eases, diseases of women, and diseases of infants, one question how the student when qualified can possibly have any practical knowledge of these subjects. Dr. J. G. Glover, one of our five direct representatives on the Medical Council, has in his two pamphlets, "The Practical Element in Medical Education," and "The Gaps in Medical Education," called attention to the present lamentable defects in midwifery education; and at the last meeting of the Medical Council he proposed that each student should attend thirty cases of labour. This motion was rejected by only two votes. I would urge that the profession make this big question, of the more practical training of the medical student in midwifery, a living one. Let every practitioner write to our five direct representatives—viz., Mr. C. G. Wheelhouse, Dr. J. G. Glover, Sir W. B. Foster, Dr. W. Bruce, and Dr. Kidd, urging them to bring this question up at the May meeting of the Council. Would it be asking too much of the different obstetrical, gynæcological, and medical societies to discuss this question at their meetings, and to forward a resolution to the Medical Council praying that they give immediate attention to this question? The profession does not keep sufficiently in touch with the Medical Council. If we kept in mind that the Council is a Council of medical education with the power to appeal to the Privy Council, and with power to refuse to register degrees granted on insufficient knowledge, we should appreciate the enormous powers given by Act of Parliament to the Council. I would propose the following recommendation of the Council: "That each student before being admitted to his final examination be required to produce certificates to the examining body showing (a) that he has attended a six-months' course of lectures, including midwifery, puerperal diseases, diseases of women and of infants at a recognised hospital; (b) that he has *personally conducted* thirty cases of labour under the immediate supervision of a registered practitioner; (c) that he has attended for three months the clinical instruction on diseases of women and infants at a recognised hospital." I hope the Medical and Obstetrical Societies will agree to work for this, and request the Medical Council to adopt it. It may be argued that a six-months' course is too long. I would only say look at the wide range of subjects. Let us remember this most important fact, that the examining bodies cannot examine the student in practical midwifery and puerperal fevers. Recognising this, it is imperative that the instruction of the student while at College should be as perfect as possible. In Germany the student, when passing his *Staats Examen*, has to conduct a confinement, attend the woman and infant for nine days, and then write and send in a thesis on the case. In connexion with the thirty cases of labour, I would ask practitioners to remember that the student has now to study for at least five years, and that six months of the fifth year may be spent under the tuition of a medical practitioner recognised by the Council. This would give the senior student—free from attendance on dissections, necropsies, and fever hospital attendances—a good chance of learning his practical midwifery. In the near future, I trust each of our lying-in hospitals will have paid district medical officers, who will each have a senior pupil under their immediate charge.

I would here point out that if midwives are given the power to attend confinements now conducted by medical men and medical students in connexion with hospitals, in the future this would lead to the student receiving his training in practical midwifery from the midwife. He might as well obtain his training in surgery from a bone-setter, or his medical education from a herbalist.

Liverpool.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

INTUBATION IN LARYNGEAL INFLAMMATIONS.

BY HAROLD STALKART, M.B.

THE subject of this case was a traveller, aged fifty-two, suffering from marked dyspnoea, very much cyanosed and nearly asphyxiated, breathing with the greatest difficulty. Gouty habit, being attacked every spring. He was suddenly seized with a difficulty of breathing, which in-

creased for five days before I saw him; he was then in *extremis*, and it was a question of immediate surgical interference. Intubation was chosen in preference to tracheotomy. I passed the forefinger of my left hand to the upper stratum and introduced a long tube through the larynx, some way down the trachea, which afforded instant relief. The cyanosis and anxious expression gradually passed off as breathing became re-established. A steam kettle containing compound tincture of benzoin was now set going, and a tent put up. The breathing continued to improve. The tube, which was of gum elastic material and fourteen inches long, was removed next day, and the patient recovered without a bad symptom. (See Fig.) The opening

A, Opening of tube. B, Movable reel.

in the side of the tube prevented blocking on introduction, and if placed so as to lie to one or other side has less chance of contact with the wall of the trachea, as the tube tends slightly to straighten itself in the antero-posterior direction. Its diameter is about a No. 16 catheter, and it may be fixed to the beard. There is a small wooden reel to be placed between the teeth, to prevent compression of the tube. Food enemata or a stomach tube may be used for feeding. I have used this in all cases of laryngitis and diphtheria requiring surgical interference with the greatest success. In cases where vomiting occurs under chloroform and obstruction of the air passages is seen, could not this be used? With leeching and fomentations locally and *natural* salicylate of soda the gouty symptoms abated, the patient being about again.

Kilburn, N.W.

TRAUMATIC CONTRACTION OF FINGERS TREATED DURING HYPNOSIS.

BY GEORGE C. KINGSBURY, M.A., M.D.

T. H.—, aged about thirty-six, consulted me on Nov. 28th, 1890. A year previously he cut the palm of his hand at the outer side, and since then his little finger had been gradually contracting, and latterly the ring finger had been following. The patient was hypnotised after a good deal of trouble, possibly due to the fact that he "did not believe in it." During hypnosis the fingers were forcibly extended, but not to the full, and absence of pain verbally suggested. A distinct cracking could be heard as the contracting bands yielded. The patient did his work next day as usual without any discomfort. Two days later he was again hypnotised, and the extension was completed. Immediately on going home he played his violin for two hours, just to test his fingers, the hand affected being his left. This test required their constant exercise, yet he felt no pain. He had not been able to finger his violin for nine months previously. On Dec. 3rd, 1890, the patient came to report that his hand remained all right, and there has been no tendency to relapse since. I have no doubt that this case, being traumatic, the fingers might have been extended under the influence of an ordinary anæsthetic; but, if they had been, the question arises, would the patient have been so free from after pain as to be able to fiddle for two hours immediately after the second extension? I do not say positively that any part of the result was due to hypnotic suggestion, but the influence of the mind upon the body is apt to be underestimated. Trousseau, Stokes, Graves, and others have pointed out that the mind alters not only the secretions, but modifies the nutrition of the organs. Whatever effect the mind may exert upon the body in the waking state seems to be greatly intensified during the hypnotic condition. One great advantage possessed apparently by hypnotic anæsthesia, where it can be induced, lies in the fact that (so far as I know) it has never had a death laid at its door; whereas the list of fatal accidents with chloroform and ether is constantly being increased. It is certain that hypnotism can never replace these agents in general surgery, for it is limited in its applicability; but I believe in a great number of cases demanding minor operations it would, if properly tried, be found quite as satisfactory and infinitely safer than the usual anæsthetics. Where it can be

applied, hypnotic anaesthesia will be found of great value in another direction; once induced, there is no further need for the hypnotist to devote himself to its maintenance, as in the case of chloroform; and, more than this, the patient will be able to obey instructions, such as to raise his arm or turn on his side, quite as intelligently as if in his normal state. Those who have frequently to operate with very limited assistance will appreciate these points.

Blackpool.

CASE OF NITRO-BENZOLE POISONING; RECOVERY.

BY ALGERNON HODSON, M.R.C.S.

R. E—, aged forty-eight, registered chemist, had measured two drachms of nitro-benzole to scent some soap, and by some mistake drank it at 1 P.M. on March 11th, 1891. He then made a hearty dinner of beefsteak pie, and felt no ill effect from the poison except tasting and smelling almonds until 2.30. He then became giddy, and was advised to go home. He was able to walk home, a distance of about half a mile, feeling all the time as though intoxicated, being unable to control his legs or see clearly. On reaching home, about 3.15, he informed his daughter of having taken nitro-benzole by mistake. She went for a doctor, and in the meantime the patient became unconscious. Messrs. Dodd and Philips came, washed out the stomach, and got rid of the contents, consisting chiefly of lumps of meat, smelling very strongly of nitro-benzole, as did the breath and the whole atmosphere of the room. A hypodermic injection of ether was also given. He was then sent to the Hove Hospital. Condition on admission at 4.30 P.M.: Strong, well-nourished man; insensible, collapsed, extremely cyanosed, short and irregular breathing. Pulse hardly perceptible, 60. Pupils contracted, conjunctiva not insensible; no paralysis. Had defecated involuntarily. Stimulants administered and heat to extremities. At 6 P.M. the breathing was quite regular; pulse 80; still extremely cyanosed; could open his eyes; looked vacantly if shouted at. Vomited twice. At 12 A.M. he was in the same condition. Micturated involuntarily. Temperature 99°. The next day the patient was much better; sensible, but still very cyanosed. Thirsty, and complained of stiffness and soreness over the whole body. The pupils still contracted; no headache; pulse 84; respiration 18. On the 13th the cyanosis was less marked and the pupils less contracted. Urine drawn off (36 oz.), very dark mahogany coloured, perfectly clear, no peculiar odour, specific gravity 1025. The condition continued to improve and the cyanosis to decrease until the 19th, when the man was discharged cured.

I am indebted to Mr. C. M. Lewis, the house-surgeon, for obtaining the information and verifying it by inquiry. The interest in the case seems to be the recovery after so large a dose as two drachms being taken and allowed to remain in the stomach for over two hours, as there are several cases on record of very small doses proving fatal, and one case where eight or nine drops proved fatal (Letheby). Another point of interest was the intense cyanosis.

Brighton.

ACUTE INTESTINAL STRANGULATION DUE TO VOLVULUS IN A NEWLY BORN INFANT.

BY G. NEWTON PITT.

AN infant came under the care of Mr. Lucas for complete obstruction, with a greatly distended abdomen, which was supposed to be due to an imperforate rectum. A left inguinal colotomy was performed, and the child died when two days old. The colon, rectum, and the lower two feet of the ileum were normal. The three feet of intestine above this were distended, black with engorged blood and acutely inflamed. There was a sharp line of demarcation from the healthy bowel above, but less sharp below. No trace of any band or of an intussusception could be found, and it was concluded that the acute strangulation was due to a volvulus, which readily untwisted. The only case on record of a volvulus in a newly born infant was reported by Mr. Harrison Cripps in Vol. xxxi. of the Transactions of the Pathological Society. In this case a Littré's operation was performed; the child died when three days old, and at the

post-mortem inspection a volvulus of the ileum was found. The earliest case otherwise appears to be that of a child three years old referred to by Keating.

St. Thomas's-street, S.E.

PRIMARY MUMPS OF THE TESTICLE.

BY T. F. RAVEN, M.R.C.S. &c.

A YOUNG man, exposed to the infection of mumps, complained of pain and swelling of the left testis on March 31st. On April 4th both parotid glands began to swell, and the affection of the testicle, which was not severe, subsided rapidly, and was gone by April 7th. Last August he had gonorrhœa, succeeded by gleet. On Nov. 10th he had a sharp attack of orchitis (right), and on December 25th a similar affection of the left testicle. Each of these attacks lasted for more than a fortnight; but for nearly three months, prior to the mumps, he had been quite well and able to take horse exercise frequently. I should imagine that the previous orchitis had rendered the testicle vulnerable, and that the virus effected an easier lodgment there than in the parotid glands. The mildness of the mumps, as compared with the previous inflammation of the testicles, may bear out the distinction drawn by Trousseau between mumps and parotitis. Mumps he regarded as engorgement (*fluxion*), but not inflammation of the gland.

Broadstairs.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

MIDDLESEX HOSPITAL.

CASES OF INJURIES OF PERIPHERAL NERVES.

(Under the care of MR. HULKE.)

SUTURE of severed nerve trunks—immediate wherever circumstances admit; where these do not allow it, then secondary suture, unless the interval of time since the accident is so great as to remove all expectation of benefit—is a practice based on such wide experience of its usefulness, and of its freedom from those risks once thought to be attached to it, that its neglect must be regarded as a grave omission. Mr. Bowlby's work, published in 1890, is an excellent summary of this subject, regarded from a clinical and an operative standpoint, and should be read by all interested in this class of injuries. There will long remain, however, some matters respecting which additional information is greatly to be desired. To mention only two points: (a) What is the longest interval after division of a nerve when suturing may be tried with some expectation of success? (b) the condition as regards restoration of function or otherwise at so great an interval after suturing as to fairly represent the final outcome. As concerns hospital patients, they seldom remain long enough under the observation of the same surgeon; but wandering from one hospital to another, and leaving London for the country, they are early lost sight of, so that in many instances the final results are not known. In the first of the following cases restoration of function soon began; it was not obviously interrupted by the supervention of suppuration, and it became complete. In Case 2, where suturing was also immediately practised, restoration of sensation was imperfect, motor conductivity was greatly impaired, and muscular atrophy was very advanced ninety-three days after the date of the injury. Here there had been considerable loss of blood; the wound had inflamed, there was some sloughing, and also free suppuration—all circumstances unfavourable to repair. In Case 3, the nerve not being completely divided, no suture was applied, the unsevered portion appearing to be a sufficient bond, and the early result was encouraging. In Case 4, which illustrates division of the sciatic nerve within its sheath by crushing,