the relaxed state of the levatores ani? and, if constantly supported during the evacuation of the rectum, what more reasonable than to suppose that the hæmorrhoids will yield to some mild treatment? or, if requiring removal, that their re-formation will be prevented?

Such was the train of reasoning that occurred to me in the after-treatment of the following case.

CASE. A. B., aged 25, had suffered from prolapsus for sixteen years. During that time, the bowel had descended invariably with each act of defæcation. On examination, I found external piles, large and numerous, and a loose fold of integument completely encircling the anus, and projecting about three-eighths of an inch. I found also internal piles, two in number, about half the size of a filbert, and a general abnormal rugosity of the mucous membrane, the nidus of future hæmorrhoids in the present state of parts. She suffered great pain at stool, and the fæces were generally more or less marked with blood. Her general health was very delicate: she had a pale, exsanguined appearance. I removed the external piles by incision, and the loose fold of (skin?) projecting from and encircling the anus. This was, no doubt, originally mucous membrane, which had been protruded, and had taken the form of skin from atmospheric exposure. The wound soon healed, but the prolapsus was as bad as ever, and, if not remedied (the parts being protruded and strangulated for a time daily), would soon have brought on fresh piles, and my patient would soon have receded into her former state.

What was to be done? Here the records of surgery give us no information. I adopted the following plan, with the utmost possible success. My patient has now used it for upwards of two years, and has not during that time had the bowel down, except when accidentally requiring an evacuation when from home. This occasional exception, so certain when the board was not used, distinctly proves that the non-prolapsus, at other times, was due to the contrivance, as truly as the non-descent of the bowel is due to a truss. It is probable that the analogy may go further, and that the *absolute constancy* of this support during defæcation will cure prolapsus, just as a truss cures hernia, when used for years without the permission of one descent of the bowel. I may also add, that, since the use of the board, I have heard no more in this case of piles, either internal or external.

The plan may be described thus:—Cover a chamber utensil with a strong flat board, taking a circular form, and projecting one inch; let into the edge of the wood three or four pieces of wood, to keep it fixed on the chamber-pot; make an opening on the surface of the board, a little behind its centre, just large enough for the anus to act; and surround this opening with an elevated ridge, to support the entire perinæum and sides of the anus during evacuation. The anal foramen which I have used, has been oval, its long diameter being antero-posterior, and four inches in length, and its transverse diameter being two inches and a half. It has been abrupt, not bevelled; the sharpness of the edge being removed. The ridge has been half an inch high, and has extended all round the anal foramen, and has been less than half an inch from it. The great object is to keep it within the ischia. Some of my patients have felt more secure and more comfortable *with*, and some *without* this ridge. For females, I have had a large anterior urinary fissure, half an inch wide towards the middle of the board, and opening into the foramen, and gradually enlarging forwards to the size of three inches in front. With males, I have recommended another utensil in front.

As "there is nothing new under the sun", some such apparatus may possibly have been already used without my knowledge; and I have no doubt that, if the attention of the profession be directed to the subject of this paper, some better plan may be discovered than that which I have suggested.

Chatteris, Cambridgeshire, Dec. 10th, 1852.

AMPUTATION OF THE ARM IMMEDIATELY BELOW THE SHOULDER JOINT, FOLLOWED BY RECOVERY, IN A CHILD AGED FIFTEEN MONTHS.

By ROBERT EDWARDS JONES, M.R.C.S.

On the sixth of September, in consequence of the absence of Mr. Mason, of Sudbury, I was hastily summoned to visit Eliza Harrington, aged 15 months, the child of poor parents, residing at Wickham St. Paul's, Essex, who had been knocked down by a waggon, the wheel of which had passed over her left arm. On examination, I found a fracture of the humerus at its lower third, the bone protruding denuded of its integuments, and the soft parts lacerated nearly to the shoulder joint: the little patient was much exhausted from loss of blood. I administered small quantities of brandy and water, which had the effect of producing reaction; and feeling there was no time to be lost, I at once amputated just below the shoulder-joint, being just able to save sufficient integument to form a good stump. I was ably assisted by Mr. Mason, jun., and very little blood was lost during the operation, and but one artery required a ligature. The child had severe convulsions the following day, which were relieved by small doses of tinctura opii; after which it progressed most favourably, and at the end of a month had perfectly recovered.

I am induced to send this case for publication, because I believe that it is rare for a child of such a tender age to recover from so severe a proceeding.

Long Melford, Suffolk, Nov. 1852.

FATAL DISEASES OF THE STOMACH.

By JOHN CHARLES HALL, M.D., Fellow of the Royal College of Physicians of Edinburgh, etc.

THE most important truths may be derived from a faithful record of those cases in which, notwithstanding all our efforts, the disease we are called upon to treat proves fatal. However pleasing and flattering to our vanity it may be, to publish those cases only in which we have been successful,—fatal cases, at least, as much as those which have had a favourable termination, convey important lessons.

CASE 1. On November 1st, 1852, I was requested to see, in consultation with my friend, Mr. Henry Julian Hunter, surgeon, Mr. F——, of Sheffield, aged 46, a brass-turner. From Mr. Hunter I learnt that he became his patient on the 20th of May, 1852, with symptoms of dyspepsia, under which he had then laboured for some time. He prescribed mild laxatives, with infusion of calumba, and prussic acid, and, on the 25th of May, the nitrate of bismuth and rhubarb. Under this plan of treatment, and a mild diet, the patient became much better. Mr. Hunter did not see him again until the 27th of August, when he called upon him, having, meantime, been under the care of Dr. ———, who had ordered him to be rubbed with the linimentum hydrargyri, etc. He had also been to Dr. M——, a physician, residing some distance from Sheffield, who prescribed calomel and the compound powder of antimony, and a simple saline mixture. He had now the same symptoms as when last attended by Mr. Hunter, and the same plan of treatment was again adopted.

Sept. 19th. He was much worse; had obstinate constipation; almost constant vomiting; and severe pain in the region of the stomach. Small doses of castor oil, and clysters of warm water, were given. An ointment of tartarised antimony was applied over the region of the stomach, which gave some little relief. He continued much the same until Oct. 7th, when all the symptoms were aggravated; the pain and sickness were constant, and the food rejected almost as soon as taken. Sometimes, however, it remained some hours, and was then vomited. The bowels were kept open with clysters; leeches, and a plaster of belladonna, were applied to the epigastrium.