hæmorrhage occurred in the case of the first artery, which was tied with the single carbolised catgut ligature; whereas the second artery, tied by the two hemp ligatures and divided between them, gave no trouble; and the wound treated by the mere approximation of the edges with sutures healed quickly. Whatever may be the advantages attendant upon other methods of securing blood-vessels after ordinary operations—and I think they are a little over-estimated by some surgeons—none is more safe and less liable to be followed by secondary hæmorrhage than the old method of tying the open artery with a hemp ligature. I am in the habit of saying, in my lectures, that a vessel which has been properly tied in this way rarely or never bleeds; and that, when secondary hæmorrhage does occur, it is commonly due to some carelessness on the part of the surgeon. It was to make sure of this condition in a case in which it was so important to reduce the risk of hæmorrhage to the minimum, that I divided the artery between the two ligatures, so bringing it into the state of a vessel divided in an ordinary operation. Thirdly, the return of pulsation and other aneurismal symptoms in the left limb with so great severity, and so soon after the ligature of the artery, is remarkable. Their cessation upon extension of the knee was probably due to displacement of coagula in the aneurism, and a consequent increase of blood-clotting. Fourthly, the suppuration in this aneurism was caused, no doubt, by the disturbance consequent on the extension of the limb. The relief afforded by the trocar, without there being any subsequent bleeding or other trouble, was a better result than might have been anticipated.

The delay in sending this case to the JOURNAL has enabled me to complete the history of the patient, which is not without interest in its last stage.

Mr. K. S. Wallis, surgeon at Edmonton, called upon me September 18th, 1875, to tell me the termination of the case. The man was admitted into the Infirmary at Edmonton November 22nd, 1874, suffering apparently from colic. He had walked from Cambridge, and had fallen in the road from pain in the body. After a few days, a pulsating tumour was found in the abdomen above the navel on the left side, and was diagnosed to be aneurism. There was some sickness and constipation. The man attributed the swelling in the abdomen to a fall upon the stump of a tree, which hurt him at that spot, some weeks previously. It rendered him insensible for a few minutes, and he kept his bed for a week. After about a fortnight from admission into the Infirmary, he was suddenly seized with syncope, and thought to be dying. Mr. Wallis had only just left him, and, returning, found him almost pulseless, in cold perspiration. There was great enlargement of the left side of the abdomen, with dullness on percussion and fluctuation. The man rallied after a few days; the swelling became more solid; and his strength and appetite returned, in spite of frequently recurring sickness. The pulsation became again distinguishable in the region of the original swelling. He continued thus till after Christmas, when he became gradually weaker, and died at the end of January. On examination the day following, extensive adhesions were found of the bowels to one another, and of the bowels to the abdominal wall. The bowels were pushed to the right side; and there were some recent clots in the abdominal cavity, the source of which was not quite clear. There was a large mass of dark coagulated blood, weighing ten pounds, behind the peritoneum, adhering to the diaphragm, and extending from it into the pelvis. This had proceeded from an aneurism springing, as far as could be then ascertained, from the fore part of the abdominal aorta, in the situation of the celiac axis. It was about the size of an orange, with thick fibrous walls. It contained but little blood, and there were no laminated clots in it. In the left side of its wall was a rent, which was plugged by the surrounding clot, so that no blood had recently passed through it. The heart and the thoracic aorta were healthy. The femoral artery was obliterated on each side about the seat of the operation; that on the right side to a greater extent than that on the left. In the popliteal spaces there were no definite traces of the aneurisms. The arteries were reduced to cords, and the tissues were adherent about them. The portions of the arteries between the seats of the operations and the popliteal spaces were not examined.

Mr. Wallis was so good as to send me the aneurism, which has been carefully dissected by Mr. Anningson of Caius College, and is in the pathological collection of this University. It is larger than an orange, and springs from the root of the superior mesenteric artery, involving the orifice of the artery, which is half an inch in diameter, and its left wall for about an inch and a half. Its coats are of unequal thickness, and there is a large rent in the lower part of its left side just below the level of the pancreas. The abdominal aorta and its branches, and the celiac, renal, inferior mesenteric, and common iliac

arteries, are all quite healthy, and retain their natural elasticity. The same is the case with the short portion of the superior mesenteric artery beyond the aneurism, which has been preserved, and also of its right wall at the part opposite the aneurism. The coats of the vessel are gradually expanded into the aneurism, and traceable for some distance in it, but are gradually lost.

ABLATION OF THE CUBOID BONE IN CONGENITAL VARUS.

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THE following sentence was published by me (*Treatise on Deformities of the Human Frame*, 1853, page 305). The italics are now added. "The author has often thought that in inveterate varus, such as Figs. 105 and 106, the treatment might well be commenced in robust subjects by ablation of the os cuboides, which, in preventing the unrolling of the foot, acts as the key-stone of the inverted arch. He is of opinion that by this means the treatment of certain cases might be reduced from twelve months to six or eight weeks." Some years afterwards, I witnessed the attempt made by the late Mr. Solly to carry out this suggested operation, the incomplete result of which did but confirm the scruples I entertained as to performing it myself in the few instances of inveterate congenital varus in adults of 35 or 40 years of age which I have since seen. The number of the BRITISH MEDICAL JOURNAL for April 29th contains an able article on this subject by Mr. Richard Davy of the Westminster Hospital, in which he relates several cases of removal of the cuboid bone without accident or permanent injury. The mode of operation is a great improvement upon that followed by Mr. Solly. One of the patients (No. 3) appears to have been most benefited by it. The report as to Cases Nos. 1 and 2 suggests the idea that much is wanted to enable the result to compare favourably with that which simple tenotomy and suitable subsequent attention and mechanical treatment, without ablation of the cuboid, would have accomplished in little more time than was required with the help of the ablation of that bone.

The result of Mr. Davy's operations justifies, it is true, the view I took in 1853 concerning the influence of the cuboid bone as an impediment to the cure of inveterate congenital club-foot in adults of 30 to 40 years of age, of robust and resisting tissues; of persons, in fact, who, through much walking in the deformed neglected state, had grown up with feet which had ultimately assumed the shape and position of the figures to which I referred. If any reader of the JOURNAL will refer to my treatise, in which the suggestion of removal of the cuboid bone was made, he will be struck with the enormous difference between the cases to which I alluded and any possible case of congenital varus in a child or adolescent within the age of 9 and 15 years, the age at which Mr. Davy thought himself justified in resorting to this radical and non-conservative operation. In fact, with all due respect to Mr. Davy's reasons for performing it in his cases, and appreciation of the skill with which he carried it out, I am obliged earnestly to protest against any repetition of it, for the simple reason that all the cases upon which he operated might have been treated with better results by the help of proper section of muscles and fascia only, by proper mechanical after-treatment, by proper attention and patience on the part of the surgeon, in as few weeks or months as Mr. Davy's cases of ablation of the cuboid bone necessitated, without weakening of the foot and risk of production of a permanent valgoid state, the evils of which are inferior only to those of the varus condition. Under no circumstances, is it desirable to substitute even a minor deformity for a major when cure can be effected without resultant deformity. The only conceivable case in which the question of ablation of the cuboid bone can be entertained should be that in which inveteracy of deformity exists, and which is curable by no other means, or in which, on account of sloughs, ulcers, necrosis, or other results of pressure, overstanding and walking, the alternative of amputation of the limb offers itself to the surgeon and to the patient. Even in such a case, I venture to commend to surgeons the case under the care of Mr. Critchett, narrated at page 306 of the above quoted work. Above all, I entreat surgeons to ponder over the remarks on the subject of infantile congenital club-foot made by me at the Edinburgh annual meeting of the Association, which appeared in the JOURNAL last September, showing that every congenital case of varus ought to be cured, and can be cured, before the age of twelve or sixteen months, before the time at which a child usually walks, and which, if properly treated, requires for walking no after use of splints, Scarpa's shoes, irons, or other mechanical aid. The accidental exceptions ought to be so few as not to invalidate the positive statement and assurance I have given.