tongue and eyes are not inspected at one and the same time unless the observer is on the *qui vive* for this movement of the eyelids; and this, I think, is one of the main reasons why it has hitherto not received any notice. 2. I think that it should always put the medical man on his guard, whether, for instance, he is treating an acute case for some urgent symptoms, or, on the other hand, examining a case for life insurance; as whenever the phenomenon is present in chronic cases—judging from my own experience—some severe asthenic condition will be always found to exist, or it will be found that the patient has been a martyr to pain for many years. 3. From observations made on a few of the cases I have noticed that the phenomenon for a time almost disappears after the tongue has been protruded several times and also after stroking the forehead or touching the lower eyelid. 4. In all the cases observed except one it was present in both eyes. 5. In three of the cases the phenomenon disappeared as the patients convalesced from their various maladies. 6. In two of the cases, though formerly the phenomenon was present in a very marked degree, it is now nearly absent and the patients are both much better in health than when I at first saw them. 7. In two acute cases in which the phenomenon was observed it disappeared when the urgent symptoms had passed off. 8. As regards chronic cases, the patients who have presented this phenomenon in my own practice have been affected with various cardiac and abdominal diseases, and two of them had suffered from very severe headaches for many years in consequence of uncorrected astigmatism. 9. The phenomenon is never present in health. It comes and goes with the onset and cure of disease, as proved in five of my cases, and therefore I think that it is a clear index or sign of disease.

Leeds.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF DISLOCATION OF THE OUTER END OF THE CLAVICLE.

By H. M. JOSEPH, M.B., B.C. CANTAB.

DISLOCATION of the outer end of the clavicle is not common, probably less than 3 per cent. of all cases of dislocation. Owing to the difficulty in keeping the bones in position this accident having once occurred is always liable to recur, and hence the prognosis is in every case doubtful. Bergmann says that the prognosis is unfavourable as regards complete restoration of form, but functional impairment is slight although the carrying of heavy burdens is difficult. Free abduction is considered the only movement endangered. It is in athletes that one usually meets with this dislocation, and to them it gives a serious handicap in their sport; football, whether Rugby or Association, has to be given up, and often tennis. One player I know of was able to continue football after having the bones wired, but the limitation of movement caused by the wiring of the acromio-clavicular joint prevented his playing tennis. Two others, although unable to play football again, or tennis with the right arm, took up left-handed tennis. Others have never taken the field again in either sport. One of the first questions therefore that arises in these cases is, "Will it be necessary to give up games?" and it is in this connexion that the following case may be of interest.

The patient, aged 26 years, received his injury while playing Association football, and he presented the usual signs of dislocation of the outer end of the right clavicle above the acromion. He complained of pain and "a feeling as if something were loose in the shoulder," and he could not raise the arm. Examination revealed the outer end of the clavicle lying just above the acromion process and causing an elevation of the outer extremity of the trapezius muscle. By pressing on this swelling and at the same time supporting the arm the dislocation was easily reduced, but it recurred at once on releasing the support of the arm. The shoulder was attended to immediately after the injury. The clavicle was kept in place by means of stout strapping tightly bound and running over the acromio-clavicular joint and under the

elbow; a pad of cotton-wool was placed in the axilla while the elbow was fixed well forward and close to the side by a broad calico bandage. The patient was told that he would probably be unable to play football again. The clavicle and acromion were kept in place in this way for six weeks, after which time gradually increasing movements were allowed—first passive and then active. The treatment thus presented no new features. The result, however, was extremely satisfactory. The patient was able to play football again four months after the injury and he has since played in county matches. He has also been able to take part in first-class tennis tournaments. There is now no deformity and all the movements of the arm are perfectly free. The only inconvenience the patient now suffers is an occasional pain felt when pressure is applied over the acromio-clavicular joint.

Oxford-gardens, W.

NOTE ON A CASE OF EXTENSIVE SURGICAL EMPHYSEMA.

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THE following is a case of very extensive surgical emphysema which came under my care some time ago. A man, aged 66 years, fell, striking his chest against the corner of a table and fracturing his seventh and eighth ribs on the left side rather towards the back. About three hours afterwards he noticed that his scrotum was becoming swollen and uncomfortable and this swelling advanced rapidly over the whole body. 24 hours after the injury the body was found to be swollen and puffy all over and the air could be felt crackling under the fingers; it was evidently immediately beneath the skin, which was lifted up in a large soft mass producing the appearance of general dropsy. The entire surface of the body was affected with the following exceptions: the scalp, defined by a line running round the head more or less coronally at the level of the external occipital protuberance, the temporal ridge, and the upper and outer angle of the orbit, and this area of immunity was continued downwards to the malar bones, and thence over the nose as far down as the tip, the eyes and eyelids thus escaping; the point of the chin; the auricles; the hands, back and front, from a line just above the wrist-joint; the region immediately over the patella; and the feet, dorsum, and sole from a line at the ankle-joint. There was no sign of pneumothorax. For the first day or two there was a little dyspnoea, with slight cyanosis of the face and lips, and rather rapid respiration, but this soon passed off. There was no pain anywhere except at the site of the fracture, though the swelling of the scrotum and penis gave rise to considerable discomfort. Treatment consisted in restricting the movements of the chest by strapping and the administration of sedatives for the cough. The emphysema gradually subsided and in a fortnight it had quite disappeared.

The chief interest in this case is the widespread extension of the emphysema and though such cases no doubt often occur I have not been able to find any record in recent writings of a similar one to this. The area of immunity over the nose and eyelids also is notable, since it is recognised that there is a fairly free communication between the subcutaneous tissue of these parts; this has been noticed during the injection of paraffin for nasal deformities, where some of the material has overflowed if not checked by pressure at the sides of the nose. The definite limiting line at the wrists is remarkable, seeing how easily cedema continues up the back of the forearm from inflammation of the hand.

Glasgow.

ROYAL NATIONAL ORTHOPÆDIC HOSPITAL.—The erection of the new building in Great Portland-street for the combined three London orthopædic hospitals is proceeding rapidly. It will accommodate over 200 beds and in addition it will have a detached out-patients' department and nurses' home in Bolsover-street connected to the hospital by means of a subway. Mr. Rowland Plumbe, F.R.I.B.A., is the architect and Messrs. Holloway Brothers are the builders.