to feed by the mouth much severe coughing was produced. He was ordered a nutrient enema every four hours.

On February 13th the wound was dressed and looking very well. His general condition not so good; the pulse was irregular and small; the breathing was good, but there was slight stridor. There were no signs of pneumonia. Hypodermic injection of strychnine was ordered, $\text{m} \times \text{v}$ of a 1 per cent. solution every six hours. He was fed by nasal tube night and morning (milk Oj , brandy 3j , egg i). The rectal feeding was continued every six hours.

On February 14th he was restless, excited, and complained of headache. The temperature 102° ; the pulse 104 and stronger. He was given morphine gr. 4 hypodermically.

On February 15th the wound was dressed; it was looking very well. The tubes were removed. The pulse was 90 , and the general condition much better. The strychnine and rectal feeding were stopped. He swallowed custard and did not cough, and could talk in a whisper.

On February 16th feeding with the tube was stopped; the patient going on well.

On March 11th he was discharged cured from the hospital, the wound having healed by first intention.

I have to thank Mr. Anderson, under whose care the patient was in the hospital, for permission to publish this case.

From a consideration of the matter I think that every case of cut throat should be treated by immediate suture unless the patient is in a dying condition from shock and loss of blood. In such a case it should be done as soon as the patient recovers sufficiently to stand it.

It is very rarely necessary to give chloroform. I have always been struck by the condition of the patient in cases of cut throat. There is great depression of the nervous system, and the patient will allow the wound to be cleaned and sutured without appearing to feel in any way, although perfectly conscious of everything going on around him.

In consequence it is hardly ever necessary to administer chloroform, which must, taking the condition of the patient into consideration, add greatly to the risk. The wound must be very thoroughly cleaned after the air passage has been securely closed; it can be washed out with some strong antiseptic: hydrag. biniodide, 1 in 500, or carbolic acid 1 in 20.

The suturing should be done carefully layer by layer from the bottom, the air passage completely and tightly closed, and muscles and the fascia taken in order up to the skin. For the buried sutures chromic catgut or silk is best. The skin wound is everted and brought into apposition with horsehair or silk worm gut, and if the wound is deep and extensive a small drainage tube can be put in at each end.

If the cleansing of the wound has been done thoroughly, in most cases the wound will heal by first intention, the period of recovery will be much shortened, and the patient will not run the many secondary risks that occur after the old treatment.

With regard to the use of a tracheotomy tube, it is never, I think, necessary to put in a tracheotomy tube at the time of suturing the wound; should the patient subsequently get oedema and severe dyspnoea, the larynx or trachea should be opened below the wound, and a tracheotomy tube inserted. This will very rarely be necessary, but in any case it must be better to do it when it becomes a necessity, rather than to leave a tube in the wound itself, or to make a fresh opening below at the time of suture. The head should be inclined slightly forward, and fixed in some way to prevent movement, and much depends on good nursing.

In the majority of cases feeding by the mouth is easily accomplished, but in cases in which the epiglottis, pharynx, or oesophagus are involved, it is best to rely for a time on rectal feeding or the nasal tube.

A CASE OF ACUTE PULMONARY GANGRENE.

By T. ARMSTRONG BOWES, M.D. CANTAB.

Herne Bay.

A SAILOR, aged 52, was taken ill at sea, and when removed on shore was delirious for about seven days. The nature of the illness could not be ascertained. There was no history of dysentery or liver disease, but he had "something wrong" with his left lung some years ago when abroad.

When first seen on December 23rd, 1896, immediately after the delirium, he was a sallow-complexioned man, perfectly rational, and quiet by day and night. He complained of slight pain in the left side of the chest, but no abnormal condition could be discovered on this side. On the right side, however, just above the liver dulness in the nipple line,

was a small area of impaired resonance, with a few *râles*, but no bronchial breathing. The heart and remainder of the right lung were natural. Over the sacrum, for the size of half a crown, the skin was abraded.

On December 25th the sputum became a little rusty, and expiration harsh over the area above mentioned.

On December 27th the temperature rose to 100.4° , the area of impairment was slightly increased, the sputum became darker in colour with a grey tinge, and began to smell. From this date to December 31st the temperature remained about 103° F., and rose on the evening of this day to 104.8° F. He was very ill, the sputum copious, very foul, and of a blackish-green colour, containing on microscopical examination pus and elastic tissue. The impairment increased rapidly, reaching to the second rib, and in the second and third interspaces bronchial breathing and coarse *râles* were present.

During the next four days his condition slightly improved, the sputum being less foul, the temperature varying between 101° and 102° F., and from this date onwards to January 29th it never reached normal, being usually about 101° , with extremes of 99° and 102.5° .

On January 10th the discoloration of the sputum was less; three days later it was slightly increased, but it finally disappeared on January 20th, the sputum after this being mucopurulent.

While slowly gaining ground, the signs of consolidation steadily progressed, till on February 7th impairment and bronchial breathing reached from the clavicle to the liver dulness. In the upper three interspaces a tympanitic note and amphoric breathing were present for a few days, but there was no bell sound. The sputum was fairly copious, and mucopurulent, and he periodically coughed up a quantity of it (about 1 ounce) which he felt collect about the second interspace. Great improvement in general condition had occurred during the last week.

On February 14th he complained of a cutting pain running up the junction of the ribs with their cartilages on the right side on drawing a deep inspiration. The condition of his chest was then as follows: On quiet respiration the left chest moved more than the right, and on the latter side expansion was shallow and deficient, the lower intercostal spaces being drawn in on inspiration. Vocal vibrations were increased from the apex to the nipple. There was impairment to percussion from the apex to the third rib from the sternum to the anterior fold of the axilla, and to a less extent below, merging into the liver dulness. The highest pitch of the note was in the third interspace near the sternum. The left lung was resonant everywhere.

On auscultation bronchial breathing and ægophony were heard in the second and third interspaces over an area 3 inches in diameter, the inner edges commencing 2 inches from the right edge of the sternum. Coarse *râles* were general on expiration and inspiration. Behind there was general impairment, with *râles* over the whole of the right lung, with bronchial breathing over the lower half of the scapula. The sputum was less in quantity, mucopurulent, and did not contain tubercle bacilli.

By March 25th the sputum had gradually ceased, and the abnormal signs in the right lung had entirely cleared up, except for harsh inspiration in the region of the right nipple. From this date the patient made an uninterrupted recovery.

DISAPPEARANCE OF A CARDIAC MURMUR.

By C. J. WHITBY, M.D.,

Limpley Stoke.

Mr. W. P., aged 59, came under my care in a hydropathic establishment on March 9th, 1897. He had been subject to persistent colds, usually following an attack of influenza. He complained of pain in the anterior mediastinum, with a feeling of constriction, "as by an iron band," across the chest. He has been an abstainer from alcohol for years, and had never smoked. Seven years ago he had what appears to have been an abortive attack of enterica, and twenty-nine years ago had nephritis after a chill. The pulse was 65, and its tension markedly high. There was no evidence of cardiac hypertrophy, but the second sound, as heard at the apex of the heart, was