tions of iodide and bicarbonate of potash; but in others, the larger number, I combine in different proportions iodide of potassium and iodide of lead; for I find that of all absorbent applications, the iodide of lead is probably the most potent in cases of strumous and rheumatic thickening, but it must always be used with care, especially as it acts upon the gouty diathesis as a direct poison.

"Dr. Garrod has described, in his work on Gout, 'the influence of lead as a predisposing cause of gout' (p. 281, *et seq.*) I find, however, an important converse to this view—viz., the influence of gout as predisposing to lead-poisoning. The first notice which I received of this fact was in private practice. A gentleman for months laid up with gout, and tired of being overdosed with colchicum, sent for me. I ordered, among other things, an application to the foot, consisting of two parts of iodide of potash and one of iodide of lead. Next day—i. e., in twenty-four hours—he had symptoms of lead-poisoning, by no means slight, and the blue gum line well marked. This fortunately gave me a clue in another case I then had in hand, of a gentleman who always fell ill after residing some days in his town house. He was the only one of the family who suffered. These illnesses were all alike, and his stay in town was always terminated or closely followed by a fit of gout. Having been given the strong hint above mentioned, I thought I could trace somewhat obscure symptoms of lead-poisoning, and on examination the water was found to contain lead. Since the cisterns &c. have been changed, this regular sequence of events has ceased.

"Now you will observe that if any signs of gout are detectable in your patient, you will avoid the use of lead, and you may substitute a drug which in these cases is more useful—viz., the bicarbonate of potash, which has a chemically solvent action on gouty chalk-stone. You may apply the materials in solution. Let lint dipped into the fluid be placed round the joint, and over this oil-silk; or, if your patient be in bed, put a thick layer of wadding over the wetted lint, and confine the whole with tolerable pressure by means of a roller. The heat will add to the rapidity of absorption, and you will find this mode of application very efficient."

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LEEDS GENERAL INFIRMARY.

AMPUTATION OF FOREARM; VESSELS SECURED BY ACUPRESSURE; RECOVERY.

(Under the care of Mr. WHEELHOUSE.)

THE notes of this case have been furnished by Mr. T. E. G. Bywater.

The patient was a mill hand aged nineteen. Whilst cleaning a revolving cylinder armed with teeth, his right hand was caught by it and severely injured. The skin was completely stripped from the back of the hand. The wound extended from a point immediately above the wrist-joint to about a quarter of an inch below the metacarpo-phalangeal articulations. The patient could move the thumb and little finger, but the extensor tendons were quite bare; the skin of the outer side of the thumb was detached and very much crushed; a finger could be passed almost entirely round the metacarpal bone. The extensor tendons of the first, second, and third fingers were gone, and the upper halves of the corresponding bones were deeply rasped. The wrist-joint was laid open, and the os magnum was dislocated. The remaining part of the fingers and the palmar surface of the hand were uninjured.

Amputation having been decided upon, chloroform was administered, and the hand removed by taking a long flap from its palmar aspect and a short one from the back of the wrist. The radius and ulna were sawn through about two inches above the joint. The radial and ulnar arteries were secured by acupressure needles applied according to Sir James Simpson's third method—that is, a needle about an inch and a half in length, having a smoothly-twisted wire attached for the purpose of removing it, was passed into the soft tissues, a short distance from the artery to be compressed; then, being brought out by the side of the vessel, it was passed carefully underneath it, and again plunged into the soft parts beyond, its point being made to protrude in the wound. A loop of iron wire was passed over the needle point, the two

ends were brought over the artery so as fairly to compress it against the needle, and were fastened by a half twist round the shaft. An ordinary ligature was applied to the interosseous artery. The edges of the flaps were carefully adjusted and maintained in apposition by means of wire sutures, and the patient was put to bed without any dressing whatever being applied to the wound.

Four hours after the operation slight hæmorrhage occurred, and Mr. Wheelhouse was sent for. The bleeding was so slight that, under ordinary circumstances—as, for instance, if ligatures alone had been used—it would not have been thought necessary to open the wound; but this being the first case in which acupressure had been relied upon for the closure of main arteries, it was thought advisable to lay the stump freely open. The source of the hæmorrhage was found to be a small muscular branch, which had escaped detection at the time of the operation. The closure of the radial and ulnar arteries was perfect.

March 14th.—No further hæmorrhage; very little swelling or inflammation in the stump. The needles securing the radial and ulnar arteries pulsate very visibly.

15th.—The margins of the flaps are securely glued together, and there is very little swelling or redness of the limb; the pulsation of the needles has ceased.

16th.—Nine A.M.: Sixty hours after the operation the acupressure needles were removed; their withdrawal was effected with perfect ease, and no bleeding occurred.

17th.—Pulse 72, soft and regular; tongue clean; skin cool. There is scarcely any redness, and very little swelling in the arm. There is slight discharge of pus from the lower angles of the wound in the track of the ligature applied to the interosseous artery. The margins of the flap are firmly adherent.

April 18th.—Since the last report the patient has gone on perfectly well. The wound healed rapidly, and he is to-day discharged.

IMPERVIOUS STRICTURE OF ANTERIOR PART OF URETHRA AND URINARY FISTULA CURED BY THE FORMATION OF ARTIFICIAL URETHRA.

(Under the care of Mr. PRIDGIN TEALE.)

In the following case, which presented difficulties not very frequently met with, Mr. Teale carried out a plan of operation suggested to him by his colleague, Mr. Wheelhouse, during the consultation upon the case.

Joseph H—, aged thirty-six, was admitted into the Leeds Infirmary on Dec. 30th, 1866. Two years before, he suffered from a phagedenic chancre, which destroyed the under half of the glans penis, and, extending some way down the urethra, produced stricture of the meatus and anterior two-thirds of the urethra. This stricture was kept pervious until four months ago by occasional use of the bougie, and then became so much contracted that an instrument could not be passed, and all the urine escaped by a fistula at the side of the penis.

During January, frequent attempts were made to tunnel through the urethral cicatrix, but without success.

Jan. 31st.—Whilst Mr. Teale was considering the propriety of opening the urethra behind the stricture, and, by stitching mucous membrane to skin, of securing thereby a permanent opening even at the inconvenience of producing hypospadias at the root of the penis, a suggestion made by Mr. Wheelhouse appeared to solve the difficulty, and was at once carried out. The strictured urethra, extending backwards two inches from the meatus, could be readily felt as a hard cord, beyond which the remainder of the canal appeared to be perfectly natural. The loose skin covering the penis having been reflected from the corona glandis backwards, like an inverted glove, until the anterior two-thirds of the penis was completely denuded, the healthy urethra was opened behind the stricture, and the stricture and cicatrix were slit up as far as the meatus. A catheter was then introduced into the bladder, and laid in the newly-made groove in the strictured urethra. Lastly, the reflected skin was drawn forwards over the denuded penis and catheter, and stitched to the base of the glans.

Feb. 4th.—A narrow ring of the preputial skin has sloughed, and is partially detached.

12th.—Catheter removed.

March 7th.—Middle-sized bougie passed. Patient returned home.

April 23rd.—His medical attendant reports his condition as follows:—"He passes urine in a good stream through the opening you made, and can easily pass No. 6. All the fistulae are healed, and the man's health is quite restored."