ness or rashness, but in that of increased caution, combined with an earnest desire that we should avail ourselves of the means of knowledge placed before us.

My cases were all treated on Listerian principles, the pedicles trans-fixed and tied with carbolised silk, and enclosed within the abdominal cavity.

PERINEAL CURVE AXIS-TRACTION FORCEPS.

By S. MACVIE, M.B., C.M., CHIRNSIDE, N.B.

RECENT attempts to obtain the advantages of axis-traction in forceps operations have resulted in contrivances so cumbrous as little likely to be adopted by the main body of the profession. I am, therefore, induced to describe a modification of the double curved forceps for the attainment of the same object, which I have lately successfully employed, and which has the merit of simplicity to recommend it. This modification does away with the necessity for traction-rods and all other extra aids; and consists simply in the addition of a perineal curve to the ordinary double curved forceps.

Taking Simpson's "intermediate" forceps to work upon, I have added about two inches to the length of the stem of the blades, that is, of the part intervening between the commencement of the cranial curve and the lock. This additional length I have so bent that, with the blade *in situ*, it shall curve round the fourchette and pass backwards over the perinæum until it touches a line prolonged downwards through the traction axis of the blades. At this point, I have again bent the stem, so that the remaining part of the added length and the handle thereon shall continue in the traction axis line.

Such is the modification. Briefly, I have neutralised the pelvic curve by the addition of a perineal curve, so that the focus of resistance lies in the line of traction; and the instrument, in this respect, becomes practically a straight forceps. Nor is this advantage obtained at any cost, except the addition of one-and-a-half inches to the total length of the instrument. The "perineal curve" simply re-confers the power of axis traction which was sacrificed by the adoption of the pelvic curve, and without limiting the range of applicability bestowed by the latter. Therefore in the ordinary "intermediate" forceps, thus modified, we have an instrument of the widest utility, endowed with the power of axis traction; suitable wherever forceps are required, except where the obstruction is exceedingly high; and neither unhandy in the simplest nor inefficient in the most difficult cases. This modification is also valuable since it is equally applicable to the "long" forceps, and, moreover, it deprives the short straight forceps of the single superiority it possesses.

I do not pause to contrast in detail the merits of the "perineal curve" with other contrivances for the same purpose. In principle, they are identical. But in efficiency the former is fully equal to the latter; while for handiness and simplicity it is much superior. But I may mention a few particulars in which my experience shows that it excels the instrument out of which it has grown.

1. With the tip of the blade directly in the line of the handle, its introduction is easier and its adaptation more precise.

2. When the under (posterior) blade is introduced first, the handle lies far behind the fourchette, and entirely out of the way of the introduction of the upper blade.

3. For the same reason, the operator is less interfered with by the patient's thighs, both while introducing the blades, and during the extraction of the head; and suffers less loss of power from the handles projecting far in front when the head is passing under the pubic arch. In fact, from first to last, the operator occupies a more commanding position.

4. The lock, being well behind the fourchette, cannot possibly inflict any injury upon the soft parts during the adjustment of the handles.

5. The instrument, being practically straight, is capable, when the head has fully entered the pelvis, of aiding the movement of rotation. This is an advantage afforded by no other instrument whatever at such an early stage.

6. Lastly, and mainly, it confers all the advantages of axis-traction. These need not be enumerated. But it may be permitted to say, that it does so with the slightest departure from the simplicity of the instruments in common use; and with no departure whatever from the manipulative procedure at present practised.

Messrs. Young and Sons, North Bridge, Edinburgh, are the makers.

DR. J. E. A. BALL, of Biard, Texas, reports, in an American contemporary, the case of a negro woman who gave birth to a child at the age of sixty. The age of the mother was authenticated by the record of her birth, in possession of her former owner.

ON A CASE OF ECTROPION SUCCESSFULLY TREATED BY TRANSPLANTATION OF SKIN FROM THE ARM.

By LOUIS H. TOSSWILL, M.B.,
Surgeon to the West of England Eye Infirmary at Exeter.

At a meeting of the South-Western Branch of the Association held at Exeter on October 5th, 1881, I showed a patient from whose arm and forearm I had removed large pieces of skin on July 28th, 1881, transplanting them to his left upper and lower eyelid respectively. The operation has proved so successful, that I propose to describe the case somewhat in detail; and I have the more reason for doing so, because the operation in question appears to have been but rarely performed in this country.

C. W., a boy, aged 10, was severely burnt about the head and face several years before he came under my care, the result being an amount of disfigurement which exceeded anything that I remembered to have ever seen before. The whole of the left side of the face and forehead presented one uniform surface of dull white cicatricial tissue; the outer two-thirds of the left upper lid was much everted, even when the boy looked straight in front of him. The edge of the upper lid was dragged up close to the margin of the brow, against which the lashes rested, with their points directed upwards; and when the boy attempted to close his eye, or to look downwards, the eversion became still more marked. There was considerable corneitis with opacity present in the left eye, due in part probably to the eyeball remaining uncovered during sleep, so that he appeared to be staring at anyone standing by his bedside. The position of the edge of the left lower lid was shown by a row of lashes, apparently growing from the cheek, an inch or so below the eyeball, and the mucous membrane was to a considerable extent replaced by what could not be distinguished from ordinary skin. Over this surface the tears were continually flowing, and had produced an excoriation. In addition, the almost complete eversion of the lower lip, over which the saliva was constantly running, the right eye with an opaque and staphyломatous cornea (sight quite lost), and a considerable ectropion of the right lower lid, produced an amount of deformity which was certainly unusual in its extent. As the dense cicatricial tissue extended over the whole of the left side of the face, and along the forehead to the outer side of the right eye, and also partly involved the right side of the nose, and the skin immediately beneath the right lower lid, there was no healthy skin available for the formation of a flap, whether sliding or otherwise, and it appeared to me that there was only one operation which presented even the very faintest hope of success. The boy being placed under chloroform, I made an incision parallel with the edge of the left upper lid, as shown by the row of lashes mentioned before, and about a quarter of an inch above it, and dissected the remains of the lid well down over the eyeball. I then made a similar incision just below the edge of the lower lid, as evidenced by the lashes growing from the cheek, and dissected up the remains of the lid, until the two lids thus formed could be easily approximated, leaving a large raw surface above and below the eye, from which the bleeding was so free, that one or two small arteries had to be twisted. I then pared slightly the edge of each lid, and united them with two or three strong silk sutures; next, I cut off from his right arm, with a sharp triangular knife, a semicircular piece of integument, about two and a quarter inches in length, by one and an eighth in breadth, carefully cleaned it from all areolar tissue and fat, and secured it in the gap above the eye by means of four fine silk sutures. The flap for the raw surface beneath the eye was obtained from the forearm, and was about two-thirds as large as the flap from the arm. It was carefully cleaned of areolar tissue like the other, and fastened into its bed by means of five fine silk sutures. Goldbeaters'-skin was placed over both lids, and over this abundance of cotton-wool, which was kept in its place by an ordinary roller bandage. The outer dressings were changed at the end of four days, but the goldbeaters'-skin was not removed until the sixth day, when some of the stitches were removed from the flaps. The remaining sutures were removed two days later. Eleven days after the operation, the stitches which united the lids were removed, and the latter were found to be firmly grown together. On the following day, the lids were separated by means of a bistoury, when the cornea was found to be much improved in appearance. The dressings were gradually left off, but were not entirely discontinued until about a month after the operation.

The graft on the upper lid remains almost exactly the same in size as when first placed in its bed; and even now, four months after the operation,