Ten, p.m. Pretty quiet; no vomiting; slight oozing of blood; pulse 140, and weak.

19. Nine, a.m. Slept tolerably; about three, a.m., vomited much blood; can swallow well; is quiet this morning; pulse 140, and very feeble.

Two, p.m. All the sutures, about twenty-four in number, were removed; the wounds were nicely glued together, and in good position.

Twelve, p.m. Pulse 134, small, and jerking; sleeps continually.

20. Ten, a.m. Has had a good night; is very feeble. To have arrow-root with wine.

23. Rather improved; the lint is becoming offensive and troublesome; the old cicatrix in the temporal region has ulcerated to the size of a silver fourpence, but this does not approach near the incision.

24. Feeling fluctuation between the cheek and lint. Mr. Smith removed all the lint, and a large collection of pus followed. The cheek is granulating healthily; no stool since the operation; an enema brought away a full solid evacuation.

25. The taste in the mouth much better; the cheek is paralysed, but sentient; it forms a large flabby pouch, which descends considerably below the inferior border of the lower jaw; the eyelid is depressed. Custard pudding and broth is allowed.

Sept. 13. To this period all has gone on well; the paralysis is gradually disappearing, and the cheek has been gradually contracting, day by day, until it has acquired its natural size. An attack of erysipelas of the jaw took place this day, which spread over the whole face and head, and considerably retarded the cure.

Oct. 6. There is still a slight tendency to œdema of the lower eyelid; the ulcer in the temple is now very small, about the size of a spangle. She is anxious to return home, and is discharged cured.

Photographic likenesses were taken of both these patients a few days before the operations; Mary Whitaker's was taken again three weeks after the operation, and Arabella Leeming's is to be taken when the ulcer is quite healed. These drawings were strikingly correct, allowing for the difference of a tumor on the right side being represented on the left.

The quantity of blood lost in these operations was not considerable, and it was not found necessary to compress the carotid; in Leeming's case, when the tumor was removed, the cavity exposed was awful to contemplate, and several well-seasoned students were overcome by the sight.

POSITION IN FRACTURES OF THE FOREARM.

TO THE EDITORS OF THE PROVINCIAL MEDICAL JOURNAL.

GENTLEMEN,—As this is a question of very great practical importance, inasmuch as on the adoption of one position or another mainly depends the happy or disastrous termination of fractures of this region, I think it is the duty of every one who has made any observations upon it in the course of practice, to publish them. I have observed, within the last few weeks, three of your correspondents defending ably

each their own position. One gentleman, Dr. Chadwick, prefers the supine, and advances as his reason that the biceps rotates the upper portion of the radius outwards in fracture of that bone below the tubercle³ and says our practice should be to follow the position of the upper portion in effecting reduction by rotating the inferior portion outwards also; or by supinating the hand, and preserving that position until union is effected; and this plan he recommends from practical experience. Another gentleman, "Semisupinus" (I am sorry he does not allow me to call him by his *real* name), tells us to place the limb in a position between pronation and supination, and his principal reason (for he advances many) is the irksomeness to the patient of the prone position. I must beg at once to state that experience teaches me, on no consideration whatever, to take the advice of "Semisupinus" in the treatment of fracture of radius below the tubercle. A third, Mr. Rodick, appears to have had his anatomical and physiological bumps highly stimulated to resistance by Dr. Chadwick's sound practical observations; Mr. R. observes, "The biceps cannot rotate the radius outwards, for it is in a state of positive relaxation, and, granting it its full active influence, if the fracture occur below the insertion of the pronator radii teres, the latter muscle will be more than a match for the former," &c.

Now, without waiting to discuss the assumed point in the latter part of this sentence, I would request Mr. R. to try the following simple experiment on the first patient he has with fracture of the radius above the styloid process, and below the insertion of pronator radii teres.

Grasp the radius above the fracture, and rotate inwards, and, while in that position, relax the hold of the bone, it will be rotated outwards with a jerk. Is that phenomenon the result of a relaxed or passive state of the biceps? My own opinion is, that it is caused by the action of the biceps and supinator radii brevis. Of seven cases of fracture of radius treated by me within the last year, two were treated on the semisupine, and five on the supine plan; in every instance the fracture was immediately above the styloid process, commonly called Colles's fracture. In the two treated on the semisupine plan, rotatory motion was in a slight degree impaired, and that notwithstanding the full employment of the means usually recommended to preserve the interosseous space. The instruments which I used to press the soft parts into the space, were two circular pieces of wood, each about an inch in circumference, enveloped in common wadding, and extending anteriorly and posteriorly from elbow to wrist, kept in situ by a moderately tight bandage—the fracture, of course, previously reduced—the same instruments were employed in the five cases treated on the supine plan, and with a result so highly satisfactory, that I am fully resolved to treat fracture of the forearm on no other plan whatever.

I am, Gentlemen,

Yours obediently,

T. O'CONNOR.

March, Combe, Nov. 13, 1843.