to if the case be mild, because they are conspicuous; or if the child be very young, because they are likely to tax its strength, and this I have known them to do. Straight wooden splints are used by some; and I have tried them, but without satisfaction, because they take their bearings upon the knee and ankle, which, if these joints be normal, is objectionable; while, as regards both irons and wooden splints, the most valuable time—namely, the many hours during which the child is asleep, and therefore no weight is upon the bones, and no muscular effort can bias treatment—is lost, as irons and splints cannot be worn in bed; and splints, if worn, are either kicked off or pushed by the child into an useless position.

This state of bent tibiae is generally observed in fine children soon after they begin to walk, and is believed to be caused by the child's legs having to carry a weight heavier than they are able to support. I believe this to be an intensifying, but not the primary cause. I hold, in fact, that, like talipes varus and talipes equino-varus, of which this may be considered the mildest modification, it is congenital, and due to the position which the child's legs and feet occupy *in utero*; the most favourable exciting cause being that of a large child lying in a uterus containing but little liquor amnii, so that the lower extremities are obliged to conform to the rounded containing cavity.

All obstetricians must have observed how newly born infants' limbs, when extended, rebound into the bent position they occupied in the uterus; and that often involves the appearance I have mentioned, and even talipes varus and equino-varus. It is well known also that a good nurse, by daily manipulations, can cure even pronounced talipes. What we need, therefore, for treatment, and early treatment, is an elastic power acting directly upon the bone affected, leaving free the knee and ankle joints, which can be worn when the child is awake and active, and particularly during the long hours of rest. These small light steel spring splints, which I have devised, and which a clever mechanist, Mr. Bryant of Lower Park Row, Bristol, made in accordance with my instructions, are designed to act in the same manner as manipulation. If we place the fingers of one hand on the upper extremity of the tibia, and of the other hand on the lower extremity, and both thumbs on the outer surface of the limb, the bone can, with gentle firm pressure, be soon made to assume almost the straight line, as at an early age it is cartilaginous. These splints consist of a spring shaft well curved outwards, having the lower extremity cupped to cover the malleolus of the fibula, and to the upper extremity fixed a transverse band of malleable iron to partially embrace the limb below the knee. In applying them, the centre of the shaft and the lower portion are first bandaged in position; then the upper part is pressed to the limb, the soft band moulded to the surface, and the bandaging completed. I have lately had straps affixed to the extremities of several, and these keep the splints in place without bandages. It is requisite that the splints be not strong, or they cause pain; but, if they be mild and well fitted, I find that mothers and nurses readily apply them, and see their operation; and children do not get them out of place, and wear them willingly both when asleep and when awake; and, so far as I have had time to observe, the results are most encouraging. I have adapted the same principle in these splints for bent radius and ulna in boys, the result of walking-stick fractures which had occurred some months before I saw them; also for keeping a toe straight after division of its flexor tendon for contraction.

NOTES ON A CASE OF DEAFNESS FOLLOWING CONCUSSION OF THE BRAIN.*

By RICHARD ELLIS, F.R.C.S. Ed.,

Senior Surgeon to the Newcastle-on-Tyne Throat and Ear Hospital.

THE patient, aged 28, the second officer of a steamer, on going on board his vessel in the harbour of Leith, at night, and where the light was bad, fell off the gangway, between the vessel and the wharf, into the water, a distance of about twelve feet. In falling, he struck his head against the sponsoom of the vessel, and he was in the water for some minutes. When taken out, he was insensible, and remained so for twelve hours. Upon recovery of consciousness, he remembered nothing of the fall; he was told he had vomited much, and bled freely from the mouth, nose, and left ear. Meantime, as his general symptoms were promising, he was allowed to proceed quietly in his vessel to South Shields. On arrival at this port, he found he was totally deaf in the left ear, for which he applied to Mr. Rajaonah, the house-surgeon at the Ingham Infirmary, who sent him up to the Newcastle Throat and Ear Hospital, where he came under my care a week after

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the accident, presenting the following symptoms. There was a lacerated wound on the upper portion of the mastoid process; the pinna was also lacerated; these wounds were in a healing condition. He could not hear the watch on contact; he said that, on closure of his good ear, he could not hear the noise of the railway-train on his journey up. The tuning-fork was heard very faintly and indistinctly. On using the otoscope, no impulse was heard from the Eustachian tube. The tympanum was dull in colour, particularly in its lower segment; the cone or pyramid of light was not seen. The diagnosis was intratympanic hæmorrhage, blocking the Eustachian tube; and laceration of the lower segment of the tympanum, which was possibly fastened down by a coagulum of blood, thus preventing vibration.

Treatment.—The meatus was filled with a warm solution of bichloride of soda, in distilled water, with glycerine. This was renewed, and the steeping continued, for about twenty minutes. The syringe was now very gently used, which brought away a small thin coagulum, about half the size of the little finger nail, and he expressed a sense of relief; but still the hearing, although much improved, was defective. The Eustachian catheter was now passed, through which a weak alkaline solution was passed by means of a syringe; finally, he was Politizerised, with the result of there and then completely restoring his hearing. I recommended him to take, for a week or so, a mixture containing five grain doses of the iodide of potassium.

PARALLEL HISTORIES OF TWO CASES OF BLEEDING MYOMA.*

By LAWSON TAIT, F.R.C.S.

IT is now just ten years since I introduced the operation of the removal of the uterine appendages for the arrest of hæmorrhage; and though at first my results were so unsatisfactory as to lead almost to a desertion of the practice, within the last six years the results, both primary and secondary, have been so brilliant, that I have every reason to regard this proceeding as the most satisfactory addition to gynaecology which has been made during the present generation.

The idea seems to have occurred simultaneously to Professor Hegar and to myself; and the performance of the operations in order of date gives only a few days' priority to Professor Hegar. But, for the relief of pain, I had performed the operation seven months before Professor Hegar. At first I was contented to remove the ovaries, but I soon found that the results were not speedily and completely satisfactory unless the tubes were removed. Increased experience in this class of cases has satisfied me that it is with the tubes that we have chiefly to do, and that the function of menstruation has little or no dependence on the ovaries. If the tubes are removed and the ovaries left, menstruation may be entirely suspended. Thus it will be seen that the principles upon which is based the operation introduced and practised by myself differ very much from those of Hegar and Batty.

I have already published several series of cases of removal of the uterine appendages for the arrest of intractable uterine hæmorrhage, in which I have shown that both the primary and the secondary results are more satisfactory than those of lithotrity in the male, so far as these are known.

I have now to give the histories of two most curiously parallel cases of bleeding uterine myoma; the contrast afforded by these being a singularly powerful argument in favour of the operation I advocate.

The first case is that of a young woman, aged 28. I admitted her to the Hospital for Women on May 15th, 1879, on account of profuse menorrhagia. She was in a condition of the most extreme anæmia, due to the presence of a small myoma in the fundus. Every therapeutic measure had failed to make the least impression on the hæmorrhage, and I therefore attempted to remove the myoma by dividing the cervix and opening the capsule. This was done on August 12th, and a mass as large as a hen's egg was removed. She hung between life and death for weeks, and was eight months in recovering strength sufficiently to get about. In a report published in the *Lancet*, I remarked that I was of opinion that, in such a case, the removal of the appendages was a much safer proceeding than enucleation of the tumour, and that it had given much better results. There can be no question that enucleation is a most terribly fatal operation; and even when it does not kill, it is not necessarily successful, as will be seen in the second part of the history of this case.

I saw her from time to time after she left the hospital, and she became strong enough to resume occupation in July 1880. She became engaged to be married about this time, and everything promised well

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