continued too long, or were too often repeated, permanent disorganisation might result, as happens to the spleen.

As to treatment, I have found a large hot poultice on the abdomen a relief during the painful period, but I do not know that it diminishes the tumefaction. An agreeable one is made of half and half linseed meal, and young laurel leaves chopped small, with a teaspoonful of chloroform added at the times of application and renewal. I have been disappointed with the effects of quinine. It is a good general tonic, but it does not in large doses cut the ailment short, as in the case of regular ague. Bark is apt to purge in large doses. Arsenic has given me more satisfaction, and I feel sure it is curative in these cases. When there is diarrhoea, opium checks it, and is not contra-indicated by the nature of the disease.

CASE WHERE A HALF-SOVEREIGN WAS IMPACTED IN THE LARYNX.

By HENRY SMITH, F.R.C.S.,
Assistant-Surgeon to King's College Hospital.

A TIPSY shoemaker, on the evening of Sunday, December 11th, placed a half-sovereign in his mouth; it at once disappeared, and he was seized with dyspnoea, which for a time was urgent. He was subsequently taken to the police-station, where he was locked up all night and half the following day. After the effects of his potations had gone off the man felt considerable pain in his throat, could not swallow, and breathed with difficulty. He applied to a hospital, and a probang was passed into his gullet, but nothing further was done, and the man returned home, remaining in great distress until Wednesday afternoon, when I saw him. He narrated his history to me as well as he could, and, from the fact of his not being able to speak above a whisper, as well as from nearly a total absence of air in his lungs, I had no doubt that the coin was in his larynx. I sent him into the hospital, but, as it was late and there was no urgent distress, I waited until next day before taking any steps to remove the foreign body. Sir William Fergusson saw the man with me, and agreed with me as to the presence of the coin in the larynx. Dr. George Johnson, who is well-skilled in the use of the laryngoscope, examined the patient with this instrument, and clearly showed to the bystanders that the coin was impacted in the larynx between the vocal chords, with its surfaces up and down, tail uppermost, almost completely filling up the inlet of the larynx, only a small space for air being left between the coin and swollen mucous membrane behind. (See Plate.)

Dr. Johnson thus made it clear that the coin was so closely impacted that it would be useless to attempt to dislodge it by placing the man head downwards; and with my concurrence he made very careful attempts to remove it with the laryngeal forceps, and repeatedly reached the coin and scratched its surface; but, from its position, it was found impossible to grasp its margin. I then made an opening in the crico-thyroid space, and passed a strong silver probe into the larynx from below, and, using considerable force, I pushed the coin out of its purse into the man's mouth, and he immediately ejected it.

The patient, who bore the manipulations of Dr. Johnson and the operations by myself with remarkable fortitude, was at once relieved. The opening was closed, and he so quickly recovered that he begged to be dismissed in less than a week.

Instances of foreign bodies in the windpipe are, I think, amongst the most interesting in surgery. In no condition of accident or disease can the value and power of the art of the surgeon be demonstrated more clearly; humanly speaking, the issues of life and death are in his hands, according as he acts with promptitude or otherwise. These cases have become even more interesting than they were since the application of the laryngoscope as a means of surgical diagnosis; for, if the foreign body be imbedded in the larynx, we can now not only demonstrate its

locality, but its exact position as well, as was illustrated in the case just narrated. A valuable guide is thus furnished to the surgeon, who can direct his operations according to the information thus afforded him. We could at once see that it would be useless to attempt the removal of the coin by inclining the body as in the well-known case of Mr. I. Brunel. Moreover, it was at once clear to me that I ought not to attempt to extract it through the wound, but to adopt the simple expedient of pushing it into the mouth from below. I must here record my thanks to Dr. Johnson for the great assistance which he rendered me in this interesting case.

BONE IMPACTED IN THE LARYNX: REMOVAL THROUGH AN OPENING IN THE TRACHEA.

By T. PRIDGIN TEALE, M.A., M.B.,
Surgeon to the Leeds Infirmary.

PHILIP MACBRIDE, aged 36, residing at Clifford, near York, was admitted into the Leeds Infirmary on September 30th, 1867, suffering from great difficulty in breathing. On the previous day, whilst drinking broth, he sucked into his mouth a thin plate of bone, which was carried into the fauces beyond his control, and drawn into the larynx. He was not immediately seized either with violent coughing or with difficulty in breathing. He made considerable efforts by coughing, tickling the throat, etc., to dislodge the offender, but without avail. Next day, he walked to the house of his medical man, Mr. Scatchard, who made further attempts to remove the bone; and, not succeeding, sent him over to Leeds. When I saw him, his breathing was somewhat croupy, and the bone could be felt by the finger to be firmly lodged in the larynx. Examined by the laryngoscope, the bone was seen to be a long thin piece, impacted between the thyroid cartilage in front and the arytenoid behind. Guided by the same instrument, I was able to seize the bone with long forceps; but, owing partly to the irritability of the muscles of the glottis and partly to the springiness of the long blades of the forceps, I was unable to move the bone from its firm position.

3 P.M.—As it seemed to be impossible to remove the bone, and the breathing was becoming more and more embarrassed, I performed laryngotomy. After the introduction of the tracheotomy-tube, further efforts were made to seize the bone with forceps, introduced through the mouth, but it was discovered by the aid of the laryngoscope that the bone had been pushed lower down into the larynx. A probe then passed into the wound struck against the lower edge of the bone, which was seized by dressing-forceps and dragged downwards. The tracheotomy-tube having been removed, two or three upper rings of the trachea were one by one divided, until the wound was large enough to allow the bone to escape. The bone proved to be generally flat and somewhat triangular, and two sharp angles had fixed it antero-posteriorly in the larynx; and the apex pointing downwards, wedge fashion, had facilitated its passage towards the trachea.

His progress was satisfactory. For two or three days there was slight bronchial irritation and congestion of the fauces; but the tube was removed on the second day, twenty-four hours after the operation. He left the hospital on the twenty-fourth day, with a voice perfectly restored, good breathing, and the wound all but healed. No injury to the larynx could be detected by laryngoscope.

The notes of this case were taken by Mr. Robert Atkinson.