I lost no time in proceeding to the operation by candle-light. I made an incision in the direction of the tumor, and exposed the sac, a little thickened. It was opened, and a small quantity of bloody serum escaped; the stricture was divided, and with some little difficulty the intestine (in a more favorable condition than I expected, from the length of time strangulated) returned into the abdomen, and in the course of three hours the bowels acted freely, and all appeared pretty well.

Oct. 26. Peritoneal inflammation has set in in its most unfavorable form; the pain is very great, the vomiting incessant, with great thirst, anxiety of countenance, &c. Leeches were applied, with calomel and opium every three hours.

27. In the morning the symptoms appeared a little relieved, but returned with greater severity in the afternoon. Leeches were again applied, and the calomel and opium continued. The stomach rejects everything.

28. Leeches were applied morning and afternoon, with hot fomentations, as she seemed much worse in every way; great anxiety of countenance; continues vomiting, and pain.

29. Symptoms not at all relieved, but great exhaustion has taken place, and, fearing further depletion by leeches, I ordered a large blister over the abdomen. This had a decidedly beneficial effect. After the blister had risen her symptoms began gradually to improve; the pain was not so great, the sickness abated, and the stomach for the first time retained a little gruel; previously everything had been rejected the moment swallowed.

30. Better in every way; a little broth given, which the stomach retained.

31. Still improving; there is no unfavorable appearance about the wound, nor has there been from the first. From this time until November 8 she kept gradually improving, and was so much better as to come down stairs.

Nov. 12. She is now quite recovered.

POSITION IN FRACTURES OF FOREARM.

TO THE EDITORS OF THE PROVINCIAL MEDICAL JOURNAL.

GENTLEMEN,—After having read Mr. Rodick's letter on this subject, in No. 163 of your Journal, I referred to the "Medical Gazette" for 1832, and there found four letters on the same subject, two of them by Mr. Lonsdale, and two by Mr. Rodick. Mr. Lonsdale recommended the same position that I have been advocating, and for the same reasons that I adduced. Mr. Rodick's letters were to the same purport as the one he addressed to you, and in the last of them he used the same arguments as in that letter, and in the same words. Now, as Mr. Lonsdale did not answer this last letter, and as it has been again brought forward, I cannot let it pass unnoticed a second time.

Mr. Rodick says, "he is quite at a loss to imagine" why, after the radius has been broken, the biceps should supinate its upper portion. Let me ask him why it is that, in oblique fractures of the thigh-bone, we cannot prevent shortening of the limb, except by

means of permanent extension? Can Mr. Rodick prevent this shortening by "requesting the patient not to make any muscular effort on his part?" The practical man does not say, Why is this? but, Is this so?

Again, a muscle is not always passive when it has been relaxed. What does Mr. Rodick think of the following case from "Cooper's Dictionary," p. 538? "I had a strong athletic bricklayer, with an exceedingly oblique, almost a longitudinal, fracture of the leg, and, notwithstanding the aid of McIntyre's apparatus, and the trial of the bent position, the projection of the upper fragment could not be prevented. The straight posture was then resorted to; but this caused the displacement to be still greater. The bent posture, as advised by Pott, with the limb laid on its outside, was then tried, but in vain; and we were obliged ultimately to return to the bent position on McIntyre's apparatus, as the most effective."

I have seen Mr. Syme treat cases of this sort most effectively in the straight posture, with a cushion and splint in front of the leg, similar to what Dupuytren used to the inside of the leg in cases of fracture of the lower end of the fibula; thus resisting, instead of relaxing, the muscles of the calf.

Then, in regard to fractures below the insertion of the *pronator radii teres*—it does not seem here to be a question of comparative strength between the two muscles. The inferior radio-ulnar articulation alters the action both of the pronators and supinators. I tried to explain in my last letter that, after fracture, the biceps turns the *whole* of the upper portion of the bone on its own axis; and I need not now explain that the pronator also in the same case acts differently.

Mr. Rodick next supposes what seems to me an almost impossible case, and one in which the hand must remain permanently fixed in some posture; and argues that because he thinks it best in such a case, to have the hand fixed in the middle posture, that that posture is best in all cases. That such cases are very rare, we have the testimony of Mr. Phillips, who says that, in museums, we very rarely see a specimen of union between the two bones. Yet experience and reflection teach us that the very inconvenience of such a case is partially produced in all cases of fractured radius by this middle posture which he would have us to adopt.

Mr. Rodick tells us that he has never tried the supine posture; but another gentleman, Mr. O'Connor, tells us in your last Number that he has tried both postures, and declares in favor of the supine one.

I am, Gentlemen,

Your most obedient servant,

JOHN CHADWICK.

Bury, Lancashire, Nov. 20, 1843.

Much has been said respecting the proneness of both ovaries to be diseased. I have carefully examined the records of twenty-nine cases of true dropsical ovaria, and found that there were but two in which the opposite ovary presented a *decidedly* abnormal character.—*Mr. Southam.*