has made he insinuates an egg; in a few hours the cellular tissue swells, a tumour is produced, and the egg becomes enclosed in a fleshy chamber, which not only serves for shelter and defence, but also for food, for the larva feeds upon it. The insect is about one-fourth of an inch long, and more than half an inch in expanse from the tips of the wings. It is pale, testaceous, clothed with a very short, silky pubescence. Notwithstanding the circumstantial account given by Olivier, it has been said that the gall-nut consists of four distinct parts, having every characteristic appearance of some other kinds of nuts which are well known to be the fruits of trees; an external or cortical covering, a resinous part, a shell and a kernel; indeed, Aikin, in his "Chemical Dictionary," has described all the parts with the greatest nicety; but those who take the trouble of examining gall-nuts do not find the corresponding parts. The nuts are always found perforated, they have a complete cavity, without the slightest appearance of any kernel. The nuts present an uneven tubercular surface, they differ much from each other in size and in colour, some not being much larger than a hazel nut, others about the size of a walnut. They are different in colour, and by this are known in commerce. Two sorts are principally recognised, the one is the produce of the first collection; they are of a blackish-blue colour, hard to break, and of a heavier texture. The others are of a whiter aspect, of a pale brown or whitish colour, smooth, round, easily broken, less compact, and generally of larger size, and are considered of a superior quality. They require heat for their complete solution in water, and the solution contains a large quantity of tannin. Alcohol digested on powdered galls takes up seven parts in ten, and ether five parts. A tincture of galls is to be found both in the Dublin and the Edinburgh Pharmacopœia; they differ in strength, but they both contain all the astringency of the galls. An infusion may be made with two drachms of bruised galls to twelve ounces of boiling water, and this is often used as an injection, and sometimes as a gargle for relaxed sore throats. It has been used as an antidote where an overdose of ipecacuan has been taken, and it quickly renders it inert. A drachm of the powder of galls to about eight ounces of lard, to which opium is occasionally added, forms a most useful astringent in chronic piles, and very speedily removes pain, and the intolerable sensation of burning which is sometimes so much complained of.

LIGATURE OF THE LEFT CAROTID ARTERY BELOW THE OMOHYOID MUSCLE.

To the Editor of THE LANCET.

SIR:—If the following observations on the mode of tying the subclavian and left carotid arteries, are likely to facilitate these operations, they are at the service of your widely circulated publication. I am, Sir, your obedient servant,

CHARLES EDWARDS, A. B., &c. &c.
88, Winchcombe-street, Cheltenham,
January 1, 1838.

First, then, with respect to the operation on the subclavian, outside the scaleni, internal to and beneath the omohyoid, and above the clavicle. Now, in this space, anatomically designated the posterior inferior triangle of the neck, the external jugular vein is liable to varieties of situation, and should be carefully avoided; in the first place, as a wound of it is embarrassing to the operator; and, secondly, ligatures on veins not being desirable.

I am aware that many suggestions have been already offered, by the different writers on the surgical anatomy of the vessels, as to the vein being drawn to the tracheal or acromial side, according to its distance from the outer border of the sterno-mastoid; yet these directions only refer to the management of the vein *after* the incision through the skin, platysma and fascia, for how could its situation be altered towards either side *whilst subjacent* to these textures and *unexposed*? But I must here be permitted to insist that *it is during* and *from the first incision* that the external jugular is principally endangered, and that the after-management of it, namely, whether it should be drawn to the tracheal or acromial side, or in what case it may, as Professor Cooper states, be indispensable to divide it after a double ligature, is *quite another*, although the next consideration. At the same time, I believe that no sufficient direction has been as yet given whereby we may safely and effectually complete our incision in depth, through skin, platysma, and fascia, and in the requisite extent, namely, from sterno-mastoid to trapezius.

If the external jugular vein lie close to the margin of sterno-mastoid, then, by commencing the incision on its acromial side, the vein may certainly be avoided; yet the incision may thus be *too limited*, it being often necessary not only to have it commencing at the outer edge, but even freely to divide the clavicular attachment of the sterno-mastoid, in order to get the ligature under the artery.

But the principal difficulty is experienced when the external jugular passes, as it frequently does, in the very centre of the space between sterno-mastoid and trapezius. Now, in this case, how is the operator usually circumstanced? He either makes an imperfect division of the parts through the *whole* length of the incision, or, *at least*, *over the vein*, or, perhaps, has recourse to two incisions, one on each side of the vein, or to repeated strokes of the knife; but, in either case, *the parts about the vein being imperfectly divided*, the operator next vainly essays to hook it to the tracheal or acromial side, and hence too often, I am afraid, concludes the presence of that emergency supposed to render indispensable the division and ligature of the vein.

In what manner, then, may *all* these difficulties be avoided, and in whatsoever part of the space the external jugular be situated, how may we freely divide skin, platysma, and fascia, commencing, if we please, at the mesial line, and carrying our knife uninterruptedly outwards, *ad libitum*, without the possibility of injuring the vein? I can accomplish all this by an expedient simple, and, therefore, the more valuable.

Since the external jugular vein runs down *beneath* the clavicle, to join subclavian vein, *draw down* the integuments of the neck to a sufficient distance *over* the clavicle, make your incision *at once* through skin, platysma, and fascia, *in the line of* and *upon* the clavicle, and when the pressure of the fingers, which, prior to the incision, drew down the integuments to the requisite extent over clavicle is removed, in the *retracted* condition of the same, the incision will exactly correspond with the *upper* border of the clavicle. We thus gain two points, first, by freely cutting the tegumentary structures *upon* the clavicle, we avoid the vein which runs *beneath* it; and, next, when the parts drawn down, prior to their division, are permitted to retract, we have an *effectual* wound in the *proper site*.

Secondly. Having thus proposed a new method of avoiding the external jugular vein in taking up the subclavian artery in its third stage, I proceed to consider some important points with respect to the parts concerned in the inferior operation on the *left* carotid, and especially of the anatomical relations of the thoracic duct.

Passing by its relations in the abdomen and posterior mediastinum, I shall confine myself to the parts of it connected with the operation, merely remarking, that, above the arch of the aorta, it ascends beneath the left pleura, *between* the left carotid and subclavian arteries, and along the left side of the œsophagus. Now I am induced to mention its relations here, because I apprehend that its situation in this part of its course, *external* to the carotid (as lying be-

tween it and subclavian), has led to the very serious mistake of its lying *external* to the carotid in its *entire* course as it ascends into the neck; whereas, in truth, the ascending portion of its arch gets *behind* the left carotid, and somewhat *internal* to it. If, in conjunction with this, we further consider a very important relation of the next or transverse portion of its arch, which has not been observed by the different writers on the vessels, namely, its peculiar relation to the pneumogastric nerve, we shall find that, as it passes behind this and the deep jugular vein, it is *crossed by the nerve exactly at right angles*, and that if, before we pass the aneurysm needle under the artery, we press the nerve and vein outwards, we shall, at the same time, drag the ascending portion of the arch of the thoracic duct more *outwards*, that is, *nearer to the artery* behind and *internal* to which this portion of the duct is situated; and consequently, in passing the needle, we should, by this approximation, take the very best method of endangering the ascending part of the arch, if, in truth, it can be in danger, lying, as it does, behind the sheath of the vessels.

Now I have been led to attach the more importance to these observations, because in a work, the very best on the surgical anatomy of the arteries, so far as my humble judgment and research are concerned, and one, too, of very great authority with the operating surgeon, namely, that by our esteemed professor in the *Dublin University*, Dr. Harrison, it is particularly directed "that the vein and par vagum be pressed *outwards*" before we pass the aneurysm needle. Now, it is with extreme reluctance that I am compelled to differ from so high an authority as to the management of both vein and nerve at this juncture, but I am confident that Professor Harrison, by reviewing the anatomy of the duct as I have done, namely, by inserting a blow-pipe in the vessel, and inflating it from the posterior mediastinum, after exposing its site in the neck, shall at once perceive that the ascending portion of its arch in the neck, is posterior, and somewhat *internal*, to the carotid artery; and that his caution to "remember the proximity of the thoracic duct," posteriorly and *externally*, is, in the first place inaccurate, as only the transverse and descending portion of the arch are external; and, secondly, might misguide the operator to a false security that by any effort at pressing *outwards* that which he supposes *already* and in *every part external*, he shall be further removing *every part* of the duct from danger.

Next, let the effect of pressing outwards the *vagus* and vein be tried, and Dr. Harrison shall find as the result, what I had the pleasure of demonstrating to several gentlemen last season, in Mr. Haydon's Anatomical Theatre, that the ascending portion of

the duct shall be thus approximated to the posterior wall of carotid in the first place, by the line of the traction from the pressure outwards of superincumbent parts, and, secondly, we should suppose, by the obstruction of the passage of its contents from the same pressure.

In what manner, then, may the aneurysm-needle be passed round the artery with perfect safety to *all* contiguous parts? I shall suppose the skin, platysma, and fascia divided; the sterno-mastoid drawn outwards; the sterno-thyroid and hyoid towards trachea; the deep cervical fascia divided; and the sheath of the vessels opened; and now I consider it a most important improvement, and an excellent adminiculum memoriæ, to divide the next proceeding, namely, the course of the needle, or eye-probe, into *two stages*, each requiring distinct management; first, its passage between vein and artery, in which we are to protect the vein; and, secondly, between the artery and pneumogastric nerve, in which we are to protect the nerve and the parts which are more directly behind the artery and its sheath, and among these the ascending and part of the transverse arch of thoracic duct. Now, in the former of these stages, I, of course, cannot object to what is absolutely necessary, namely, to so much pressure of the vein outwards as shall be sufficient to push it from the peculiar superincumbent position on the artery which exists on the left carotid; but as the needle passes farther along the side of the artery, I should advise the vein to be pressed more directly *backwards*, to avoid that portion of the transverse arch of the duct, as well as of other parts, which are now opposite the needle, and only separated by the posterior and external part of the sheath.

But it is in the next stage of the course of the needle that I would beg especially to differ from authors, and to propose a plan essentially different from what is generally directed. At this juncture I should, *in no instance*, attempt to draw the nervus vagus outwards, as I should, as before stated, drag that part of the duct which is behind, and *internal* to the artery, as closely as possible on the point of the needle, being merely protected by the intervening cellular sheath; but recollecting that important and beautiful relation of the nervus vagus to the transverse part of the arch of the duct, which I have *first* pointed out, viz., that it crosses the latter at right angles, I would advise that the vagus be pressed *directly backwards* against the longus colli; thus, separating the posterior wall of artery from the posterior part of sheath pressed backward by vagus, and, of course, at the same time from the parts posterior to the sheath, we can safely bring the needle between the artery and vagus, and close to the former; and now it only remains slightly to elevate the

artery, as it were, *from* the sheath, and somewhat in the direction outwards on the concavity of the needle. Thus we are sure that we include nothing but the artery in the ligature, and, by the slight traction outwards, we best avoid the oesophagus, which is here internally related to the artery.

It is evident that the needle has now completed its course around the vessel with all that perfect security which the knowledge of anatomical relations can bestow.

SYMPTOMS APPARENTLY VENEREAL
ARISING FROM
CONSTITUTIONAL CAUSES.

To the Editor of THE LANCET.

SIR:—The following case is presented for insertion in your Journal. I am, Sir, your obedient servant,

R. L. DAVIES, M.R.C.S.

37, Dorset-street, Bryanston-square,
January 1st, 1838.

M. J., aged 20, a kept woman, and one who had been subject (to within a week of the time that I was called to attend her) to promiscuous intercourse, was affected with the following symptoms:—A yellow, uniform, and continuous discharge from the vagina; a sore on the inner surface of the right labium; a swelling in the groin of the same side; an ulcerated sore throat, and followed in about a fortnight or three weeks, by a hard red swelling on the anterior edge of the tibia, and a similar swelling on the inner edge of the ulna.

The casual observer (and I do not mean to exclude myself from that class) would say that it was natural enough a girl placed under such circumstances should be affected with such symptoms, and without making the necessary inquiries would thoughtlessly jump to the conclusion that the case must be venereal. Let us, Sir, inquire into the causes of the symptoms in the present case, and in our investigation I think we shall see that we can more justly attribute them to an ordinary, or constitutional, than to a specific cause.

First. Of the Discharge.—Upon inquiry, then, I found that my patient had had repeated attacks of this symptom before; they had usually come on when her system was from any cause weak and debilitated, and had always given way to tonic medicines, astringent injections, and the recumbent posture. These discharges had always been uniform and continuous, and could only be distinguished from gonorrhoeal by their colour and absence of pain in micturition. The distinction, then, here is very imperfect.

Secondly. The Sore.—We all know when leucorrhoeal discharges occur frequently, or