

Medicine, for January, 1839. He first discharged the pus through the colon downwards, and afterwards through the lungs. He finally recovered.

I am inclined to think that Mr. Bundick would have recovered, if proper professional aid had been rendered after his first medical attendant was taken sick. The case should teach us never to despair, but under circumstances the most unpromising to ply our measures to the last. Few cases can occur where less is promised than was afforded by this at one time, and yet the recovery was so far completed, that the patient was able to resume his laborious trade. It is greatly to be regretted that he did not receive in his relapse the same judicious treatment which attended his first illness. The omission of the autopsy is one which I also very much regret.—*Western Journal of Medicine and Surgery.*

RANULA.—ABSCESS OF THE PAROTID GLAND.

From Sir B. O. Brodie's Lectures at St. George's Hospital.

I SHALL take this opportunity of speaking to you of another disease which corresponds to the one I have just mentioned. It occurs under the tongue, and it is principally among the out-patients that you will meet with it. It is called "ranula." If you lift up the tongue you will find a tumor as large as a horse bean, and this soon becomes larger; examine it with your fingers, and you will find it contains fluid; these tumors produce very considerable inconvenience. Well, you puncture it with your lancet; out comes half an ounce of fluid, and your patient immediately tells you he is well, and can move his tongue again as freely as ever; he is well perhaps for a week, but by-and-by the tumor returns, and he comes to you again; but why does he return? because the opening has closed, and the fluid collects again of course. What is this tumor? It appears to be in the duct of the submaxillary gland. The orifice is stopped up, but the gland goes on secreting; the secretion is lodged in the duct, which gradually dilates so as to form a bag, just as when an impediment occurs to the flow of urine down the ureter, it will dilate to the size of the small intestine. I have seen the urethra dilate in the same way, making a large membranous pouch in the perineum. You cannot apply the same remedy here as in the labial glands, because extirpating this tumor would be worse than doing nothing at all. From the number of small glands in the lip you can extirpate one with impunity, but not so with the submaxillary gland. What you have to do here is to make a permanent opening in the duct; this I have done by making a small incision, then introducing the forceps and cutting out a circular piece. At other times I have run a seton through and left it there. I have also had a metallic or wire ring made, and kept it open in this way; at other times I have destroyed a portion with the caustic potash. But there is not one of these methods which has not disappointed me; I have even removed half the bag; it has taken a long time to close, and I thought I had effected a cure; but in three or four months it has closed and the tumor

has returned. I have run a seton through, composed of several silk threads; then I have fastened them to the cheek with sticking plaster, and the saliva has run out by them; I have made the patient wear this several days, but on its removal the part closes. The best way seems to be letting the seton ulcerate out, and then there is a chance of its remaining fistulous. There is this advantage in employing a metallic wire for your seton, viz., that it does not irritate so much as silk, and it is said there is more chance of the opening remaining pervious. After all, I think the best way is to allow a seton to remain in a few days, then remove it, and teach the patient to introduce a probe daily; this he will soon learn to do if he is an intelligent person; this will act precisely as in stricture of the urethra, where the patient is taught to pass a bougie. It is a remarkable circumstance, that I never saw the duct of the parotid gland so affected, and I suppose this to arise from its great width. I have seen fistulous openings and the saliva escaping externally; but this is widely different from the affection of the submaxillary gland, of which we have been speaking.

Now that we are upon this subject, I shall make some remarks on *abscesses of the parotid gland*. These sometimes, after a very short time, heal readily; but at other times they will not, in consequence of the continued escape of the saliva externally. At a meal this occurs in great quantity, and, of course, produces very great inconvenience. Some have said that half a teacupful may flow out on these occasions, but this is evidently an exaggeration. The cure of this affection is performed without trouble. The abscess will go on healing till it leaves a very small opening; this you are to touch every day with nitrate of silver, and as it contracts, the saliva will find its way by another passage; but every now and then this is insufficient. In these cases introduce a probe by the external opening to the gland; then pass it carefully on till you feel it inside the cheek, where you will have nothing but mucous membrane between it and your finger; having done this, you are to puncture the mucous membrane and pass the end of the probe into the mouth (an eyed probe should be employed); you will then have one end inside and the other outside the cheek. Then arm the eye of the probe with silk and draw it through, remove the probe and allow the silk to remain in. Then, at the external end of the silk, make a large knot and bring it to the mouth of the wound; this will prevent the saliva flowing externally, whilst the thread directs it into the mouth. Keep this in, till the inner opening is well established, which generally requires about a fortnight or three weeks; then remove it and touch the external opening daily till it closes. I don't know whether the internal opening always remains pervious; but certainly the saliva finds its way through some internal canal.—*London Medical Times*.