cele. In spite, however, of the success in this instance, I am not inclined to think that the plan would prove generally efficacious in the treatment of even recent hematocele, and I do not now at all desire to advocate it in such cases.

In regard, however, to hydrocele, it appears to me that we have in this plan of tapping and stripping one which satisfactorily fulfils the idea of curing safely, quickly, and pleasantly, and which, though perhaps not about to prove infallible, is one which should be certainly tried in all cases (especially, I would add, those treated away from the patient’s home). Before the injection of saline or other stimulant is resorted to, if cases occur in which neither the mode I here advocate nor the iodine treatment is successful, I am of opinion that a combination of the two would be likely to prove so.

CHLOROFORM DEATHS.
By W. F. MORGAN, F.R.C.S.,
Consulting Surgeon to the Bristol Royal Infirmary.

I beg to add my testimony to the truth and importance of the statements contained in the valuable paper on chloroform contributed to the last number of the Journal by my friend and colleague Mr. Green. I fully believe with him that failure of the heart is the great source of danger in its administration; and that electricity, cautiously employed, is the most prompt and certain remedial measure. I shall not soon forget the striking example in the case of an old man admitted with strangled hernia. The hernia under ordinary circumstances having failed, he was put under chloroform for another trial previously to operation. The hernia was now readily reduced, but immediately he became deadly pale, his pulse stopped, and he seemed in articulo mortis. Instant recourse was had to the electro-magnetic battery, and almost instantly the pulse returned, and the man was safe.

In my experience, whenever dangerous symptoms have arisen, the heart has been the organ affected; and that is, I believe, the result to be watched and provided for when chloroform is administered. I can readily imagine that the lungs may suffer and asphyxia be produced by complicated apparatus and falling valves, mechanically suffocating the patient. Nothing can be more simple, and in my judgment more safe and effectual, than the plan adopted at the Bristol Royal Infirmary. A hollow sponge, conical in shape, with a hole at the apex, is held loosely over the mouth and nostrils, the chloroform being sprinkled on the interior, with or without the intervention of a bit of lint, the admission of air being regulated by a thumb on the hole at the apex. In the two deaths from chloroform which have occurred in the Infirmary, only a very moderate quantity was used, as, if the unfortunate result were due to some idiosyncrasy, my chief object, however, in supplementing Mr. Green’s paper, is to give a word of caution in the use of electricity in cases of threatened death from syncope. It is well known that a powerful electric shock sent through the par vagum will paralyse the heart and stop its action. Hence, if we be not careful, we may inadvertently increase the evil which we are endeavouring to remedy.

OBSTETRIC MEMORANDA.
STATISTICS OF OVARIOTOMY.

I send, as it were, a drop in the ocean. I have only had one case of ovariectomy, which did well for three days, when a low form of peritonitis set in and killed on the tenth day. If particulars of this case of ovariectomy, successful and unsuccessful, could be collected, the statistics would be instructive.

Miss ——, a farmer’s daughter, aged 35, a private patient, was operated upon at lodgings in Stamford. Chloroform was not given. The ether spray was used to the skin of the abdomen. An unilocular cyst was removed from the left ovary; it contained two gallons of thick glairy fluid. She had not been tapped. No fluid escaped into the peritoneum. The pedicle was three inches long. Hutchinson’s clamp was applied. She died on the tenth day after the operation, from aspecific peritonitis.

The following represents the whole of my experience.


HEALING OF WOUNDS AND ULCERS BY A NEW METHOD.

By JAMES BRAITHWAITE, M.D., Leeds, Editor of Braith-"worth’s Annual Retrospect of Medicine and Surgery.

The application of an aqueous solution of carbolic acid (one drachm to eight ounces of water) conditioned ulcer, cleans it from all purulent matter, and causes it to assume a healthy red appearance, with each granulation distinctly visible. If a wound in this state be freely exposed to warm dry air for some hours, it becomes glazed and dried on the surface. It becomes covered by what is practically an impermeable transparent membrane, closely applied to the surface of the granulations, and exercising a certain amount of mechanical pressure upon them. In many cases, no matter forms underneath this membrane, and cicatrisation goes on underneath it with great rapidity. In time, the membrane assumes the appearance of a thin dry scab, and drops off. If matter forms under the membrane, it is at once visible through it; the lichen should then be scraped off, and the wound dried by exposure, as before. Immediately this is done, the inflamed edges of the ulcer commence to pale in colour, and in twenty-four to thirty-four hours have nearly the tint of natural skin.

This treatment is especially of value in the cure of ulcers on the leg, as no confinement to bed is necessary; and what is required in the application of the lotion and subsequent drying can be done in the evening, after the conclusion of the day’s work.

The first case in which I tried this plan was that of Godfrey S. He had been thrown off his ordinary business twice, for a period of four to six weeks, with an ulcer on the shin of the right leg. He healed the first time; but on the second occasion resisted all treatment, although he laid in bed two weeks. I then tried the plan recommended, and he returned to work in a week. Of course, the wound was unhealed, but it was covered with a firm scale. This dropped off many weeks after, leaving a healthy cicatrisated surface.

Another case was that of John M., a hairdresser, accustomed to be on his feet all day. The lower half of his left leg anteriorly was one mass of inflammation and deep ulcers, secreting unhealthy pus, and with irregular edges. This was cured by this plan alone, thanks to his own intelligence and care, without his being one day off his work.

I have tried this plan in numerous cases of small wounds, but do not think it applicable for sores of large size—say six or seven inches across—from a scalp. I have met with one case which defied this plan of treatment. It was a chillblain on the foot of a very strumous child, just returned from India. She had at the same time pemphigus on the backs of both hands. The profuse suppuration was too much for the mechanical pressure of the membrane to check it; and although cleaned, dried, and glazed repeatedly, pus always formed underneath. I at last simply dressed it with spermatic ointment, and it healed by contraction in about two months. Of course, the membrane or scab acts not merely by pressure, but by exclusion of the air.

The following represents the whole of my experience.

1. Elizabeth W., aged 18, single, had ovariectomy performed June 17th, 1869. The cyst was unilocular; the pedicle was clamped. She was discharged cured August 1st, 1869.
2. Mary B., aged 35, married, the mother of five children (the youngest three years old), had an ovarian cyst with a solid portion, and ascites in small quantity. She was admitted February 23rd, 1879. On March 17th, ovariectomy was performed. The pedicle was clamped. The cyst consisted of one large and a few mural cysts, and at the lower part a large intracystic growth of a colloid character. She was discharged cured May 17th, 1879.
3. Mrs. B., aged 35, mother of two children, was admitted March 22nd, 1879. She was an anxious and careworn woman, and was suspected of drinking slightly. Her family history was indifferent. Her mother died of uterine cancer in the Samaritan Hospital, London. She had a multilocular multiloculated ovarian cyst of six years’ duration. Extensive adhesions were suspected. In April, ovariectomy was performed. There were adhesions to a coil or two of small intestine and omentum, and to the fundus uteri; they were separated before the cyst was clamped. The pedicle was short; it was ligatured (the ends being retained outside the wound). The operation was prolonged. Death took place forty-eight hours after the operation, from shock. There was no internal hemorrhage, as was ascertained by post mortem examination.
4. Eliza F., aged 42, unmarried, was admitted November 22nd,
1870, with a multilocular ovarian cyst of six years' duration. She was a fairly healthy woman. In December 1870, ovariectomy was performed. The operation was prolonged, adhesions being extensive.

Death took place two days afterwards. She had great collapse; and occasional vomiting.

VINCENT JACKSON, Senior Surgeon of the Wolverhampton and South Staffordshire Hospital.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN

THE HOSPITALS OF GREAT BRITAIN.

ST. GEORGE'S HOSPITAL.

TRAUMATIC ANEURISM OF THE UlnAR Artery, TREATED UNSUCCESsFULLY BY Pressure, AND BY GALVANO-PUNCTURE CONSECUTively: REsult OF THE SAC: ULTIMATE GOOD Recovery.

(Under the care of Mr. Pick.)

W. B., aged 29, a zinc-plate worker, was admitted March 6th, 1872. Twelve days previously to admission, while he was sharpening a chisel, it slipped and entered his arm. This was followed by profuse hemorrhage, which was arrested at the time by a ligature tied tightly round the arm, and subsequently by direct pressure over the wound. The pressure was maintained for two or three days; and on its removal the wound was healed; but in the course of a few days a swelling appeared.

On admission there was found to be an oval swelling of the size of a walnut on the front of the left wrist, in the course of the ulnar artery. The skin over it was discoloured and marked on its summit by a semi-lunar cicatrix, which lay parallel to, and a little external to, the flexor carpi ulnaris. The swelling consisted of a sac, the wall of which was evidently very thin, containing fluid, and which could be easily emptied of its contents. There were a very marked and forcible pulsation and an audible bruit.

The forearm was forcibly flexed on the arm for twenty-one hours (a proceeding which materially diminished, but did not entirely stop pulsation in the tumour), but without any appreciable result. Two horse-shoe tourniquets were now applied, one on the brachial, the other on the ulnar artery; and for twenty-four hours the circulation through the aneurism was entirely arrested. This was followed by a very marked consolidation; but the pressure was badly borne by the patient, it was, therefore, omitted during the night and continued only during the day. At one operation drainage only had taken place; and, the limb having become very edematous, the patient objected to further pressure. A pad was, therefore, placed over the tumour, and the arm tightly bandaged. This was followed on the third day by slight superficial sloughing, but without any further consequence.

All further treatment was, therefore, abandoned until the sore healed.

On April 15, galvano-puncture was applied by means of two needles introduced across the sac and connected with the negative pole of the battery. Some little bleeding followed the withdrawal of the needles, but was controlled by pressure. The opening was continued for a considerable time, and a small amount of decolourised film were turned out. The posterior part of the sac was seen to consist of the coats of the vessel, in which could be seen the upper and lower orifices. The vessel was tied above and below, and divided between the two orifices. The man made a good recovery.

THE MIDDLESEX HOSPITAL.

EMPYEMA: PARACENTESIS: DRAINAGE-TUBE WORN FOR THREE AND A HALF YEARS.

(Under the care of Dr. Living.)

For the report of this case, we are indebted to A. W. Harding, B.A., M.B. Lond., Resident Physician's Assistant.

John H., aged 20, was admitted into the hospital on July 9th, 1867, with pleuritic effusion on the right side, the duration of the illness being thirteen weeks. Pneumonia was performed, the opening being made between the third and fourth ribs, half an inch to the inner side of the nipple. The patient afterwards went to the Brompton Hospital for Consumption, where the fluid was collected, and discharged itself spontaneously by the opening in the second interspace. During the summer of the next year the fluid accumulated again, and burst through the opening first made. He was re-admitted, and the fluid was again discharged through the same opening; and a drainage-tube was introduced. The tube was passed in at the original opening, and out of an aperture between the ninth and tenth ribs in the dorsal line; it was worn as long as the patient remained an out-patient of the hospital.

On March 20, 1872, he was again admitted into the hospital. He was now tall, over six feet, and very thin, his weight on admission being seven stones four pounds. About six fluid drachms of pus oozed from the side daily. The right side of the chest was found to be much sunken; crepitation and moist sounds were heard all over the chest, and the pulsation of the pericardium could only be distinguished quite at the upper part-over the two first or two ribs in front, and the upper part of the scapula behind. After the patient had been in the hospital about a fortnight, a tube was fastened in at the lower opening. The tube was worn in this way for about a month, slight bleeding occurring from the side from time to time; but, on March 9th, considerable bleeding came on suddenly, while, at the same time, hemoptysis occurred. This was checked by the application of an ice-bag to the side, and the administration of ergot internally, and the tube was now removed. The patient had been placed on a liberal diet and tonics, and, in spite of the continual purulent discharge, and the occasional bleedings, his weight had steadily increased. From this time the discharge decreased in quantity, and the patient rapidly gained weight and strength. On May 1st, his weight was eight stones. The openings of the tube, however, but the discharge was about half the quantity it was when the patient was admitted. The movement of the respiration was more perceptible, and the resonance improved.

The moist sounds were much diminished, being scarcely heard over the back; at the same time, the area over which the respiratory murmur could be heard was much increased, the breath-sound being clearly distinguishable over the whole of the upper part of the front and chest as low as the anterior opening, and over the back as low down as one inch above the posterior one. The urine was normal, and there was no enlargement of the liver or spleen.

This case shows the length of time that a drainage-tube may be left in with impunity. The patient did not suffer, except from weakness, from the long-continued drain. He was very thin on admission to the hospital this last time; but, it was stated by those who remembered him, that he was not thinner than when first taken ill. Moreover, he lay in the hospital, in which he gained flesh in the hospital, before the removal of the tube, it is probable that his emaciation was due quite as much to bad hygienic conditions as to the continual discharge. There was no evidence of albuminoid degeneration of any of the organs. It also shows a possible danger which may arise from the introduction of the continual purulent discharge, for it would appear that the friction of the end of the tube against the visceral pleura caused erosion of that membrane, giving rise to slight hemorrhage, and, ultimately, even to perforation. The pleural surfaces certainly went into closer apposition after the removal of the tube during the patient's convalescence; for while there was still some evidence of fluid in the sac when the patient was first admitted, this had almost entirely disappeared at the last examination. No bad effect whatever resulted from the removal of the tube, during the month that the patient remained in the hospital after this was done.

CASE OF SUPPURATING HYDROCELE WHICH HAD BEEN TREATED WITH A SETON.

(Under the care of Mr. Hulke.)

While we have so generally successful and safe a method of treatment for the radical cure of hydrocele as the injection of iodine, the passage of a seton through the tunica vaginalis will, by all prudent surgeons, be restricted to those rare cases where iodine injections have failed, and also where exceptional conditions (e.g., very great thickening of the tunica with calcification of its tissues) which would not otherwise exist; because, experience has proved that the seton has frequently induced suppuration even where, in order to avoid this, it was withdrawn on the first appearance of redness around the punctures, or of swelling; and suppuration is not unattended with danger.

While suppuration is not desired, it is imperative to watch most closely, day by day, or even at shorter intervals, the progress of the case, in order that the right moment for renewing the seton may be seized; and, where suppuration is desired, the case should be watched as closely, in order to avert the extension of the inflammatory process to the other scrotal tissues, and necrosis of these and of the tunica vagnalis, by timely incisions, for the purpose of giving a free escape to the