able to apply their knowledge not merely to the improving of old methods of treatment, but also to the devising of new methods to meet the new conditions they had to deal with and the new environment in which they found themselves.

It is largely due to team work by the younger men that great advances have been made, not only in wound treatment, but in the early and late treatment of fractures, especially fractures of the femur, in wounds involving the joints, in injuries to the nerves, and in military orthopaedics generally; also in wounds of the lungs and pleura and their complications, as well as in injuries of the skull and brain. Special mention must also be made of the wonderful work which has been accomplished in connexion with the repair and reconstruction of the parts after severe facial injuries. In this work the dental surgeon has taken a prominent part; indeed, he has been indispensable. Lastly, much valuable information has been obtained also with regard to the nature of shock and to the methods of combating it.

PROFESSOR CAIRD.

I feel I cannot conclude my address without taking this opportunity of saying what I owe to my distinguished predecessor, Professor Caird. Lister's love of surgery was well known. Caird's is certainly no less profound. His enthusiasm for surgery and his love of teaching have been unbounded.

Fortunately, although Professor Caird has reached the age at which he must retire from the chair, he is as vigorous as ever, both in body and mind. It is to be hoped now that, freed from arduous hospital work and clinical teaching, he will find time to give to the surgical world some of the fruits of his ripe experience.

I have already referred to the splendid system of clinical teaching adopted by the late Professor Kocher. I feel sure I am correct in stating that a similar system has been followed—and with the same thoroughness and success—by my distinguished predecessor in this chair, and it will be my endeavour, as far as in me lies, to follow in his footsteps.

TWO CASES OF TRAUMATIC ANEURYSM OF THE COMMON CAROTID.

BY

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I VENTURE to publish an account of these two cases because I think them to be of interest from a surgical point of view, and also because the patients not only survived their original wounds but also operative interference.

CASE I.—*Gunshot Wound of Neck: Arterio-venous Aneurysm of the Left Common Carotid.*

The bullet had traversed the left side of the neck horizontally at the level of the cricoid, leaving a perfectly clean wound. The man came under my notice about three weeks after being wounded, when there was a visible pulsating swelling, with its greatest prominence in front of the anterior border of the sterno-mastoid. The swelling presented the usual signs of an aneurysm, including a loud bruit, which ceased on pressure being made at the root of the neck.

Operation.—A long incision was made over the anterior border of the sterno-mastoid, and deepened until the internal jugular vein was exposed. The vein was enormously distended, having a diameter of 2 in. No doubt the division of the fascia had allowed it to expand to an extent greater than before the disturbance of the parts. There was a communication between it and the internal carotid just below its division. The internal carotid was clamped with a guarded pair of forceps with a view to seeing if the communication could be closed. However, although this proceeding lessened the tension in the vein, it had no effect on its size, and this, coupled with the dense cicatricial tissue of the bullet track, prevented a safe exposure of the main vessels. The vein was accordingly divided and tied. The clamp on the common carotid was removed, and the vessel ligatured in two places and divided between them. A somewhat difficult dissection exposed the external and internal carotids. These were ligatured at their origin from the common trunk.

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CASE II.—*Gunshot Wound of Neck: Dissecting Aneurysm of the Left Common Carotid Artery.*

The bullet passed from a little below and behind the mastoid process to a point on the left side of the trachea at its commencement. The entry wound was clean and newly healed when he came under observation, but there were signs of inflammation round the bullet. This case differed in appearance from the last only that the swelling steadily increased and was more tense.

First Operation.—The bullet, which was found lying in a little pool of pus, was extracted. The wound was left open, and at the end of a week was reasonably clean and nearly healed; the steady increase of the aneurysm, however, necessitated interference.

Second Operation.—A similar incision was made and gradually deepened until the sac of the aneurysm appeared. It was roughly fusiform, and extended from 1½ in. above the clavicle to somewhere about the level of the lower jaw. Its upper limits were not investigated. The sac was perilously thin, and appeared to consist only of some of the outer coat of the artery. The internal jugular crossed it somewhat far back. It was firmly adherent, so that the main bulging was directly forward. In order to reach the common carotid in the little available space above the clavicle without dragging on the vein, it was necessary to divide and tie the vein below the sac. The tying of the carotid was then begun; during the process the sac burst spontaneously in its upper part, and a high pulsating jet of blood shot up. A swab was pressed on the hole and controlled the bleeding. The tying of the carotid was then finished. On removing the swab for a moment the jet of blood was in no way diminished, but had lost its pulsation. The sac entirely overlay the external and internal carotids, preventing any search for them, so two swabs were placed on the hole in the sac and pressure maintained on them by sewing the inner edge of the carotid sheath firmly to the edge of the fascia covering the sterno-mastoid. This proceeding stopped the haemorrhage for the time being, at any rate, and the wound was closed.

Third Operation.—No signs of haemorrhage having occurred after the second operation, the wound was reopened five days later and the swabs removed. The sac had been obliterated entirely and no haemorrhage occurred. The wound was reclosed and a small drain put in the lower angle of the wound to give early warning of any bleeding.

Both patients were young men of nineteen or twenty, and made uninterrupted recoveries. Case I complained of headache for three or four days after his operation, but otherwise neither of them showed any sign or symptom of being the worse for the loss of both arterial and venous channels on the one side.

My best thanks are due to Colonel G. St. C. Thom, A.M.S., D.D.M.S., N.R.E.F., for permission to publish these cases.

TRAUMATIC RUPTURE OF THE SUBCLAVIAN ARTERY: DEATH NINE DAYS LATER.

BY

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THE following is an account of a case of sufficient interest to warrant publication on account of its rarity.

Semenko, a Russian mechanic belonging to H.M.S. *Josephine*, was admitted to the 53rd Stationary Hospital, Archangel, in the evening of October 4th, 1918.

History.

He was on board a small tug which was coming alongside one of H.M. ships, and was warding it off from the ship's side. To do this more effectually he had the boat-hook against the ship's side, and the near end of the pole placed under his left clavicle. He was leaning on the pole. Unfortunately for him the wash of a passing vessel caught the tug and threw it towards the ship. Immediately behind him was the cabin of the tug; he was therefore caught between the cabin and the end of the boat-hook, which pinned him to the wall of the cabin. When the swing of the boat was over he dropped on deck. The doctor of the ship was called, and he was seen also by Colonel Ormrod, R.A.M.C., who sent him up to the stationary hospital at once.

Complete absence of all pulse at the left wrist was noted. Morphine had been given to him before removal.