away the adenoids. The free hæmorrhage is allowed to drain into the right cheek, and is speedily swabbed away, the gag always being *in situ*, with tongue forceps, if not actually in use, ready at hand. After the first free bleeding is checked, it is my custom to feel with the finger for remaining growths, these being removed either with the scraper or Loewenberg's forceps. If enlarged tonsils are present I remove them with the guillotine before the administration of an anæsthetic, either at the time or a day or two before.

In this paper I have avoided touching upon the treatment of nasal stenosis, so frequently an associated condition, but have only gone sufficiently into the subject of the treatment of adenoid vegetations to show the advantages as they appear to me of my modification of Hartmann's scraper. It is obtainable in three sizes of the makers, Messrs. Reynolds and Branson, Leeds.

A NEW METHOD OF FIXING THE SIGMOID IN INGUINAL COLOTOMY.

By LEONARD A. BIDWELL, F.R.C.S.,
Senior Assistant Surgeon to the West London Hospital.

THE following method is so simple that I venture to suggest it in all cases where an artificial anus will be required permanently. In this method, too, a bridge of normal skin separates the openings into the upper and lower portions of the sigmoid, so there is no chance of any fæces finding their way into the rectum.

The incision being made in the ordinary position, the peritoneum is stitched to the skin; a loop of sigmoid is brought out of the wound, and a good-sized hole scratched in its mesosigmoid. A silkworm-gut suture is passed through the whole thickness of one edge of the wound; it is then carried across the wound through the hole in the mesosigmoid, and is finally passed through the whole thickness of the other edge of the wound. When the suture is tied, the two edges of the wound are united within the hole of the mesosigmoid. This stitch should be inserted at the junction of the middle and lower thirds of the incision. No other sutures are necessary; but as I find that, after the gut is divided, it is desirable to stitch the four corners of the upper portion to the skin, so as to keep the opening free, I usually pass two sutures through the skin on each side of the incision, and leave their ends untied, so as to avoid having to give chloroform when the gut is divided.

On the fourth day the bowel is completely divided on a director passed beneath it, and the sutures, previously passed through the skin, are inserted into the upper end of the gut and are tied. The stitches are removed on the eighth or ninth day.

I do not give an anæsthetic when completing the operation, since the section of the gut does not appear to be painful; traction on the bowel, on the other hand, usually gives rise to a good deal of pain. The cases on which I have operated after this method have been very satisfactory.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

DIVERGENT DISLOCATION OF THE ELBOW—ULNA BACKWARDS, RADIUS FORWARDS.

THE above injury is admittedly rare. Many of our textbooks make no mention of it; others refer to it as very infrequent. Keen and White (Ed. 1893) state that 11 cases have been reported. Nowhere have I been able to find it described in detail. These facts should invest each new case with some interest, and as the following example presented entire absence of certain of the classical signs of elbow dislocation I venture to record it:

A gentleman, aged 30, hurrying to catch a train, slipped over a very high kerbstone and fell. How his arm was placed in falling he could not recall, but he found it lying under him when his thoughts got cleared. He was taken to a

hotel, where he spent the night, and next morning made a journey home of nearly fifty miles. I then saw him for the first time, when I found great swelling around and above and below the elbow-joint. The arm was fully extended and the hand slightly off the supine. Any attempt at flexion or rotation was resisted. The tip of the olecranon was found, when compared with the sound limb, to be raised an inch and a-half upwards on the back of the humerus. Owing to the swelling and the difficulty of rotation the head of the radius could not be located with certainty. On reduction of the swelling and administration of chloroform, however, there was no difficulty in finding the latter bone to have been pushed upwards in front of the external condyle of the humerus. It was no easy matter to replace it, but this was at last accomplished, and a little manipulation effected the same result as regards the ulna. The arm, though being still at rest—six days after reduction—is now capable of its proper movements.

Perth.

JAMES FERGUSON, M.B., C.M.

CINNAMON IN URINARY FŒTIDITY.

IN THE BRITISH MEDICAL JOURNALS of March 16th and 30th allusion is made to the efficacy of cinnamon in influenza. This simple drug has a wider sphere of usefulness than it is generally credited with. For instance, I have had lately a case of very foul-smelling urine, which rendered life miserable, accompanied with a slight degree of cystitis, which nothing relieved so well as oil of cinnamon internally.

If in such cases this drug be combined with *sodæ hyposulphitis* in, say, *mist. amygdal.*, we have a pleasant and an exceedingly efficacious mixture.

Finsbury Pavement, E.C.

JAMES MACMUNN.

TREATMENT OF AFTER-COMING HEAD.

I WAS called to attend a black married woman, aged 20, in her first labour. On arriving I found a dead child at full term tightly impacted. The woman had been all night in labour. There was no room for the forceps owing to a contracted pelvis. An army medical friend near by assisted me by giving chloroform, and I perforated the head and delivered. About a year after I attended this woman again. At the seventh month I induced labour, and with the forceps delivered her of a living male child, who is now a healthy, well-grown boy.

Two years after the second labour I was called to this woman, who had gone farther away from me, and had allowed her pregnancy to run on to full term. She had been in labour for over sixteen hours, and, being in the hands of an ignorant nurse, did not seek medical assistance until all movements of the child had ceased. I found a head and funis presentation and a dead child. I had no instruments with me, but luckily an ample supply of chloroform. I at once placed my patient fully under chloroform, and without much difficulty brought the feet down, but, on attempting to complete the delivery through a narrow pelvis, the head parted from the body. The uterus was acting pretty vigorously, and soon contracted on the child's head within it. I made the nurse press down the uterus, and, hooking my right index finger into the mouth, attempted to deliver the head, but to my great disappointment the lower jaw began to give way, and, not wishing to leave a jagged surface to wound the soft parts of the mother, I at once desisted, and by steady digital manipulation in the absence of a pain, I was able to turn the head so as to bring the vault of the skull within touch. I then passed my finger through the posterior fontanelle, and took away as much brain as I could; this diminished the calibre of the skull, and after some hard work I happily delivered the "after-coming head" without hurting the woman, who made a speedy and good recovery. She is now a widow, and I have advised her to remain one.

In my opinion, where the harmony of the child's head and mother's pelvis is at fault, the head had better be separated and diminished than forcibly pulled through by such powerful leverage as the body affords. The muscles of a dead child are more easily torn than those of a living one, but in any case it is quite possible to tear them away and at the same time badly wound the soft parts of the woman.

St. Andrew, Jamaica.

JASPER CARGILL, M.D.