been cut off from each, were fairly well brought together, and kept in contact by sutures. The previous separation was about two inches only, yet there was no trace of connective tissue developed between their ends. The operation-wound in the fascia was closed as nearly as was found possible by means of carbolised catgut sutures; but, after the extensive loosening of the subjacent parts by the dissection, this was by no means easy, and, indeed, could not be effected for the whole extent with precision.

After thorough washing with the antiseptic fluid, the skin-wound was closed by nine or ten sutures, two drainage-tubes being put in. The whole was well powdered with iodoform, and covered with salicylic wool (10 per cent.) a domet bandage being applied over all. The limb was then placed on a Neville's splint. A grain of opium

was given at night. On May 15th, she did not sleep much, but had a fair night without pain. Pulse 80; temperature 99.5°. Evening pulse 83; temperature 100.0°. After this the temperature never rose above 99.4°, and in a few days it became normal. On May 19th, the wound was dressed; it was healing; there was no pus. On May 24th, the wound was dressed, and the drainage tubes which, by pressure, had caused a little ulceration, were removed. The wound was washed with sublimate solution, powdered with iodoform, and a few adhesive straps were applied across.

On June 12th, all was soundly healed. On June 15th, the Neville's splint was removed, and a poroplastic splint was applied. She was allowed to get up, and in a few days she left Melbourne for her own home. On June 29th, massage, which had been ordered, excited a good deal of movement of the flexors of the toes, and she had distinctly more power of extending them. On July 9th, there was more power. The tendon of the tibialis anticus was thought to come up a little on stretching. She could raise the foot from the ground while standing up, which she could not do before.

On October 20th, I was almost as much surprised as delighted to see her walk into my room without stick, crutch, or any assistance whatever. The power regained over the foot was quite remarkable, although the toes drooped and turned inwards slightly when she took a step. A week later, the calf of the injured leg was barely half-an-inch less in circumference than the other. The tendon of the extensor longus digitorum pedis could easily be felt under the skin when the muscle acted. She could stand firmly on the injured leg, and she told me that she could walk "any distance."

REMARK.—It was to be expected that, in the absence of efficient means to keep them together, there would be found wide separation of the ends of the tendons divided by the accident, and that their lower portions would be closely adherent to the scar and its neighbourhood; it was therefore part of my plan in operating, not only to join the ends, but also to avoid lateral adhesion of the tendons to the tissues around them, and this was more or less well attained by antiseptic management, and by massage in the after-treatment, which, doubtless, also conduced towards the favourable result.

A CASE OF CHLOROFORM POISONING; RECOVERY.

By WILLIAM MARTIN, M.B., C.M., Stockton-on-Tees.

THE following case may be of interest. Between two and three o'clock on the morning of Sunday, March 7th, I was called to see a young man, aged 26, who was said to be in a "fit." The account given to me by his father was that he came home at 11.30 on Saturday night a little under the influence of liquor, but was able to speak and act correctly. The family retired to rest at twelve o'clock, but he remained in the sitting-room, saying that he was going to write a letter. Some time after this, his father called down to him, and, receiving no answer, he went down, and found him sitting on a sofa with one leg under him, his body and head bent over to one side, almost black in the face, and "salivating." Thinking he was in a fit, he laid him straight out on the floor in front of the fire, and came for me.

On my arrival, I found him, as stated, lying in front of the fire. He was breathing stertorously; his pupils were widely dilated; reflex action was completely abolished; temperature low, and pulse slow, very weak, and irregular. His breath smelt very strongly of what I thought was chloral-hydrate, and, therefore, I asked his father if he ever used it, but he did not know. His father, who is conversant with the use of drugs, then smelt his breath, and immediately declared he must have taken a dose of methylated chloroform, a large quantity of which was in the house, and which his father was in the habit of using; but he could not say how much had been taken out of the bottle.

As the case was serious, I called in the assistance of my principal, Dr. Dale, who at once recognised the strong smell of chloroform in his breath. The stomach-pump was applied; and, after pumping in fully a pint of water, he began to retch; and the tube being withdrawn, he vomited all the water. We could not be positive that there was a smell of chloroform in the vomited water, as the sour gastric smell was strong, and no doubt disguised it, and also because the room was so full of the vapour from his breath that, unless it had been very marked, we could not have detected it. As he was unable to swallow, we pumped in some strong coffee. Galvanism was used, but with no apparent effect. The character of his breathing changed rapidly. He would breathe stertorously for half an hour; for the next half hour he would breathe as if in a deep sleep; then the stertorous breathing would come on again; and so on alternately all through