three inches, this portion of bone being partially destroyed and somewhat expanded. The lower end of the ulna was not implicated, and the extensor tendons were stretched over the tumour. As far as could be ascertained, the growth was confined to the parts mentioned, and no glandular enlargement could be detected. The movements of the wrist were very slight, but the fingers had fair movement.

In considering the treatment of the case, I had to take into account the fact that, in order to remove the disease without amputation, nearly four inches of the lower end of the radius, together with the tumour and skin over it, would require to be taken away; and also that, if a corresponding portion of the lower end of the ulna were excised so as to allow the carpus to become connected with the divided end of the radius, the result would be an useless and flail-like hand. Remembering the condition of the parts in Dr. Fiddes' case, I decided to try to save the hand by removing the lower end of the radius and the tumour, and then bringing the hand round, so that the carpus might make an articulation with the radial portion of the lower end of the ulna.

On November 19th, I performed this operation, taking special care to avoid as much as possible any injury of the extensor and other tendons. As all the affected skin required to be removed, a sore of the size of two half-crowns remained after the operation. The operation was performed with careful Listerian precautions, and the hand and arm were placed upon an angular splint, specially made for the purpose of keeping the hand in the position referred to.

Fig. 2.

On January 7th, 1881, the antiseptic dressing was removed, as the wound was small and superficial. Careful movements of the wrist and fingers were commenced about a month after the operation, and these were regularly continued.

On February 14th, the patient left the hospital with the wound quite healed. His fingers had considerable mobility, and he had also some power of flexion and extension at the wrist.

In July of this year, the patient returned to show the result. The hand, fingers, and wrist had improved much in strength and mobility.

A cast of the hand and wrist was taken at this visit, and the illustration shown in Fig. 2 is a careful copy of it.

PRESENTATION TO DR. P. O'CONNOR.—A meeting was held at the West Derby Union Workhouse, on November 24th, for the purpose of presenting a handsome writing-desk to Dr. P. O'Connor, by the officers of the workhouse. A second presentation was made, through the master, by the inmates of the union hospitals, with which Dr. O'Connor has been connected as resident medical officer for nearly three years.

A NEW AND RELIABLE OPERATION FOR THE CURE OF WEBBED FINGERS.

By ARTHUR T. NORTON, F.R.C.S.,

Surgeon and Lecturer on Surgery at St. Mary's Hospital.

C. K. was sent to me by Mr. Moore of Chiswick. The boy, one of four children, was about four years of age, and had the three inner fingers of the left hand webbed together. No relative had suffered from the same deformity. The operation which I performed can be best explained, and, indeed, can only be understood, by referring to the diagram.

A tongue of integument was cut from between the knuckles, and another, corresponding in shape, and position, and size, on the palmar surface. These tongues were then raised by dissection, and the webs cut through. The knife was then carried back so as to sever all the tissues as far back as the bases of the tongues, and a little superabundant tissue was removed. Next, the apices of the tongues were sewn together, and lint, dipped in cold water, applied. The flaps or tongues united by the first intention between the little and ring fingers, but one of the pair between the ring and middle fingers sloughed at its apex from its suture. The cause of the sloughing was incomplete section of the tissue between the fingers up to the base of the tongues, the result of which was too great tension, and consequently giving way, at the suture. However, even in this case, the tongues separated only a very short distance, and the interspace rapidly healed, so that there was no redevelopment of the web.

A drawing of the hand was taken after the operation, by which it will be seen that, in the case of the middle and third finger, a little more tissue might have been removed with advantage after the raising of the tongues, in order to bring the line of the natural web into proper position. The healing of the fingers progressed rapidly in the middle finger and on the outer side of the ring finger. Between the ring and little fingers the healing was not so rapid, because the web between these fingers was thick and narrow, so that, after its section, a larger surface was denuded.

The points to be considered in performing the operation are these. 1. The tongues should be cut thick, so that their vascular supply may be complete, and the chance of their sloughing reduced to a minimum. 2. They should be cut rather narrow, with judgment; otherwise, they are compressed laterally and bulge upwards at the margins, instead of lying in adaptation to adjacent tissues. Such compression, of course, interferes with their circulation. 3. The tissue between the knuckles is to be cut back, or, if necessary, cut away, so that the apices of the tongues shall lie well in contact with each other without tension. 4. The tongues must be of sufficient length, so that there shall be no tension

when the suture is applied; they had better be too long than too short. 5: The apices of the tongues are very small, so that a very small needle should be used to carry the suture. 6. In shaping the tongues the line of the natural web should be carefully observed. If the tongues heal by first intention, no web can redevelop. There is no reason whatever why union by the first intention should not invariably take place if the above points are remembered whilst performing the operation, and thus one of the most troublesome and unsuccessful of operations is converted into one of the most simple and most certain of success.

RHEUMATIC FEVER WITH PERICARDITIS: HYPERPYREXIA: TREATMENT BY COLD: RECOVERY.

By J. MAGEE FINNY, M.D.Dub., F.K.Q.C.P.I.,
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Dublin Hospital.

MARY L., aged 37, a mother of five children, was admitted to hospital on July 27th, 1881, suffering from well-marked arthritic rheumatism, the ankles, knees, and elbows being chiefly engaged. She was ill for about a fortnight before admission. Careful examination failed to detect any cardiac complication. Pulse 108; temperature 101.8°. She was ordered salicin in fifteen-grain doses every fourth hour; the patient was placed between blankets, and the painful joints were wrapped in wadding covered with gutta-percha tissue. Relief followed the treatment, though not in so marked a degree as had occurred in other cases similarly treated, and the temperature fell a degree in twenty-four hours. On the third day, the temperature in the morning was higher

chloric acid and water; it was not, however, retained, being vomited at once. The patient was now partly unconscious, wandered in her mind, complained of no pain, while her face and lips were flushed of a purplish tinge; the respiration was shallow and rapid; the temperature in the axilla was 107°, and pulse 136. I was communicated with, and I saw her at 5.20 P.M., when the heat had increased by a fifth. The cardiac phenomena had not increased; but, as the heart was beating 136, it was not possible to speak positively as to the presence or absence of the friction-sound. Percussion showed there was no effusion. As it was evident that the patient was in imminent danger of dying of hyperpyrexia, I proceeded at once to apply cold in the following manner; the cold bath being kept in readiness in case it became necessary to employ it.

The patient was stripped of the blanket covering her, gradually from above downwards; and towels wrung out of water, in which stood a large block of ice, were assiduously applied, one after another, first to the head and neck, then over the front of the thorax, next over the abdomen, then the thighs and legs. By the time the last cloth was applied, the first had become warm, and it was replaced by a cold towel, and so on with each. In ten minutes, the temperature fell half a degree, and, after this process was continued for forty minutes, the temperature had fallen from 107.2° to 103.8°, and the pulse from 136 to 120. The face and lips had lost their flushed appearance, and the patient made complaints of feeling cold. The iced cloths were placed quite irrespectively of the inflamed pericardium or the joints. The temperature was observed every ten minutes by a thermometer placed in the axilla, which had been kept closed by the approximation of the arm (the parts being fat). The patient was then well dried, and fresh blankets were placed under and over her. At 9 P.M., the patient was very much inclined to sleep, answered questions dreamily, and appeared to

by .5° than the preceding night, and much pain was complained of in the left ankle. The salicin was then ordered to be given every third hour. At this time, there was noticed occasionally a third sound with each movement of the heart, presystolic in time, and resembling a reduplication of one of the sounds. Its locality was towards the base, in the left parasternal line. This sound was better marked in the evening, and was considered to be pericardial in nature. The following morning (July 30th), the temperature showed signs of a tendency to rise, having gone up rapidly from 101.2° on the morning of the 29th to 104.4° in the evening, and 104.6° this morning, and the pulse from 100 to 114. The abnormal cardiac sounds had also assumed a more decidedly frictional character, confined to the apex of the pericardium. As it was evident that no good had been obtained from salicin, it was stopped, and instead, five grains of quinine were given at once and ordered to be repeated every third hour; and six leeches were applied to the præcordium.

At 5 o'clock P.M., my resident pupil, Mr. Law, finding that four five-grain doses of quinine had been taken without producing any effect on the temperature, gave twenty grains, dissolved in a little hydro-

have little or no recollection of what had happened. She vomited three times in the last two hours. Temperature 100.6° in the axilla, and 101° in the rectum. Pulse 108°. At 10 o'clock P.M., the temperature in the axilla was 101°; and the bowels, which were very free all day, were moved unconsciously at this time. The patient slept well during the night, and on the morning of July 31st the pulse was 96, and the temperature 102°. The tongue was coated with white fur; she had slight sordes on the teeth; and she complained chiefly of pain in the right foot and ankle. There was no effusion into the pericardium; and, at the base, the friction-sound was slightly audible, presystolic in time. The heart was acting strongly. During the last twenty-four hours, the bowels had been moved six times, and they continued free all through the day, until checked by starch and opium injection at 9 P.M. A sleeping-draught was given, and she had a good night. There had been no return of hyperpyrexia. Temperature 100.4°; pulse 92.

August 1st. The pericardial sounds had disappeared, and the first sound was quite clear, loudest at the apex. The urine was examined, and found to be alkaline and phosphatic, and free from albumen.

From this day forward, the patient uninterruptedly progressed to