tube, as it was not thoroughly incorporated with the vomited matters, which would have been the case had the stomach been injured. In this case there was much to be hoped for by careful and persevering treatment. The patient was of temperate habits, sound health, and was supplied with every comfort. His employers went to see him, and requested that great attention should be given. Sensation, respiration, and deglutition were perfect, and the tongue well protruded. Insensibility, from which he soon recovered, and loss of power over the sphincter muscles were the only dangerous symptoms of cerebral and spinal derangement. After clearing out the bowels, the object was to place the system under the influence of mercury, and to keep up its action. The jerking character of the pulse was very striking; it lasted many days, in spite of the bleedings and digitalis. The pain at the back of the head on the day after the accident was extreme; the patient was obliged to be held in bed; this was, no doubt, meningitis rapidly setting in, as it was so effectually relieved by the cupping. The constant abstraction of a small quantity of blood tended to promote absorption; it also kept the brain in a quiescent state during its recovery from such a shock. The great irritation at the extremity of the nervous power was very remarkable, and I do not remember having noticed it before in such cases. Starvation diet and great abstemiousness upon convalescence were rigidly adhered to.

This case is vividly impressed on my memory from an accident connected with the summons. A companion who had climbed the tree with Mr. U— drove to my house in a dog-cart, begged me to go immediately, as his friend was dying, and offered to drive me to the spot and back. As my carriage was not ready, I assented, but was scarcely seated before the vehicle was upset. The driver was obliged to be put to bed at the nearest public-house, quite insensible, with concussion of the brain. I was much scratched, and proceeded, with plastered chin, &c., to the case of fractured skull.

Norfolk-street, Park-lane, Sept. 1856.

DISPLACEMENT OF THE TRACHEA, AND ITS SEPARATION FROM THE LARYNX,

CONSEQUENT ON A KICK FROM A HORSE.

COMMUNICATED

By J. ROBERT ROBERTSON, M.D.,

RESIDENT ENGLISH PHYSICIAN FOR THE BATHS OF WIESBADEN.

THE following, I believe, unique casualty occurred recently to a Prussian soldier at Schwest, on the Oder; and as the particulars may be interesting to my professional brethren in England, I send an abstract of the report of Dr. Berger, the Surgeon-general.

Cannonier B—, of the Artillery of the Prussian Guard, was kicked by his horse a little below the lower jaw, whilst engaged in washing its hind hoofs. A small, unimportant skin-wound exhibited itself at the edge of the jaw, and some blood, but not much, flowed from the mouth. The neck, however, rapidly swelled to an extent sufficient to materially impede respiration. The patient complained only of a peculiar sensation of weight in the epigastrium, and stated that he felt as if blood had collected in his windpipe and prevented his breathing freely. There was no fracture or injury to be discovered in the larynx. The patient was at once bled, generally from the arm and locally by leeches, without the slightest effect upon the orthopnoea. The latter symptom continued to increase rapidly until so fearful an emphysema had established itself, that the chest, neck, and face of the man were swollen to a frightful extent; and in this state, suffering great agony, he died, within an hour and a half of the receipt of the injury.

The *post-mortem examination* discovered a complete rupture of the trachea from the larynx, the latter being uninjured. The separation commenced at the left side of the cricoid cartilage, proceeding to the right as far as the middle of the posterior edge, so that a third part only of the union of the trachea and larynx remained intact. Several of the cartilaginous rings and ligaments of the trachea were ruptured, and it was found filled with coagulated blood. The thyroid, cricoid, and arytenoid cartilages were quite uninjured. The heart was in a normal condition; the lungs were congested, and of an unusually dark colour.

This I regard as a very singular and interesting case; not only from the peculiar nature of the injury sustained, but from

the great disproportion of the external wound to the internal damage effected. A slight abrasion of the skin at the edge of the lower jaw was all that could be observed or discovered during life, and yet the autopsy displayed organic dislocation and rupture of so extensive a character that death ensued within an hour and a half of the occurrence of the injury. Whether, had its true nature been at once ascertained, an immediate resort to tracheotomy might have been attended with temporary advantage, may perhaps be a question. I say temporary advantage, for, with so serious a displacement, anything approaching to a cure could not, I apprehend, be expected.

Wiesbaden, August 30th, 1856.

REPORT OF

CASES OF DISEASE OF THE HUMERUS.

By V. B. WEBB RICHMOND, M.D., M.R.C.S.,
Brighton, near Melbourne.

IN a file of THE LANCET which has reached me, I notice a case reported at one of the hospitals, of disease of the humerus, arising from gun-shot, in an Italian officer, wherein the success of recovering the use of the arm by removing the carious portion of bone is doubted. I have had several cases in the course of my practice, which leave no doubt on my mind, that in healthy subjects, where accompanying circumstances are favourable, very large intervals of bone will be filled up by fresh deposit. I was led to this conclusion when a student at the Bristol Infirmary by the post-mortem examination of a man in the dead-house of that hospital. I found an old fracture of the radius, in which the original structure had either exfoliated or been removed (appearances warranted the former conclusion) to the extent of three inches, and supplied by new bone; the ulna had not been fractured.

CASE 1.—When surgeon to the Maestry Ironworks in Glamorganshire, I was called by a neighbouring surgeon to amputate both legs of Rees D—, a farm-labourer, employed in hulling lime for a tramroad. Having fallen, both legs were crushed by the trains passing over them, the muscles much lacerated, and the tibia and fibula perfectly comminuted to the extent of three or four inches. On examination, I found the vessels were not wounded. The man declared that we might as well remove his head as his legs, and prayed that an effort might be made to save them at any risk. I considered the operation might be delayed; but after removing a vast amount of spiculae I had little doubt that amputation must take place. Not so, however; the legs were placed in position, and the patient went on to perfect recovery, without an unpleasant symptom. I watched the case for about seven weeks, and then left him to his local surgeon. This case established the conviction the post-mortem examination had commenced.

CASE 2.—On the voyage to India, in medical charge of the reserve companies of H.M. 49th Regiment, Patrick R— got in the way of the main-brace while the ship was going about, the velocity of the rope as the yard swung round inflicting a severe wound in the perinaeum, rectum, and neck of the bladder, also cutting the leg about the middle of the tibia, and destroying the periosteum; while the wound of the perinaeum was being cured, exfoliation of the tibia was going on, and as soon as the faeces and urine took their natural course, and the patient was progressing towards convalescence, after making a careful examination of the tibia, I found it carious to the extent of two inches and a half, which I at once removed, and its place was supplied by the time we landed in Calcutta by a new deposit. Now, in this case it was manifest that the fibula did not contribute, and I should feel no doubt as to the humerus.

CASE 3.—William G—, a farmer, residing at Brighton, in the colony of Victoria, in May, 1850, rode against the stump of a tree, fracturing the tibia near the centre, and the tibia and fibula five and a quarter inches lower,—a double compound fracture, with protrusion at both wounds; the fractures were clean and transverse, without comminution. I placed the limb in position, and called a consultation with Mr. Thomas, of Melbourne, very deservedly enjoying a high reputation as a surgeon and a former pupil of Mr. Liston. This gentleman at first advised immediate amputation, but finally yielded to my reason for delay. In a few days, a protrusion of the intermediate portion of the tibia rendered its removal or amputation necessary. Having again consulted with Mr. Thomas, we determined on its removal, which was done by a free incision,

and five and a quarter inches of tibia removed in one piece. In five months he used the leg without support. There is a firm bony union, but a shortening of the limb of about an inch; and to this hour he has experienced no other inconvenience. He went to the gold-fields, and was amongst the fortunate and wise; as he invested his gain in extending and improving his farm,—an employment, if not so alluring, far more certain of a beneficial result.

ON A

NEW METHOD OF OPERATING FOR FISTULA ANI.

By ANCELL BALL, Esq., M.R.C.S. & L.S.A., Spalding, Lincolnshire.

THE difficulty sometimes experienced in operating for fistula ani,—1st, as regards the penetration of the bowel without wounding the index-finger of the operator;* and 2nd, by the sudden withdrawal of the patient, and simultaneous approximation of the glutei maximus muscles at the moment of division of the intended parts,—has induced me to devote some attention to the subject, and ultimately led to the employment of a gum-elastic speculum ani, lined with glass plated, and containing an incisura half an inch in width and extending two and a half inches from the orifice of the instrument, which I have found to possess the desired property of completely overcoming the difficulties already alluded to. After deciding upon the propriety of an operation, and the proper evacuation of the bowel, the patient may be placed upon the side, near to the edge of the bed, taking care that the light may have full access to the diseased part. When the fistulous canal is somewhat tortuous in its course, the director should be introduced prior to the speculum; but when otherwise, it is not of much importance. A straight, sharp-pointed bistoury (the blade of which is immovably fixed in the handle) will readily slide along the groove of the director, and may, with ease and perfect safety, be then passed through the coats of the bowel and the incisura speculi into the interior of the speculum, where it can be easily perceived, and may then be withdrawn, in order to divide the intervening sphincter; after which the wound may be dressed in the usual manner. In the event of undue hæmorrhage the speculum may be retained for a time, and plugged with lint saturated with appropriate styptics; and should not that suffice, the actual cautery may be employed, or the artery seized with a long pair of forceps bent at right angles near to its points, and then passed round them a piece of silver wire, the two extremities of which may afterwards be passed through a small double canula, fastening one end to the ring at the side of the canula, and then drawing the other end tight enough to close and even divide the inner coat of the bleeding vessel, in a manner similar to the strangulation of a nasal polypus.

September, 1856.

ON A

CASE OF LARGE CONCRETION IN THE RECTUM.

By J. JONES, Esq., M.R.C.S., L.S.A., Llandyssul.

T. J.—, aged forty-five, a farmer, had enjoyed good health until about two years ago, when, after eating plums, he felt uneasiness in his bowels, which continued to torment him ever afterwards. About six months ago the pain became more violent, and he began to be troubled with piles. He often took aperients, but, though they operated, he was never relieved; for he said that he felt something that he could not pass. For the last fortnight the pain had been intolerable. He had taken a great quantity of medicine without relief.

July 20th.—I was requested to visit him for the first time, and found him in a most deplorable state. Violent pain existed in the lower part of the bowel; the fæces passed involuntarily; and the anus and adjacent parts were much swollen and excoriated. To have an anodyne mixture, and the painful parts to be fomented with water.

* A medical friend of mine has recently had a narrow escape of his hand, and even life, from inflammation of the hand and arm occasioned by a punctured wound of the index-finger while operating for fistula ani.

21st.—Somewhat easier, but not relieved.

22nd.—Has voided a hard substance, which gave him great pain in passing. On examination, I found the rectum quite blocked up, with a substance as hard as stone. After some difficulty, I succeeded in extracting a concretion as large as a man's fist, which somewhat relieved him; and felt another, which could not be reached without giving much pain.

23rd.—Was summoned to him in great haste, as he was in the most excruciating pain, being unable to pass a substance which presented at the anus. Extracted another concretion, not quite so large as the last, to the great relief of my patient, who up to the present time is going on favourably.

The concretions, three in number, consisted of layers of a substance of a brownish colour, much harder than leather, each of them containing a plumstone for a nucleus. Did these substances travel progressively (by no means at a railway pace) during the whole of the time he was ailing, or did they halt to acquire that magnitude before proceeding on their journey?

August, 1856.

A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.* lib. 14. Proœmium.

CASES OF RESECTION OF JOINTS.

KING'S COLLEGE	{	<i>Excision of Knee-joint</i> ...	Mr. FERGUSSON.
		" <i>Knee-joint</i> ...	"
		" <i>Knee-joint</i> ...	"
		" <i>Knee-joint</i> ...	Mr. PARTRIDGE.
		" <i>Elbow-joint</i> ...	Mr. FERGUSSON.
UNIVERSITY COLLEGE	{	" <i>Wrist-joint</i> ...	"
		" <i>Knee-joint</i> ...	Mr. ERICHSEN.
		" <i>Knee-joint</i> ...	"
ST. GEORGE'S HOSPITAL	{	" <i>Elbow-joint</i> ...	"
		" <i>Knee-joint</i> ...	Mr. CUTLER.
		" <i>Knee-joint</i> ...	Mr. TATUM.
WESTMINSTER HOSPITAL	{	" <i>Hip-joint</i> ...	Mr. C. HAWKINS.
		" <i>Knee-joint</i> ...	Mr. HOLT.
		" <i>Knee-joint</i> ...	"
		" <i>Elbow-joint</i> ...	"
		" <i>Elbow-joint</i> ...	Mr. HOLTHOUSE.
BARTHOLOMEW'S HOSPITAL	{	" <i>Elbow-joint</i> ...	"
		" <i>Knee-joint</i> ...	Mr. STANLEY.
		" <i>Elbow-joint</i> ...	Mr. LAWRENCE.
GUY'S HOSPITAL	{	" <i>Knee-joint</i> ...	Mr. BIRKETT.
		" <i>Elbow-joint</i> ...	"
		" <i>Elbow-joint</i> ...	Mr. HILTON.
MIDDLESEX HOSPITAL	{	" <i>Knee-joint</i> ...	Mr. MOORE.
		" <i>Hip-joint</i> ...	Mr. SHAW.
		" <i>Hip-joint</i> ...	"
ST. THOMAS'S HOSPITAL	{	" <i>Elbow-joint</i> ...	Mr. MOORE.
		" <i>Knee-joint</i> ...	Mr. SOUTH.
		" <i>Elbow-joint</i> ...	Mr. SOLLY.
ST. MARY'S HOSPITAL	{	" <i>Elbow-joint</i> ...	Mr. SIMON.
		" <i>Elbow-joint</i> ...	Mr. WALTON.
WEST HERTS INFIRMARY	{	<i>Excision of Elbow-joint</i> ...	Mr. SOLLY.
		" <i>Elbow-joint</i> ...	"
METROPOLITAN INFIRMARY, (for Scrofula,) at MARGATE.	{	" <i>Knee-joint</i> ...	Mr. P. C. PRICE.
		" <i>Knee-joint</i> ...	"

IN continuation, we record this week the two other cases of excision of the knee at King's College Hospital, the remaining one at University College Hospital, and two at St. George's. The first of the two at King's College, under Mr. Fergusson's