pass the straight ones through the upper angle. These needles are rarely an inch in length, and are held in the ordinary Sims' forceps needle-holder, whilst the tissue is steadied with a tenaculum. Most of the American gynaecological surgeons bend the wire on a silk thread, which is placed in the eye of the needle; but for many years I have dispensed with the silk, and place the wire directly in the eye of the needle, which is purposely made larger. Great care should be exercised in passing the needle, lest it snap just at the critical moment. The needle-holder should never grasp the eye, and the needle should be placed at such an angle as to be pushed straight through. I am rather particular about these technical details, as upon their proper manipulation depends the complete success of the procedure. The trocar, or pyramid-pointed needles, penetrate without cutting; and, the body of the needle being larger than the point, somewhat of stretching takes place, and there is less oozing of blood than with any other form of needle. I have used them for fifteen years, and they have never yet disappointed me.

Before the wires are twisted, all clots should be sponged away, and the edges of the wound accurately approximated without strangulation by the sutures, which are to be bent on the flat, curved on the cervical tissue, and cut off about two lines from the wound-line.

For many years, I was in the habit of passing only as many wires as were necessary to bring the raw surfaces accurately together; latterly, I rather multiply the sutures, as the presence of good silver wire does no harm, and a surplus insures success, as well as prevents accident. The patient is kept in bed ten days or so, when the sutures are removed, provided union is perfect; otherwise, they are to be tightened, or some additional ones passed, to remain as long as it may seem proper—ten or twelve days more. During the presence of the sutures, the carbolic or thymolised hot douche should be constantly used.

In the whole range of gynaecology, there is nothing so satisfactory as the successful issue of an operation for the cure of laceration of the cervix. Symptoms of the most rebellious nature succumb to the closure of divided tissue, and reflex phenomena often disappear as the mist before the sun.

The rules I would lay down are, to close the laceration at the time of the accident, just as we do habitually for similar perineal lesion, and, in default of making the immediate restitution, to perform the plastic restorative operation as early as practicable. The stitching of the neck of the womb upon the immediate accident is not only necessary, sometimes, to stop the hæmorrhage, but it occasionally is the sole method left to us to save life; besides, it prevents septicæmic trouble pending the lying-in, and union avoids all subsequent breaking-down in health. When the woman arises from the parturition with a division of the cervix, she will, sooner or later, be subjected to more or less of menorrhagia or metrorrhagia, or she will be the prey to the inconveniences and miseries of bad health, as evidenced by leucorrhœa, neuroses of various manifestations, dyspepsia, frequently sterility, and uterine displacement. The operation for the cure of this condition, whilst it is difficult in performance, is comparatively free from danger; and now that we know there is danger of secondary hæmorrhage, not before anticipated, we can take due precautions to guard against it.

The chief deduction in the study of laceration of the cervix is, that the prophylaxis of skilled obstetrics will do much to diminish its frequency, particularly if, in the management of the pregnant woman, the accoucheur directs special attention to its histological status; and should any condition exist which is liable to impair the progress of a normally rapid labour, the hydrostatic dilator should be used, to open the cervix before there is a possibility of the production of œdema, perivascular effusion, ecchymosis, or tissue-bruising. These preventive measures are not only necessary in the scleremic cervix to save it from rupture, but the benefits to the general condition of the woman are most apparent, by saving her the additional dangers of a tedious and exhaustive labour.

The hiatus yet to be filled in obstetrical and gynaecological literature, is a thorough and complete treatise on the management of the pregnant woman, more particularly with regard to the prophylaxis of accident and disease at parturition, as preventives of subsequent pelvic trouble. The skilled accoucheur must forecast his patient's horoscope of health by common sense, and the dictates of the tenderest humanity.

CENTRES OF VISION IN THE CEREBRAL HEMISPHERES.—Dr. J. C. Dalton (*New York Medical Record*), concludes a paper on this subject thus. 1. Extirpation of the angular convolution causes loss of visual perception on the opposite side. 2. This operation is not followed by any disturbance of the intelligence, attitude, power of locomotion, or general sensibility. 3. It does not interfere with the general sensibility of the retina or conjunctiva, the reaction of the pupil to light, nor with the normal consentaneous movements of winking. Its effects are therefore confined to the exercise of visual sensibility.

CASE OF STRANGULATED CONGENITAL HERNIA IN A CHILD TWO MONTHS OLD: OPERATION: RECOVERY.

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THE following case is interesting, from the extreme youth of the patient, as also the contradictory nature of the symptoms, which rendered the diagnosis more than usually difficult.

On July 2nd, 1880, a child, nine weeks old, was brought to the Royal Dispensary, Richmond Street, Edinburgh, for advice. The mother stated that the child had for ten hours been suffering great pain, which had come on suddenly after a fit of coughing. The pain was increased by pressure on the scrotum, which was swollen to about the size of an egg. The mother stated that the child had had a swelling in that position since its birth, which she could always cause to disappear gradually by continued pressure, and which gave the child no apparent discomfort, though it always filled again slowly when the pressure was removed. It was evident, from her description, that the child had suffered from a congenital hydrocele. Since the appearance of the acute symptoms, the patient had been unable to pass urine; the bowels had been freely moved, and there had been no vomiting; the chief symptoms being the apparently intense pain, and the pinched and exhausted expression of face. With these apparently conflicting symptoms in view, I put the child under the influence of chloroform, in order to make a more careful examination than was otherwise practicable. The right half of the scrotum was tense, shining, and full of fluid. Though the neck of the tumour felt somewhat thickened, I could distinguish nothing that felt like intestine, nor was there the least impulse noticeable on the child crying or coughing. Thinking it just possible that the swollen and painful state of the scrotum might be due to some blow or fall upon the previously existing hydrocele, I inquired of the mother whether the child had sustained any such injury. She assured me that such was not the case. I then concluded that the symptoms were due to a minute strangulated hernia, complicating the hydrocele; though the absence of vomiting, and the particularly free movement of the bowels since the supervention of the acute symptoms, apparently contradicted such a conclusion. Such, however, turned out to be the nature of the case; for, having failed in attempts at taxis, on making an incision over the neck of the tumour, and opening the sac, there escaped about two ounces of dark blood-stained serum, and in the uppermost part of the sac there lay a small knuckle of intestine, not much larger than a pea, and deeply congested. This was easily returned on division of the neck of the sac. Having then gathered up the funicular portion of the sac as tightly as possible round the cord, I put two deep catgut sutures through the sac and the surrounding textures, in such a way as to bind it down to the cord, and lessen as much as possible the liability to return of the hernia. I sewed up the superficial parts of the wound closely, and covered the line of incision with a thick layer of collodion.

The child made an excellent recovery, and has now dispensed with any retentive apparatus, though I recommended one to be worn for the first few months, as the child was suffering from a severe attack of whooping-cough.

In infants, where the antiseptic dressing is unsuitable, the collodion dressing will be found useful in preventing the urine from coming into contact with the wound, and thus preventing the healing process.

CASE OF CROUP TREATED BY PASSING CATHETERS INTO THE TRACHEA BY THE MOUTH.

By J. WILSON PATON, M.D., M.R.C.S., Rockferry.

IN THE BRITISH MEDICAL JOURNAL for July 24th and 31st, 1880, are two papers by Dr. Macewen, on the Value of Tracheal Tubes introduced by the Mouth in (Edema Glottidis, etc. The cases he records are all in adults. I am not aware that this treatment has been used in children; but its simplicity and advantages are so great, that a few notes of a case of croup in which catheters were used may be interesting.

H. J., aged three years and ten months, had measles, the rash appearing on February 15th, 1881. On the disappearance of the rash, a hard cough supervened, which gradually increased in severity till March 1st.

On this date, I found him, at 1.30 A.M., suffering from intense dyspnoea, quite unable to speak, and his lips of a dark livid colour. His cough was constant, brassy, and without expectoration. The respira-