The wound healed so kindly that the cicatrix could scarcely be perceived in a week's time. Nine months afterwards this man had no return of the disease.—*Dublin Quarterly Journ. Med. Sci.*, Aug. 1847.

47. *New Process for Removal of Toe Nail.* By M. LENO, Surgeon to the Civil Hospital of Toulon.—M. Long, basing his idea on the mode of connection of the nail with the tissues; conceived it possible to tear away the nail by its root, by the aid of a simple spatula. Numerous experimental trials made on the dead subject confirmed him in this opinion, and he became able to remove the twenty nails in the short space of five minutes. Some of the nails on some bodies he found to tear, and a similar thing happens if the nail has been softened by topical applications.

The mode of proceeding M. Long finds to be of easy execution, quick, and but slightly painful, requiring no preparation, and but an ordinary iron spatula to effect it. The patient is seated on a chair, his foot being placed on the knee of the operator; the latter takes with his right hand the flattened end of the spatula, placing his thumb on the concave surface, his index and middle fingers on the convex, his two other fingers being disengaged. The spatula being thus held, the surgeon slowly separates the skin, which covers over the root of the nail. Having gained its posterior border, he executes a rapid movement from side to side, so as to bring the spatula to a very acute angle with the diseased toe. This being effected, the end of the spatula is found engaged beneath the nail, which still adheres by its sides and middle portion. Then, by pushing forward the instrument between the nail and subjacent tissues, the evulsion is accomplished without any further trouble.

Such is the operation adopted by M. Long, and he has always obtained good results from it. Among the patients operated on by him, one may be cited. He was a custom-house officer, whose nail of the right great toe was deeply buried at its sides in the flesh, to the depth of about two-fifths of an inch. The evulsion of the nail was practiced without pain, and without the loss of a drop of blood. The next day, morning, the patient returned to his employment, and fifteen days afterwards a new nail made its appearance. M. Long also performed the operation in a man suffering from traumatic onychia, and having his nail also grown over by the flesh; on the fourth day the patient got up, and on the twentieth left the hospital, a new nail beginning to appear.

The proceeding advocated by M. Long, seems adapted for all cases, in which the evulsion of the nail becomes necessary. The advantages it offers are—1st, the prospect of a complete and definite cure; 2d, the sparing the patient great suffering; 3d, its performance being attended with no loss of blood; 4th, and lastly, always allowing the tissues to reproduce a new nail.—*Lancet*, Sept. 18, from *Gaz. Méd. de Montpellier*.

48. *On Abscess of the Female Breast.*—By M. VELPEAU.—“Subcutaneous inflammation of the breast proceeds much as an ordinary phlegmon. When the abscess is formed between the mamma and the chest, the swelling is considerable, the breast raised up, but after an incision the cure usually takes place rapidly. But when the phlegmasia invades the substance of the breast itself, it is rare to find only a single abscess produced. We sometimes see ten, twenty, forty or fifty manifesting themselves in succession. An instant's reflection will show that this result is a natural consequence of the anatomical disposition of the inflamed tissue. The glandular parenchyma consists of different lobules, each of which constitutes a little organ having its own function, and which may become heated and irritated under the influence of lactation. Each lobule does not attain at the same time the same degree of irritation. One first inflames, then suppurates, and constitutes a first abscess; a neighbouring lobule then becomes affected, and, in its turn, forms an abscess; and so it may go on with all of them until we have as many successive abscesses as there are lobules.

“This distinction of abscesses of the breast into at least three orders is of the highest importance; and if we do not adopt it, our ideas upon the subject will be but very vague, and devoid of all precision as respects prognosis and treatment. Parenchymatous abscesses may last four or six months, or a year even, according

to the rapidity of their succession and their number. The subcutaneous abscess lasts only as long as an ordinary phlegmon; and the submammary abscess has not the long duration of the parenchymatous one.

"Each of these has again its special treatment. We may endeavour to procure the resolution of *subcutaneous abscess*, and that by ordinary means: and, if suppuration occurs, we open it promptly, in order to avoid the burrowing of the pus among the tissues. *Sub-mammary phlegmon* should be treated especially by general measures, and leeches around the nipple. Topical applications are of little use, as they are separated from the centre of inflammation by the whole substance of the mammary gland. When an abscess is formed here, its prompt evacuation is desirable; but the perception of fluctuation is difficult, for the pus is surrounded by a large mass of tissues, and the thoracic parietes have not fixity enough to serve as a point of support. Nevertheless, you may recognize the existence of pus by the following characters. 1. An acute phlegmon rarely exists more than seven or eight days without suppuration taking place. 2. The breast is raised up like a sponge, and if we press upon it, it seems as if it were lying on a bladder full of fluid. 3. We find the breast surrounded by a kind of inflammatory œdema. Having recognized the pus, we should let it out promptly, or we expose ourselves to seeing it traverse the gland and form one of those abscesses I call *shirt-buttons*. These abscesses, moreover, have a mischievous influence upon the chest, and may lead to a purulent pleurisy. They may, too, penetrate into the cellular tissue for a distance, and give rise to a diffused phlegmon. The incision should be made into the most dependent part, the place of election being below and at the outer side of the nipple; but, in some cases, a projecting point of the abscess indicates the place at which the opening should be made. It is always advantageous to make the incision towards the circumference of the breast, because the gland itself is not touched, and its weight tends to expel the pus. The bistoury should be directed almost parallel with the thoracic parietes, so as to slide it in between these and the mamma. The danger of such incisions is not great, there being no large arteries to fear. *Parenchymatous phlegmon* requires an energetic and varied treatment—bleeding, purging, and the so-called anti-lactal medicines. When pus forms, which is almost always the case, topical applications and incisions seldom prevent the successive implication of the lobules. Nevertheless, there is some advantage derived from the prompt opening of the abscess, if the patient agrees to it; for you should recollect that, in practice, if you open one abscess and others form, she never fails attributing these to your proceedings. These details will, I think, suffice to show you how important it is to distinguish the different abscesses of the breast, and to explain to you the confusion which prevails in the minds of some surgeons, as regards their treatment."—*Med. Chir. Rev.*, Oct., 1847, from *Gazette des Hôpitaux*, No. 89.

49 *Indurated Chancre of the Neck of the Uterus*.—Although most, if not all, surgeons now admit the possibility of the existence of chancres on the os and cervix uteri, yet few cases are on record; and the following abstract of one occurring in the practice of M. CULLENEN, at the Hôpital de Lourcine, may prove interesting:—

A woman, seven months gone in pregnancy, entered the hospital, presenting, at the time of admission, a squamous and tubercular eruption over all the limbs. She stated that, up to the date of admission, she had been ill two months; that at the commencement of the disease, there appeared an ulcer on one of the external labia, and a profuse discharge from the vagina. On examination the morning after her admission, no trace of any ulceration was observed on the labia, but there was a vaginal discharge still going on. Examined by the speculum, the neck of the uterus was observed to be enlarged and flattened antero-posteriorly, so as to present a greater transverse diameter. Nearly two-thirds of the anterior lip were occupied by an ulcerated surface, of a grayish-yellow colour, and circumscribed by a circular margin of a deep-red colour. At first this ulcer was taken for a simple one, unconnected with syphilis; but at subsequent examinations, M. CULLENEN was led to believe it to be analogous to an indurated syphilitic ulcer, in which opinion he was afterwards confirmed by the touch, which rendered sensible that peculiar resistance which is noticed on touching an indu-