A MODIFICATION OF HYSTERORRHAPHY FOR CHRONIC SENILE PROCIDENTIA.¹

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THE practical requirements for successful ventral uterine fixation are—to heal erosions and ulcerations, and reduce the size and weight of the uterus before attempting fixation. So far as practicable, vaginal prolapse must be corrected by astringent douches—for example, oak bark, quebracho, etc. The uterus should be temporarily supported by a pessary; above all, hyperplasia must be corrected by rest in the horizontal position. As a lesser operation, perineorrhaphy, with or without colporrhaphy, may be first tried, especially in cases where rectocele or cystocele is a marked complication. Despite all these measures, a few cases will be found to require something more. Unless a trial of shortening the round ligaments is made, ventral fixation of the uterus is the only radical cure.

For chronic senile procidentia, the following procedure seems to me likely to become more generally used than any hitherto employed:

Operation.—The uterus is well returned within the vagina; then, by means of a broad-pointed sound-like repositr, it is pressed up against the abdominal peritoneum. A short incision is made in the mid-line through the superficial and deep abdominal layers down to, but not through, the peritoneum. A narrow curved needle, with a fairly large eye, of Hagedorn's pattern, and fixed in a long firm handle, is introduced *per vaginam*, and brought out through the right side of the uterus and through the exposed abdominal peritoneum. The needle is threaded with strong silkworm gut or reindeer tendon, or silver wire, from the abdominal side; the needle is withdrawn through the same puncture, the thread is drawn through, and the lower end brought into the vagina. The ends of the suture are fixed with catch forceps. The needle is disinfected, then reintroduced, and made to pass through the left side of the uterus and the abdominal peritoneum covering it; the needle is threaded as before, and, on being withdrawn, brings the left side thread into the vagina. There are now two single threads or two free ends inferiorly, with a loop on the abdominal aspect; the latter should be divided, and the ends fixed with forceps. The forceps on the vaginal ends of the sutures are removed, and on each suture a small, stout flattened ovoid glass disc, with rounded edges, or a plate of decalcified chicken bone is slipped. A little manipulation may be needed to get the discs through the cervix. As a rule this can be managed by steadying the uterus, if need be, by volsellæ, and then guiding the discs sideways by forceps, or by gentle traction on the abdominal ends of the sutures. Before tightening the sutures, care must be observed that the intrauterine repositr maintains the fundus uteri in close apposition to the abdominal peritoneum. The sutures are now drawn tight from the abdominal ends till both discs are closely applied to the inner uterine wall: the operator should be able to lift up the uterus by means of the threads. If the uterus is unduly large, or if there is any doubt about the position or strength of the sutures, a third or fourth disc may be introduced in the manner already described, but this will seldom be necessary. The abdominal ends of the sutures are now threaded in an ordinary Hagedorn's needle, and passed through the muscular layers of the abdomen; discs of bone or glass may be slipped on, and the sutures secured and buried. At times the sutures from the opposite sides are tied together and then buried. The intrauterine repositr is withdrawn. (Two deeply buried silkworm gut stitches, including the whole thickness of the uterine wall, but not passing through the endometrium, may be used to further connect the uterus with the abdominal muscles. These latter stitches are only to be used when the uterus is large and heavy). The abdominal wound is closed. The vaginal ends of the sutures are not cut short, but allowed to remain as drainage tubes for ten days. The vagina is packed with antiseptic tampons for a fortnight. If the sutures

are not loosened by the end of a fortnight, they are cut off at the level of the os. The patient should be kept in bed for three weeks after operation, and, in a considerable proportion of cases, it may be desirable that a pessary should be worn for two or three months after getting up. In event of retro-uterine adhesions, it may be necessary to open the peritoneal cavity and break these down. If this has to be done, a strip of uterine peritoneum should be dissected off by scissors and the uterine surface stitched to the parietal peritoneum, as practised by Caneva, of Milan, and many others.² This should be done after the intrauterine sutures have been passed, but before they are tightened.

The advantages claimed for this operation are—

- (1) It gives more secure and reliable fixture than any other.
- (2) The time occupied in performing the disc operation is much shorter than in plastic methods.
- (3) Sufficient adhesive peritonitis is induced to warrant belief that, after the absorption of sutures (if destructible sutures are employed), the uterus will retain its relations to the abdominal wall.
- (4) The risks of bleeding are *nil*. The risks of septic absorption from the thread passing through the uterus are practically *nil*; fluid matter will come down into the vagina, and the sutures, passing through the substance of the uterus with the closely applied discs, block the uterine end of the suture tract, and prevent passage of fluid into the peritoneal cavity.

(5) The operation is much easier than a plastic method. Any operator conversant with the uterine sound can do all that is needed.

I believe that strands of glass threads might make an excellent and imperishable suture, pliable as silkworm gut, non-irritating, and more durable than silver.

In senile uteri, the small glass discs do no harm; probably they pass out in course of time. In younger women, chicken-bone plates (like Senn's intestinal plates) should perhaps be preferred. They may pass out or become absorbed. The adhesions produced may also become absorbed. But if the uterus is kept well up for a time and the vaginal walls regain tonicity, the procidentia will be found cured, even if time destroys the adhesions and absorbs the sutures.

ON OPERATION FOR FRACTURE EXTENDING INTO JOINTS.

By W. WATSON CHEYNE, M.B., F.R.C.S.,

Surgeon to King's College Hospital, and to the Paddington Green Children's Hospital, etc.

FRACTURE in the immediate vicinity of and extending into a joint is an injury which must always cause serious anxiety with regard to the future function of the joint, more especially if the fracture is a comminuted one, or if, owing to the occurrence of swelling before the case comes under notice, a satisfactory diagnosis of the exact injury cannot be made. No doubt, in some cases, a fairly satisfactory result is obtained where early passive motion and subsequent massage are employed, but too often the result is considerable and sometimes serious impairment of movement. The question, therefore, arises whether, at the present time, seeing the impunity with which we can open healthy joints under aseptic precautions, we ought not to cut down at once in certain cases of fracture extending into joints with the view of restoring the fragments to their proper position or of removing useless fragments, especially where the fracture is a complex one, or where comminuted fragments are present which cannot be manipulated into position, and which tend to lock the movements of the joint, and interfere permanently with its function. I venture in this paper to bring forward four cases in which, for the reasons above given, I have interfered by operation with, I think, great benefit to the patients. I only speak here of recent cases. Some years ago, in my book on *Antiseptic Surgery*, I mentioned several instances in which joints had been opened in the course of operation for badly united fractures in the neighbourhood of joints, or extending into them, and since that time the number of cases of that kind has considerably increased; nor have I included opera-

¹ Read in the Section of Obstetrics at the Annual Meeting of the British Medical Association held in Birmingham, July, 1890.

² *Hystéropexie*, par M. Baudoin, pp. 318-370. Paris: 1890.

tions for recent fracture of the patella or olecranon, of which I could have brought forward a considerable number, for operative interference in these cases is looked on now by a number of surgeons as the proper immediate treatment; it is the treatment which I always adopt, and I have seen no reason to abandon it.

CASE I. Partial Fracture of the Head of the Radius.—This case is not one of immediate operative treatment, for I did not see it till some weeks after the accident, but I have included it because it is a rare injury, and because it is a typical example of one class of cases where early operation is called for—namely, those where a joint is locked by a loose fragment which cannot be replaced in its proper position.

Miss S., aged 26, was thrown out of a carriage on August 3rd, 1888, and in falling struck the outer side of her left elbow joint against the edge of the seat, and the carriage in overturning struck the arm again about the same place. The result was a small contused wound above the olecranon, which, however, did not extend deeply and soon healed, and a fracture of the head of the radius, which was diagnosed as fracture of the shaft of the bone, and treated with anterior and posterior splints. When the splints were left off four weeks later the following was the state of matters: the forearm was completely pronated and supination was impossible; the forearm was almost completely extended, the range of movement was very slight, and attempts at movement caused great pain in the elbow joint. When I saw the patient for the first time on September 20th, the condition of the arm was as above described, and on examination of the elbow-joint a loose fragment of bone was felt at the posterior part between the olecranon and the head of the radius; there was no swelling of the joint and no evidence of any fracture of the shaft of the radius. The diagnosis was partial fracture of the head of the radius, the loose and displaced fragment locking the joint.

On September 25th I made a longitudinal incision over the posterior and outer aspect of the elbow, and on opening the joint and exposing the loose fragment I found that it consisted of about half the head of the radius, which had been chipped off and become wedged between the bones, thus completely locking the joint. On removing this piece of the bone and breaking down the adhesions, which were pretty firm, perfect movement of the joint could be obtained. The remaining portion of the head of the radius was left, the wound stitched up and dressed aseptically.

As regards the after-progress of the case, very little need be said. The wound healed by first intention, and at the present time the movements of the joint are absolutely perfect. At first there was considerable tendency to stiffness, more especially as regards flexion and supination from reunion of the previously existing adhesions, but by careful passive motion and massage this was ultimately completely overcome.

This case seemed to me to be worthy of record, for two reasons: first, on account of the peculiarity and rarity of the fracture; and, secondly, on account of the treatment adopted.

The broken fragment consists of about one-half of the articular surface of the radius at the posterior part. The line of fracture runs in the first instance directly downwards through the cartilage and the shell of the bone, and then turns backwards, downwards, and inwards. Thus the thickest part of the fragment is at the posterior and inner surface. About one-half of the anterior and inner part of the articular surface of the radius was intact, and remained united with the shaft. Another point of interest is the displacement which had occurred. The detached fragment had been turned completely upside down, so that the articular surface looked downwards, and not only so, the fragment had been turned round so that no manipulation could have put it in its place. I suspect that in the first instance, the force, acting obliquely downwards and outwards chipped off this portion of the head of the radius, and turned it upside down, and then the second blow or the subsequent movements of the arm turned it round, and wedged it in between the bones. There was no attempt at bony union of the fragments.

Partial fractures of the head of the radius are rare, but Bruns records twenty-two cases of longitudinal fracture, in five of which this was the only injury. Mr. Wainwright, in the *Clinical Society's Transactions*, vol. xx, records a case com-

plicated with fracture of the coronoid process of the ulna (the most common complication), in which he removed the whole of the head of the radius and part of the coronoid process of the ulna thirteen weeks after the accident, with a fairly satisfactory result; and in this paper he refers to all the published cases. Where operative treatment has been adopted in these cases, it has, with the exception of Mr. Wainwright's case, been excision of the whole joint.

The other point to which I wish to refer is the treatment. The operation which I performed was, of course, clearly indicated as the only means short of excision of restoring the functions of the joint; and had the injury been recognised at the time, and the portion of bone removed aseptically, much trouble as regards stiffness of the joint would have been avoided. The point which, however, seems to me to be of chief interest is that the function is perfect, although only about half of the articular surface of the radius is present. It was a question with me at the time of the operation whether I should leave the remains of the head of the bone or remove it altogether; but I thought that in the latter case there might be a little outward deformity. As a matter of fact, the patient states that on flexing the arm she occasionally feels something (no doubt the small head of the radius) slipping in the joint, but it causes her no pain or inconvenience.

(I have lately had another case of partial fracture of the head of the radius, where half the head was detached and had not united, and the movements of the elbow-joint were considerably limited. The accident occurred from a kick from a horse. I cut down and removed the loose fragment, and the wound healed by first intention. When the patient left the hospital the movements of the elbow-joint had much improved.)

CASE II. Fracture of the Neck of the Left Femur: Pegging together the Broken Fragments.—M. M., an Irishwoman, aged 52, was admitted to King's College Hospital under my care on October 1st, 1889. The patient was a feeble woman who looked much over 60, and had been a hard drinker. She had infantile paralysis on the right side, the right leg from the knee downwards being paralysed and withered, and the right foot much deformed.

When admitted she was suffering from a pretty severe attack of bronchitis, and could not lie on her back. Some hours before her admission to hospital she had been pushed over and fell heavily on her left hip on the pavement. When admitted she was found to be suffering from a fracture of the neck of the left femur; there was no impaction, and the shortening was about 1½ inch, as determined by the height of the trochanter above Nélaton's line.

From the condition of the right limb it was evidently of great importance, if possible, to obtain bony union of the left femur; while, on the other hand, her bronchitis prevented treatment in the recumbent position. Treatment by long splint, extension and prolonged rest in bed was therefore impracticable, nor did I think it expedient to trust to any apparatus such as that recommended by Senn, and I, therefore, determined to cut down and peg together the trochanter and neck of the femur. Accordingly, on October 4th, the patient was placed under chloroform, and a longitudinal incision was made in front and to the outer side of the hip-joint in the same line as in excision of the joint by the anterior incision. The joint was at once laid open, and I was able to feel exactly the line of fracture. The fracture was partly intra-but chiefly extracapsular. It ran from just in front of the trochanter above, where the finger passed freely into the joint to a point immediately below the lesser trochanter at the inner side, the smaller fragment thus consisting of the head and neck of the femur and the small trochanter. Towards the lower part the neck of the bone was split in the line of its axis, the split extending into the head of the bone as far as I could feel, but whether it involved the whole of the head I could not say. The upper fragment was thus divided into an upper and a lower portion, the upper consisting of by far the greater part of the head and neck of the bone, and the lower of the lesser trochanter and a thin scale of the neck. I imagine that the vertical fracture occurred in the first instance, and that then, as the patient rolled over, the great trochanter pressing on the neck split up the bone, but no impaction took place. Extension by means of pulleys was now applied to the leg, and the trochanter drawn down and manipulated till I felt that the

fractured surfaces were in fairly good apposition. The pulleys being fixed and my finger kept in the wound, I made a small longitudinal incision over the centre of the outer surface of the trochanter, and an assistant then drilled two holes half an inch apart through the trochanter and along the neck of the femur. Ivory pegs were then driven in for about $3\frac{1}{2}$ inches, and by this means the main part of the neck and the trochanter were firmly fixed together; the lesser trochanter had, however, still a tendency to tilt forwards, but by flexing the thigh it was readily brought into good position. The wounds were then stitched up by a continuous suture, and antiseptic dressings applied. No drainage tube was used. The limb being semiflexed, the thigh and pelvis were then enclosed in a plaster-of-paris bandage applied outside the dressing. When the patient was put to bed she was propped up in a semirecumbent posture, the thigh resting on a pillow, and extension by a light weight was kept up to relieve the strain on the pegs.

The patient did not suffer at all from the operation; the bronchitis troubled her a great deal, but she was much more comfortable in the semi-recumbent posture than when lying down. The plaster was taken off and the wound dressed for the first time on October 15th, and healing was found to be complete; the stitches were removed, and a fresh plaster case applied. The plaster was reapplied a second time on November 23rd, and was finally removed on December 4th, when bony union was apparently complete; the great trochanter was then about three-quarters of an inch above Nélaton's line, and moved freely in the arc of a large circle; the other movements of the joint were good. The patient was allowed to get up at the end of December, but it was some days before she could be persuaded to try to stand or to use crutches. From the end of January she got on more rapidly, and was discharged on February 12th, 1890. She was seen again on March 17th, and was then able to get about very well with one crutch, and could stand without a crutch, but could not take more than two or three steps without some support. I have tried in vain to see her since, but I hear that she has been seen going about Drury Lane with one crutch, much as she used to get about before the accident.

On looking up the literature of the subject, I find that pegging of the trochanter to the neck of the femur with the view of getting bony union was in reality suggested some time ago by Dr. Senn as the result of some experimental work which he had done on the lower animals; but, so far as I can find, this suggestion has not been carried out in practice. In a more recent paper¹ he gives up this suggestion in favour of a method of fixing the fragments by means of a plaster-of-paris case and a movable pad, and he narrates some excellent cases treated by this plan. There is no doubt that an operation such as I have described must be very rarely called for in fracture of the neck of the femur, but in this particular instance it was essential to obtain bony union, while, owing to the bronchitis, Senn's plan could hardly have been carried out, and I can easily conceive that under other circumstances also operative interference may be the best way of dealing with some of these cases.

CASE III. Fracture of the Olecranon, the Coronoid Process of the Ulna and the External Condyle of the Humerus: Dislocation of both Bones of the Forearm backwards.—T. H., aged 13, was admitted under my care at King's College Hospital on January 31st, 1890, suffering from the above injuries to the right elbow. On the day of his admission he was climbing a ladder, when he fell about ten feet, and, as far as he can tell, struck his right elbow on the ground. When I saw the case on February 1st, I found the whole region of the elbow-joint enormously distended with blood, and it was impossible to make out the exact injuries. It was clear, however, that the olecranon was broken, and also that there was another fracture about the outer side of the joint, and it also seemed as if the forearm were displaced backwards. The injury being evidently a complex one, I determined to open the joint, ascertain exactly what the injuries were, and try to remedy them if possible.

On February 4th, the patient was placed under chloroform, and a free incision made over the outer part of the joint. It was at once seen that the posterior part of the external condyle of the humerus had been chipped off, and was almost

completely loose. This piece of bone was removed, and then it was found that both bones of the forearm were dislocated backwards. On passing the finger in front of the joint, the coronoid process was found to be detached and broken into several small fragments. As there seemed no hope of getting proper union of these fragments, I removed them. An incision was then made over the olecranon process, an oblique fracture was found, and the parts were wired together. The dislocation was reduced, the wounds stitched, and the arm put up at right angles on a splint.

In this case, as I now usually do, I stitched up the wound with continuous suture, and did not put in a drainage tube, but bleeding occurred into the joint, and I found it necessary to put in a tube on the outer side on February 10th, when I changed the dressings for the first time. This delayed healing, but the wounds were completely healed on March 17th, when the boy was discharged, passive motion being kept up every other day, and easily performed. The splint was left off on April 2nd. On April 3rd, he got a blow on the outer side of his arm, and the scar where the drainage tube had been broke down, but this had healed again by April 30th. On June 2nd, I removed the wire from the olecranon, as it pricked him when he moved the arm. Careful movements have been kept up from time to time under chloroform, and when I last saw the patient in the middle of June the movement of the joint was good, and was steadily improving.

In such a severe injury as the above the result by any means short of operation could hardly have been satisfactory, and the joint would probably have become fixed, or at best there would have been slight movement with ununited fracture of the olecranon. It is in these complex fractures about the elbow-joint that I think we should most often intervene by operation, for their exact diagnosis is a matter of great difficulty, while subsequent stiffness of the joint is very apt to occur.

CASE IV. Old-standing Dislocation of the Patella: Fracture of the Projecting Edge.—J. G., aged 26, was admitted to King's College Hospital on March 29th, 1890. Two years previously he fell on his right knee, and went to a hospital, but beyond bandaging it nothing further was done. Since that time the movement of the joint has been much impaired, but it was impossible to get an exact account of the condition from the patient. On March 28th, 1890, he was carrying a sack of potatoes, and fell on his right knee. He was unable to stand afterwards, and the knee became swollen. On admission, the knee was much swollen, a little crepitus could be felt in front of the joint, and the patella was dislocated outwards, lying on the outer side of the external condyle. It was firmly fixed in that position, and could not be replaced.

On April 1st I made a long vertical incision (ultimately 7 inches in length) over the middle of the joint in front, and dissected the skin and subcutaneous tissues off the patella and capsule. The patella was found firmly bound down on the outer side of the external condyle; its articular surface was concave from long pressure in that position, and the external condyle was much atrophied; the cartilage was still intact. A small portion of the internal edge of the patella had been broken off, and was removed. The strong fibrous tissues binding down the patella to the outer side of the joint were next divided freely, the incision extending sufficiently high in the vastus externus to enable the patella to be brought forwards to its normal position. The old V-shaped tear in the vastus internus was seen and pared, and a sufficient amount of the fibrous tissues in front of the joint was cut away, so that when the tissues on the inner side of the patella were stitched to the remains of the capsule on the inner side of the joint and the rent in the muscle brought together the patella should remain in its proper position. The synovial membrane, especially on the inner side and in the suprapatellar pouch, was very villous, and was removed. The capsule on the inner side was then stitched to the inner side of the patella, the tear in the muscle brought together, and the wound in the skin united by a continuous suture; no drainage tube was employed. Naturally the patella did not move at all smoothly in its new position, but I hoped that in time it would regain to some extent its proper form. A posterior splint was applied.

On the second day after the operation the patient developed delirium tremens, but this had passed off by

¹ *Journal of the American Medical Association*, 1889.

April 9th. On April 11th the wound was dressed for the first time, and was found to have healed by first intention; the stitches were removed. On April 16th a small collodion dressing was applied over the line of incision, and the splint was left off; passive motion could be performed nearly to a right angle. Massage was commenced, and on April 26th the patient was allowed to walk about the ward; this he was able to do without sticks and without much pain, but the knee was very stiff. On May 2nd, and once a week till the date of discharge, the knee was moved under chloroform, while massage was continued in the intervals. He was discharged on June 2nd, on which date he could walk without a limp and could himself bend his knee to a right angle.

I kept the patient in hospital till June 2nd partly for the sake of the massage, but chiefly because he was a drunkard, as I feared that he would be falling again and tear up the young adhesions. As a matter of fact, he was brought back on the evening of June 3rd in a state of intoxication, having fallen on his knee; but I was glad to find next day that, though the joint was somewhat swollen, there was no recurrence of the displacement. I met him in the street in the middle of July, and he was walking well and could bend his knee to a right angle.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

THE TREATMENT OF DIPHTHERIA.

I SHOULD like to put on record a method which I have found exceedingly useful in the treatment of diphtheria; it consists in the hourly spraying of the fauces and naso-pharynx with a saturated solution of biborate and bicarbonate of soda (about 40 grains of each to the ounce of water). The *rationale* of the thing is, I believe, that the bicarbonate of soda tends to loosen and liquefy the tenacious mucus which is always present in these cases, and thus allows the borax to exert its action as an antiseptic; it is, of course, a weak antiseptic, but it has the advantage of being compatible with the bicarbonate, which I believe plays an important part as I have said above.

I have not the smallest doubt, in my own mind, that it tends to shorten the course of the disease; in fact, in one case the recovery was so rapid that I should have doubted my diagnosis if it had not been that a sister of the patient, who was living in the same house, had just died of the disease in St. George's Hospital.

In severe cases it is well to spray up the nostril to prevent the membrane spreading upwards, but for this the solution should be diluted, for if it is saturated with the alkali it causes hyperemia and soreness of the mucous membrane.

I must say, in justice to Dr. Soltan Fenwick, that in all my cases I have given iron, though only in one according to the prescription which he gives in the *BRITISH MEDICAL JOURNAL* for February 14th.

It is now nearly two years since Dr. R. H. Coall mentioned the line of treatment to me; he tells me that he had used it for several years previously—in fact, it is to him that the credit is altogether due if the method should prove useful after a more extended trial.

Bedford Square. VERNON JONES, M.B., B.Ch.Dubl.

MINERS' NYSTAGMUS.

I HAVE long argued with my friend Mr. Snell that this disease is due, not to position, but to faulty illumination, and I now give the following reasons:

1. Less than half of the men who work down the pit are colliers (these are the only men who use the lying down position), but the disease is common to all the underground men.

2. It is especially common in men who work in headings, who do very little "holing." As a rule, the air in headings is very impure, the work is very hard, and the men have to concentrate their eyes on their work.

3. It is very liable to come on in men who have previously worked with naked lights.

4. It is very much more common in the winter than in the summer. In the winter almost every underground man I examine in my surgery has nystagmus more or less. In the summer I only see the confirmed cases.

5. The disease is not confined to the oblique muscles. It is as often met with in the recti.

There is very little difference in the position of the collier in the thin and the thick seams. When a collier says he "sits" to his work, he means he lies down. This peculiar nomenclature will account for some of the discrepancies as to position.

I believe the disease is a clonus of any or all of the ocular muscles due to the fatigue following their tonic contraction, which is correlative of the dilatation of the pupils which occurs when the eyes are fixed on any object in a bad light. I also believe that the presence of "fire damp" favours its development.

Wath-upon-Dearne, Rotherham. W. MAKEIG JONES.

IODIDE OF POTASSIUM IN ABDOMINAL ANEURYSM. G. B., aged 34, came under my care in March, 1889; he had recently undergone several weeks' in-patient treatment at a general hospital, apparently by Tufnell's method, without benefit. There was a history of syphilis, also of a blow three years previously; the symptoms were of one year's duration; the tumour had steadily increased in size since first noticed.

In the epigastrium, arising from, or from the immediate vicinity of, the coeliac axis was a rounded mass, with well-marked *bruit* and expansile pulsation; the latter sign began 2 inches above the umbilicus, extending upwards in the middle line to $\frac{1}{2}$ inch from the tip of the ensiform cartilage, laterally 1 inch towards the left side, $\frac{1}{2}$ inch to the right. Violent paroxysms of pain were frequent; the cardiac second sound was strongly accentuated.

The patient was placed in bed, and treated with 15 grains of potassic iodide, 5 minims of tincture of aconite, and some gentian infusion, three times a day, in a tumblerful of water. Tea, coffee, and stimulants were prohibited, otherwise the diet was unrestricted. The dose of iodide was gradually increased to 1 drachm; and that of the aconite to 15 minims, taken every four hours, freely diluted. No iodism or other ill effect was noticeable, but the pulse became accelerated to 105 beats in the minute. On June 8th, 1889, the man was allowed to get up; all pain had long ceased.

The patient has since been kept under observation, and the iodide is still given from time to time. The aneurysm is considerably diminished in size, causes no pain, and the man follows a light occupation. A *bruit* is still audible, but only in the middle line, down the course of the aorta; not at all at the lateral parts of the tumour. It is, therefore, regarded as a pressure *bruit* only. Pulsation, in like manner, is no longer expansile, and is felt only along the large vessels, as though transmitted through the superincumbent remains of the aneurysm. It is, of course, impossible to affirm that these conditions will remain permanent, but no reason exists to doubt the fact, and there can be no question of the advantages conferred by the iodide treatment.

Gloucester Place, Portman Square. HERBERT SNOW.

RECRUDESCENT INFLUENZA OCCURRING IN THREE MEMBERS OF A FAMILY.

G. C., aged 27, felt unwell on the evening of January 25th. On the morning of the 26th he sent for me; said he "felt just the same as he did last year with the influenza." Temperature 104°. Bowels confined. All organs appear to be healthy. Complains of nothing but aching of limbs and slight thirst. 27th, 28th and 29th, very little change; 30th, slight dullness under left clavicle, with fine crepitation, over an area of 2 inches square. Rhonchus and sibilus over upper part of left lung, right lung normal. Expectoration frothy, slightly rusty coloured. 31st, temperature 102°. February 1st, temperature 101°; cough less, dullness almost gone; no crepitation. February 2nd, much better; temperature 99°. February 3rd, breath sounds normal, rather weak, otherwise feels well; temperature 98.6°.

This patient had a similar attack last year, but the lung