bone, and hammered cautiously with a mallet in an inward direction till felt to be in the softer central part of the bone, when it was withdrawn and driven in towards the anterior surface of the bone in the same plane, then towards the posterior surface. On withdrawing the chisel and pressing the limb outwards with the line of incision fixed as the fulcrum, the hard bone on the inner side was easily snapped and the limb could be bent inwards and rotated apart from the upper fragment; it could not, however, be drawn down away from it, nor could it be bent much outwards. This appeared to be due partly to the firm contraction of the muscles and tissues on the inner side of the leg and partly to the locking on the upper fragment. A wedge-shaped piece of bone was therefore sawn off this, and a probe-pointed curved bistoury, passed into the wound round the anterior and then round the posterior surface of the bone, was made to cut through the fibrous tissues around it as far as was deemed safe without endangering the large vessels. Considerable traction being then made on the foot, the position of the limb judged by its inner aspect was found to be greatly improved, while the traction was maintained, though the upper fragment still remained in its previous position and its lower end could not be forced inwards, owing apparently to the contraction of the glutei. No spray was used during the operation, but the wound was constantly washed out with a 1 in 1000 per.

chloride of mercury solution, and after the operation about three drachms of a saturated solution of iodoform in ether was syringed into it; the wound was dressed with lint soaked in carbolic oil and the limb put up in a MacIntyre splint. The following day the morning temperature was $98^{\circ} 2'$, evening 100° , after which it never rose above normal during his stay in the hospital. The day after the operation the limb was taken out of the MacIntyre splint and an extension apparatus fastened to it, ten pounds weight being used, and the foot of the bed raised four inches, the heel being one inch off the bed, and the calf steadied by sandbags. The wound was syringed daily with iodoform dissolved in ether and dressed with carbolic lint; there was very little discharge from it, and it healed in three or four weeks. On Jan. 14th, elastic traction was commenced on the upper fragment by a broad piece of adhesive plaster fastened round the thigh just above the wound, both ends of it being carried under the left thigh and attached to a stout indiarubber tourniquet fastened to the left side of the bed, and attached when stretched so as to get considerable elastic extension inwards and slightly backwards on the lower end of the upper fragment. On Jan. 19th the foot extension weight was increased to 13lb., 2 or 3lb. of which were probably taken off the limb by the support of the sandbags; the foot of the bed was further raised to eight inches. On Feb. 14th the sandbag supports were discontinued, so as to get the entire weight for extension. On

March 25th the limb was examined with gentle movements. There appeared to be no adhesions in the hip-joint. Union had taken place between the chiselled ends of the bone, the limb moving as a whole up to the hip-joint. The adhesions were firm throughout the knee-joint, with thickening around it. There was a considerable amount of hard callus at the seat of fracture, and the limb appeared nearly straight, the femur operated upon being straighter than the other one. Extension and lateral traction were continued as before. April 25th: On examination, the right leg was found to be only from an inch and a half to two inches shorter than the left leg, and quite straight; the bony thickening about the seat of operation had diminished, and the femur felt quite sound and firm. The patient could move the right leg off the bed nearly as well as the left. The extension apparatus was discontinued. On May 1st the patient was anaesthetised with the object of breaking down the adhesions about the knee-joint and restoring its mobility; but, on partially flexing the knee, the patella still remained fixed on the condyles of the femur, and a depression formed below its lower border, with rapid effusion in the neighbourhood below the patella. It was found impossible to move the patella from its adhesions to the femur directly, and further force only increased the rupture of its ligamentous union to the tibia. The patient was therefore put to bed and evaporating lotions applied. Within a fortnight the swelling had subsided, and he could lift the foot off the bed with comparative ease. For the next two or three weeks he got about on crutches, after which he was allowed out, using two sticks, the limb being rather less than two inches shorter than the other. He was discharged on June 10th. His report the following November was that he could walk comfortably several miles without a stick though he generally uses one. The lameness seen in his gait is not very noticeable considering the shortening.

Guernsey.

CASE OF GANGRENE OF THE SCROTUM; RECOVERY.

By FREDK. W. GIBBON, L.R.C.P., L.R.C.S., L.S.A.

J. M—, aged thirty-five years, a master plumber, of robust frame, good family history, and of a healthy constitution, active and temperate habits, came under my care on Feb. 1st, 1889, suffering from laryngeal catarrh, attended by the ordinary symptoms. No especial fever or disturbance of the general system beyond increased huskiness of the voice and tickling of the fauces, supposed to have been brought on by cold whilst working overnight in a ship's hold. I ordered him to bed, and attended him until the 24th. On the 18th, however, he complained of hæmorrhoids. I did not examine for them, but simply ordered hot fomentations and a dose of castor oil, presuming that they were due to costive bowel and his lying up. On inquiry the following day they were better, and I heard nothing more of them during my attendance. On March 4th, however, he came to my consulting room, and informed me that he had taken another "bad turn with the piles" three days previously, and "that morning whilst at the closet felt something pricking at the back body, and, putting his hand down, drew from it a piece of stick." This was an inch and a half in length, with a sharp point, and most resembled a spike from a hawthorn tree. I take it to be a fish-bone of an unusually large size. I sent him home to bed, put him on light milk diet, and gave him an opiate. I had an urgent message to see him next day, as he was seriously ill. I found him in bed, with deep cellulitis of the left buttock, extending from the margin of the anus on the same side. His tongue was furred; great thirst. Temperature 99° ; pulse 100.4; respiration 36. He complained of great heat at the back of the body. I applied a lotion of lead and opium to the parts, gave a full dose of quinine, and thirty-minim doses of liq. ferri

every two hours. His pulse went up to 108; respiration 48; temperature 100°, rising and falling until March 9th. The cellulitis made a marked improvement, softening, yet spreading to the right buttock; and he continued to improve under treatment until the 8th, at 10 P.M., when I noticed a thin red line running along the median raphe, and the scrotum slightly enlarged, not painful, but erythematous. I took the precaution before leaving for the night to suspend the scrotum in a flour-bag, and promised to see him early next day. I failed to do so until 4 P.M. The scrotum was then the size of a child's head, and black gangrene had set in. I learned that his scrotum had commenced to swell at 4 A.M. and continued until I saw him. He did not complain of much pain, had no difficulty in passing his urine, and his stools were normal, but this was attended by marked typhoid symptoms. I called into consultation Mr. G. E. Williamson, surgeon to the Newcastle-on-Tyne Infirmary, and the scrotum was freely laid open, most fetid gas escaping on the incisions being made, and a boggy swelling from which ichorous pus exuded was opened over the tuber ischii, which on examination was found to extend upwards and inwards in the course of the rectum, although no fistulous opening could be detected or any opening from or into the bowel.

I continued the quinine and iron, and applied charcoal poultices to the parts, frequently washing with a solution of boro-glyceride, until the sloughs came away. The erysipelalous inflammation passed upwards to the abdomen as far as the umbilicus, and a gangrenous patch appeared in the right groin, midway between the spine of the pubis and anterior superior spinous process of the ilium. On the 23rd the temperature was 102.4°; pulse 84; respiration 26. I opened up this patch, letting free a quantity of pus, and passed a drainage-tube through to the opposite side, making another free incision where I detected pus. Another patch of gangrene appeared in the median raphe on the 27th; this I also opened up.

The whole of the scrotum came away, attended with frequent hæmorrhages, which gave a little trouble, leaving the testes exposed and the urethra intact. I now commenced to use chloride of zinc; but this caused so much irritation that I discontinued it next day, and used boro-glyceride until healed. The large surfaces exposed induced me to graft, all of which were successful, and the patient made so much improvement that he was able to be out of bed at the fourth week. During the whole attendance I paid particular attention to his dieting and medicine, having due regard to the great amount of erysipelalous inflammation I had to contend against. I have implicit faith in the boro-glyceride on account of its cleanliness, its non-irritant properties, and because I have always found discharges lessened by its usage—in fact, in all operations in which I have used it I have had unqualified success, and am confident nothing could have brought about such a speedy termination of the case.

Remarks.—The uniqueness of the case may account for my giving details in their entirety. It is difficult to understand how so large a foreign body could have been swallowed unconsciously, yet to my mind the peculiar tickling of the fauces was the first symptom of its presence. There was no history even of a fish dinner. There is no doubt that it punctured the rectum, and the faeces and faecal matter passed along, taking a course similar to that in extravasated urine, and resulting in gangrene of the entire scrotum.

Tyne Dock.

CHILDREN'S HOSPITAL, BRISTOL.—The work accomplished during the past year exceeded that of any previous twelve months. There were 753 children admitted. Of these, 385 were medical and 368 surgical cases. The deaths were 37, giving a mortality of 4.97. The special ward for measles had been utilised to great advantage. The numbers occupying the women's ward were considerably more than in past years, and the attendance at the out-patient department also showed a very large increase. The additional work done in the course of the year had involved an expenditure much beyond any previous year, and, with no corresponding augmentation in the income, there was a cash deficiency on the year of £448 10s. 10d. due to the treasurer.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CASE OF PRIMARY HYDATID OF LEFT LUNG.

BY FRANK NICHOLSON, M.D. LOND.,
PHYSICIAN TO THE HULL ROYAL INFIRMARY.

G. D—, a labourer, aged forty-four, was admitted under my care in the infirmary on July 2nd, 1889. He stated that he had had good health all his life, with the exception of "low fever" twenty-five years ago, when he was ill for three months. His present illness commenced nine weeks before admission, but he kept at work till June 27th. For nine weeks he had been complaining of anorexia, loss of flesh and strength, and for seven weeks he had had a slight cough. Five days before admission he had a severe pain in the left lumbar region, which still continued, and the cough was much worse, but there had been no shivering, sweating, or hæmoptysis. On admission he was a good deal emaciated, and had a bad cough, with copious muco-purulent expectoration, and he complained much of a severe pain in the left loin, which was worse on taking a deep breath. On physical examination there was marked dulness over the lower two-thirds of the left chest posteriorly, with feeble breath sounds and diminished fremitus; in front there was no dulness, but the breath sounds above the clavicle were harsh. On the right side the physical signs seemed natural. The heart appeared healthy, and there was no increased area of dulness or displacement. Neither the liver nor spleen seemed enlarged, and the abdominal organs appeared healthy. The temperature was 98.4°. A hypodermic needle was inserted into the ninth interspace posteriorly, but with a negative result. For the next six days the patient remained much the same, the temperature being 98.4° each morning and 100° to 101.4° each evening. The physical signs continued the same, so a hypodermic needle was again inserted (but higher up) in the seventh interspace, and it filled at once with thick pus. Looking upon the case as one of empyema, the surgeon of the week was asked to make a free incision. This was done the same day over the spot where the needle had been inserted, but with negative results. Nothing further was done for seventeen days, by which time the wound had healed, but the patient still continued to cough up a great deal of muco-purulent expectoration; the temperature was normal every morning, and varied between 99° and 101° each evening. On July 25th the patient stated that he felt distinctly better, and for three days his temperature had been quite normal both morning and evening. The physical signs were, however, as on admission, so a hypodermic needle was again inserted (a space higher) in the sixth space posteriorly; it filled at once with a perfectly colourless fluid containing a few whitish flakes, which was free from albumen, contained much chlorides, and, under the microscope, numerous echinococci and hydatid membrane. During the procedure the patient began to cough, and brought up in ten or fifteen minutes about two ounces of watery fluid stained with blood. It was obvious the needle had opened up a communication with the bronchial tubes. The temperature rose that evening to 102.5°, but quickly fell, and remained normal till his discharge on Aug. 15th, when he was coughing very little, and the expectoration was only slight. There was, however, yet a good deal of dulness at the left base posteriorly, and the breathing was feeble.

A few months later we heard that the man was well and at work, and not coughing at all. I may add that throughout no evidence of the existence of hydatid in the liver or elsewhere was discoverable. At first I did not recognise the nature of this case, but this is scarcely ever possible unless some of the cysts have been coughed up, or fluid containing echinococci has been withdrawn by syringe. I looked upon it, on admission, as a case of empyema. The history fitted in with this view; the physical signs were those of fluid at the left base, and the withdrawal of a drachm of pus seemed to clench the diagnosis. But a free opening into the chest by my surgical colleague failed to give exit to any pus. When later the