with whom rests the responsibility of approving or otherwise, while in the case of a vessel no such provision obtains.

As a general rule, in designing a vessel a certain space is set aside for the crew, and when she is completed this space is utilised in the best way possible by an artisan without reference to the sanitary authority and without any control, except that exercised by the Board of Trade under the powers limited (from a sanitary point of view) of the Merchant Shipping Acts.

The arrangement and fitting of crews' quarters under the supervision of a sanitary authority, advised by an expert, would be a benefit both to owners and seamen, and would be of great value in preserving the health of those on board. The constant and close supervision of vessels while lying in port, and the prompt abatement of all nuisances and conditions likely to prove injurious to health, are essential. A foul ship is itself more to be dreaded than anything she may have on board.

The United States Government have always laid great stress upon the sanitary condition of vessels leaving foreign ports for their shores. They require a bill of health with actual information as to the health of the vessel on leaving.

Rohé quotes as an illustration of the value of this system from a report by the medical officer of the Marine Hospital at Naples that eight vessels left that port during the year 1893, when cholera was epidemic. These vessels were under similar conditions as to water supply and food, and carried passengers of similar class and origin. In four leaving without any sanitary conditions, there were 50 deaths, 90, 84, and 230 respectively. Of the four leaving for the United States on which sanitary precautions were compulsory, one which left before cholera was declared had 3 deaths, the other three had none: and further, every vessel leaving Naples had cases of cholera on board except those on which these regulations were carried out.

LEFT TRAUMATIC SUBCLAVIO-AXILLARY ANEURYSM CURED BY LIGATURE OF THE THIRD STAGE OF THE SUBCLAVIAN ARTERY.

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A. N., a pensioner, aged 50 years, was placed under my care at the Adelaide Hospital by my friend Surgeon-Major F. A. B. Daly. He had served in the army for twenty-one years, during eighteen of which he was in the band as a clarinet player, and was discharged from the service in July, 1887, in good health. In the summer of 1892 a heavy board fell on his left shoulder, and although he had no pain until May, 1895, he attributes his affection to this accident. In November, 1895, he consulted Surgeon-Major Daly for pain in the left shoulder, clavicular and scapular regions. The superficial veins over the left clavicle were slightly enlarged, and a slight difference was noticed in the radial pulses, but no *bruit* could be obtained; aneurysm being suspected, he was given large doses of potassium iodide, and his diet was regulated. This treatment gave such relief that he resumed his work as night porter at the United Service Club.

In January, 1896, the pain in the shoulder and back returned with increased violence, and at times shot down the left arm and to the region of the diaphragm. He was then admitted to a civil hospital in this city, but was soon discharged without relief, his case not being recognised. He then again consulted Surgeon-Major Daly, who found his symptoms to be much better marked than when he saw him before, and that a well-marked tumour had developed in the left posterior inferior triangle of his neck.

The patient was admitted to the Adelaide Hospital under my charge on February 26th, 1896. He is a well-built, healthy-looking man, and states he has a severe continuous pain in his left shoulder and back, in the region of the scapula. This pain is relieved by placing his arm over his head. The left arm is greatly swollen and oedematous, its superficial veins are markedly distended and tortuous, the

left clavicle is raised and the supra- and infraclavicular depressions obliterated owing to a tumour which occupies the subclavian triangle and the axilla as far as the lower border of the pectoralis minor. This tumour has a distensible pulsation, and well-marked *bruit* and thrill. There is marked difference between the right and left radial pulse, and visible pulsation of the carotid and brachial arteries.

Ligature of the subclavian artery being decided on, the usual transverse incision for exposing the third stage was made, and the artery exposed as it passed from beneath the scalenus muscle. It was of normal appearance, but its sheath was very adherent. A strong catgut ligature was passed round the vessel and tied, the ends of the ligature being removed, the deep structures were united by catgut hidden sutures, and the skin by silkworm. The wound was dressed with zinc sulphite gauze, and the arm swathed in cotton wool.

The subsequent progress requires little note; the wound healed by first intention, although a stitch abscess occurred at the site of the most anterior skin suture. Pulsation returned in the radial artery on the eighth day after operation, and the patient left hospital on the twenty-third day to resume his duties at the United Service Club.

The patient was shown at the Surgical Section of the Royal Academy of Medicine in Ireland on May 1st, two months after operation. Since leaving hospital he had been engaged at his usual work as night porter at the United Service Club. The left radial pulse was small, but the artery was of good tension. The tumour had lessened considerably in size, and had no pulsation or *bruit*. All the other symptoms had disappeared. Eleven months have now elapsed since operation, and the patient continues in perfect health.

On referring to Edmond Souchon's article on Aneurysms of the Subclavian Arteries in the *Annals of Surgery* for November and December, 1895, it will be found that out of 120 aneurysms of the third stage of the artery, 35 implicated that of the left, and 85 that of the right side, and that of 31 traumatic aneurysms operated on by proximal ligature 19 recovered (about 66 per cent.), 4 of those being on the right and 15 on the left side.

A CASE OF REUNION OF TENDON NEARLY FIVE YEARS AFTER ITS DIVISION, WITH GOOD RESULT.

By R. CARMICHAEL WORSLEY, M.R.C.S., L.R.C.P.,
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L. B., a cook, in 1890, when aged 30, broke a window and cut her right wrist badly. The wound was six weeks in healing, some fragments of glass working out. The thumb, index finger, and middle finger afterwards became firmly flexed into the palm. A year after the accident, the tendons of the index and middle fingers were cut down upon and reunited by suture, with good result, after long extension on splints; the extension movements of the index finger, however, remained weak and imperfect. In December, 1895, the thumb was strongly adducted and flexed into the palm. The extensor *primi internodii* and extensor *ossis metacarpi pollicis* had escaped division, but the extensor *secundi internodii pollicis* had been cut, and its retracted ends could be obscurely felt in the scar tissue on the radial side of the wrist.

On January 16th, 1896, assisted by Dr. Bowden and by Dr. Tamplin, who gave the anæsthetic, I cut down on the scar, having made the limb bloodless, and found the ends of the tendon separated by $1\frac{1}{2}$ inch of fibrous tissue traversing the scar. This band contained in its centre some gelatinous-looking substance, which on microscopic examination proved to consist of a few genuine tendon bundles running through the fibrous material. It was impossible to bring the ends of the true tendon together without splitting them, and as I was anxious to obtain strong union I excised an inch only of the fibrous band, and brought the ends together with one stout and two fine silk sutures. Rigid antisepsis was aimed at, and the forearm and hand placed upon a splint, with the thumb over-extended on a wire arm. The wound healed by first intention. There was very severe pain for a long time up the