DESCRIPTION OF CONDITIONS FOUND IN THE HEAD AND NECK TWO YEARS AND A-QUARTER AFTER LIGATURE OF ALL THE CAROTID ARTERIES, JUGULAR VEINS, ETC., OF THE LEFT SIDE.

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In the BRITISH MEDICAL JOURNAL of December 7th, 1895, I recorded a case of cut throat, and the treatment of the case was summarised thus:

October 5th, 1894. Ligature of the common carotid artery in two places, of the internal jugular vein in two places, of the external and anterior jugular veins; perfusion of 20 ounces saline fluid.

October 27th. Secondary hæmorrhage; attempted ligature of common carotid, which was rotten, so that the external and internal carotid arteries were tied, along with other ligatures on the internal jugular vein and a branch, by my colleague Mr. R. A. Bickersteth, who was fortunately at hand when the hæmorrhage occurred.

November 5th. Hæmorrhage from internal carotid artery arrested by packing and pressure. A quart of warm water in the rectum revived the patient.

He was discharged on January 25th, 1895. After following his occupation—house painter—for nearly two years, he was admitted into the infirmary, under Dr. Caton, on December 19th, 1896, on account of severe cough and pain in the right chest. He was very ill, with a high temperature and copious expectoration. He rapidly failed, and died on January 17th, 1897, two years and a-quarter after the injury, and two years after discharge from hospital.

a. Small vessel dividing into lingual and superior thyroid. b. Left sympathetic nerve. c. Left pneumogastric nerve. d. Left common carotid artery ending in cicatrix. e. Left phrenic nerve. f. Left internal jugular vein. g. Right internal jugular vein. h. Right pneumogastric nerve. i. Right common carotid artery.

A post-mortem examination was allowed, and, under the kind direction of Professor Paterson, the valuable—and, I venture to think, unique—specimen herewith described was obtained. We were particularly requested not to mark the face during the examination, but, with that exception, all

the blood vessel arrangements of the head and neck were carefully noted.

The blood vessels forming the circle of Willis appeared normal, the last half-inch of the left internal carotid artery being hollow, but the portion in the cavernous groove was a fibrous cord. The lungs and heart, with all the tissues forming the neck (skin alone excepted) were skilfully extracted, along with the first ribs and a portion of the base of the skull, and the dissected specimen is now placed in University College Museum. Its main features are:

Left Side.—Total absence of sterno-mastoid muscle, its place being occupied by cicatricial tissue. The common carotid trunk was small, and ceased suddenly, 5 inches from the arch of the aorta, in a mass of scar tissue, there mingling with the cut ends of the pneumogastric, sympathetic, and some cervical nerves (the phrenic nerve was normal). Above this fusion nothing but the two nerves (vagus and sympathetic) and a small artery could be found. This artery, not so large as a normal facial, came down from above, and gave off the small facial, lingual, and superior thyroid, and was the sole representative of the external carotid. No traces of internal carotid nor of the internal jugular as far as the base of the skull could be found. The inferior thyroid artery was smaller on this side, but the left vertebral was half as large again as its fellow; this, in fact, appeared to be the only special provision made for collateral circulation. The deep cervical artery was much smaller on this side. The left lung was normal, and had thus not suffered from interference with the pneumogastric and sympathetic nerves.

Right Side.—The common carotid artery seemed a shade larger than the normal, but the superior thyroid, lingual, facial, and inferior thyroid arteries had not apparently enlarged. In the right lung some pathological changes, with a collection of pus, had caused death.

The specimen illustrates how little reliance can be placed on the theoretical collateral circulation so carefully enumerated in textbooks, based on ordinary anatomical anastomoses, for it will be noted that, with the exception of the increased left vertebral, and some little enlargement of the right common carotid, all the other arteries not only forgot what was expected of them, but were actually smaller; and that delight to examiners, the deep cervical artery, was so far indifferent to expectations as to be considerably smaller than its fellow of the opposite side.

A CASE OF ABSCESS OF THE TEMPORO-SPHENOIDAL LOBE, OPENED AND DRAINED THROUGH THE OSSEOUS AUDITORY MEATUS.

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CASES of successful operation for cerebral abscess of aural origin are fairly common, but the methods of operation are by no means perfect. The ordinary method of trephining an inch above and behind the auditory meatus is the most simple, but the drainage and after-treatment are not at all satisfactory. The method adopted in the following case was, I believe, first suggested by Dr. Watson Browne, of Belfast, and has recently been recommended on the Continent:

M. W., aged 28, had pain in the left ear five years ago for some weeks, and the ear has discharged more or less ever since. In November last there was severe pain for a few days, which returned about the middle of January. On February 1st the patient was suddenly taken ill in his office, and had to be carried home. When I saw him on February 4th he was semi-comatose; he complained of intense, unbearable pain in the head, and the cerebation was much impaired. The pulse was 60; temperature, 104°. The optic discs were distinctly inflamed, and their edges blurred.

On February 5th we decided to operate. A large incision was made round the left auricle. The cutaneous auditory meatus was cut through and the auricle drawn downwards. The remains of the membrana tympani and the ossicles were removed. The attic and neighbouring mastoid cells were found

to be diseased. With a sharp chisel I removed the upper wall of the osseous auditory meatus, and then, cutting upwards, I chiselled through the root of the zygoma and opened up the cerebral cavity. The dura mater was incised and a Macewen's pus-searcher passed upwards and inwards for about an inch into the temporo-sphenoidal lobe. Here (the usual place) a large abscess cavity was opened and a quantity of offensive pus escaped. The attic and neighbouring mastoid cells were then opened and scraped. The cutaneous auditory meatus was slit open so as easily to admit a finger, and its upper and posterior parts were excised so that a large drainage tube might at some future time be introduced. An india-rubber tube was then passed through the upper wound above the ear into the abscess cavity and the wound plugged with gauze and iodoform. The three following days a fair quantity of pus escaped. Then for three days there was no discharge of pus, and the cerebral symptoms began to return. The tube was removed, and the pus-searcher re-introduced. A large quantity of pus came away. After this the patient made an uninterrupted recovery. He left the hospital on March 22nd, and has since returned to business, and feels perfectly well. The wound was kept plugged from above, and allowed to heal from below by granulation. At first the drainage tube was introduced through the upper wound, but after ten days the ear was drawn up and the tube was passed through the enlarged cutaneous auditory meatus. The abscess cavity was never syringed, but insufflations of boric acid and iodoform were used daily for two months.

The advantages of this method of operating are obvious. In the first place, we get good and efficient drainage from below. The drainage tube can, if necessary, be kept in position for months without any discomfort. It can easily be removed and replaced, and there is no danger of not again finding the abscess cavity. We can also at the same time efficiently treat and cure the attic and mastoid cells, which in these cases are nearly always affected, and thus prevent any recurrence of the disease. Only one incision and only one operation are necessary. The operation and after-treatment are more difficult and tedious than in the ordinary method of trephining, but the results are certainly more satisfactory.

NOTES OF TWO CASES OF DYSTOCIA ARISING FROM RELATIVE SHORTENING OF THE UMBILICAL CORD.

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DYSTOCIA arising from this cause is not a common occurrence, but probably it exists more frequently than is reported. These few facts noted below may be of interest as bearing on the diagnosis and treatment of this and allied conditions.

CASE I.—Mrs. H., aged 24, 2-para, was admitted to the Glasgow Maternity Hospital in February, 1897, with strong labour pains and with the history of being in labour for the previous two days, and of having had an easy first confinement. Abdominal palpation elicited the following facts: The quantity of liquor amnii was excessive, bordering on the condition of hydramnios. The foetal parts were masked and the position could not have been made out but for the violent action of the limbs, which made the diagnosis easy. The head was situated above the brim and balloted freely from side to side. On auscultation the foetal heart sounds were readily heard, but were irregular in rhythm, and especially in intensity. The sounds of the foetal movements were very distinct.

From these observations the conclusion arrived at was that the delay in the fixation of the head was caused by the degree of hydramnios present. The item in the history regarding the length of labour was discounted. Preparations were made to rupture the membranes, coincident with the vaginal examination, should this be thought desirable. The vagina on examination was found blocked by the protruding membranes, and the os was fully dilated. After rupturing the

membranes and pushing the head into the superior strait, the descent of the head was very rapid. The head was soon born, and the cord was found so tightly grasping the child's neck that it was impossible to slip it over the head. By exerting pressure on the fundus the cord was with difficulty slipped over the shoulders, and labour terminated successfully. The length of the cord was $19\frac{1}{2}$ inches.

CASE II.—In this case—which occurred before No. 1—the relative shortness of the cord was more marked and the hydramnios less so. Mrs. R., aged 36, 10-para, was admitted to the Glasgow Maternity Hospital in January, 1897, with strong and very rapid labour pains and with a history of being in labour for some hours. Her previous confinements had been natural. The position of the child was readily made out abdominally. The head was found freely balloting above the pelvic brim. The foetal heart sounds were distinct during only a period of from ten to twenty seconds, with absolute pauses during intervals corresponding to the duration of the pains. The stoppage of the sounds was very abrupt, and showed the interference with the circulation to be very complete. A diagnosis was made of dystocia due to short cord or of one relatively so from being coiled round the child's neck. Vaginal examination revealed the same state of affairs as existed in the other case. The membranes were ruptured and the case left to Nature. After an interval, notwithstanding powerful contractions, the head still remained above the brim. Suprapubic pressure was applied so as to depress the occiput into the superior strait, after which engagement and descent were very rapid till the head was born. The cord was found very tightly coiled twice round the child's neck, and was pulseless. On applying pressure to the fundus enough of the neck was available to allow of the cord being cut. Just as this was being done, and as the result of an extra strong pain, the shoulders, trunk, and breech were successively swept past the head, which remained anchored at the vulva, thus performing, outside of the pelvis, movements similar to those which go by the name of "spontaneous evolution" when performed in the pelvis. In this case the actual length of the cord was 30 inches, and the available less by two turns round the child's neck.

REMARKS.

The points which occur to me as being worthy of notice are:

1. Neither patient was a primipara.
2. In both the presenting part failed to engage, and in No. 2 the head remained free, even after rupture of the membranes.
3. The condition was in each accentuated by the excess of liquor amnii.
4. The utility of abdominal examination, and especially of auscultation, as illustrating the feasibility of diagnosing interference with the circulation through the cord, be it due to tension or compression.
5. The success of suprapubic pressure in causing or hastening engagement.
6. The indication for treatment being to express the child rather than deliver with forceps, so as to push down the placenta *pari passu* with the child.

HERPES ZOSTER OF THE FACE WITH PARALYSIS.

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EICHHORST has written an article on this subject epitomised in the BRITISH MEDICAL JOURNAL of June 12th, 1897, in which he refers to the recorded cases of those combined affections—only 18 in number. Usually the herpes has appeared before the paralysis, there being only 3 exceptions to this. Herpes occipito-collaris has been most frequently seen, but when the facial paralysis has appeared first the herpes has been in the distribution of a single branch of the fifth nerve. Only 1 case is recorded in which the herpes was present on a mucous surface; taste may be affected.

On looking up the literature of the subject I find no reference to it in the early edition of the *Medical Digest*. Hebra