cutting off the lower end of the loop and bending an inch or more of each side bar inward at a right angle. Fig. 5. The bed splint is applied and pushed well upon the straightened limb, a point is marked on each side bar an inch below the sole of the foot, and an inch or an inch and a half below this; the side bars are cut off and the bend is made at the point marked. Figs. 6 and 7 show the tool used for cutting off these bars, and the process of bending them. A shoe is cut at the heel as shown at Fig. 8 or Fig. 9; a hole is bored through the heel, Fig. 10, line AB, or a slot made by a second hole, line CD, Fig. 11, and a tube inserted, Figs. 8 and 12, into the hole or tube the bent ends of the side bars are passed, the leather

Fig. 19.

strips drawn fast and sewed, and the limb tied or bandaged in place, as shown in Figs. 13, 14, 15, 16, 17. If the knee is swollen so that the inner bar presses against it, this bar is drawn outward with wrenches, or the tool, Figs. 18 and 19, employed. When a joint has been straightened under an anesthetic, it should be left in the splint, without change of shoe, stocking or bandages until all pain and tenderness have passed off. In a word, the joint has been more or less sprained by the maneuver, and must be treated with all the consideration which a sprain demands.

The deformity corrected, the patient should be kept off his feet until the muscular spasm which tends to deformity has subsided; then he may be allowed to walk about. If, for any reason, the patient has to be gotten up before this time, he should use crutches.

Is Fond of Press Clinics.—Superintendent Marks of the City Hospital, St. Louis, according to the veracious *Chronicle* of that city, has decided to admit reporters of the daily papers to the clinics of that institution.

STENOSIS OF THE LARYNX AND TRACHEA.

(Reported from the Transactions of the Chicago Medical Society.)

BY E. FLETCHER INGALS, A.M., M.D.

PROFESSOR OF LARYNGOLOGY AND DISEASES OF THE CHEST AT RUSH MEDICAL COLLEGE, ETC.

Dr. Ingals presented the history of a young woman, 23 years of age, who came under his care for stenosis of the larynx and trachea:

Five years previously she had been on the point of suffocation from the pressure of a large goitre, when tracheotomy had been done by Dr. Senn and artificial respiration established, which had saved her life. Dr. Senn had at that time removed a wedge-shaped piece of the thyroid and opened the trachea with the thermo-cautery. He had then introduced as a tracheotomy tube, a new device of his own, which possessed some advantages over the ordinary tubes.

Fig. 1.—Half size. Senn's tracheotomy tube.

A B—Rubber trachea tube. C D—Silver tube to be worn inside the rubber tube A B, as shown at c d.

This tube, represented in Fig. 1, consists of a curved silver tube about one-quarter of an inch in diameter and two and one-half inches in length, which was placed inside a rubber tube of the same caliber and about five inches in length, but which might have been either longer or shorter, according to the indications in the special case. The silver tube maintained the proper curve, and the whole was easily retained in the trachea. This tube, while in position, was cleansed by the patient by means of a feather, or after it had been worn for a few weeks it could be removed and cleansed, the patient having a similar tube to insert immediately after its removal to prevent contraction of the wound and trachea. The enlargement of the thyroid had practically all disappeared.

The patient had been referred to Dr. Ingals during the past summer by Prof. Senn, whom she had consulted at the Presbyterian Hospital, on account of inability to speak, or to breathe through the mouth. Dr. Ingals found complete closure of the lower portion of the larynx between the cords and the tracheal wound. Finding a cicatricial tissue so firm that it could not be torn, he passed a forceps down upon it from the mouth and cut down to the instrument from the external wound. The cicatricial tissue was very tough and about six millimeters in thickness. It was cut away upon the sides with the punch forceps shown in Fig. 2, which had

Fig. 2.—Ingals' punch forceps (half size).

been devised for this special purpose. The wound was then kept open by a rubber tube similar in size to that which had been used for the trachea. This tube was split down about three-quarters of an inch at one end, and the two sides were sewed together at the extremity, the edges of the cut being pared off so as to make an opening through which the tracheal tube could be passed. This laryngeal rubber tube

was passed upward, through the opening in the trachea, to the larynx, and the tracheal tube was passed through the place prepared for it in the end of the laryngeal tube.

Subsequently, after several experimental tubes had been made the laryngo-tracheal tubes, shown in Fig. 3 were constructed. Although somewhat larger in caliber than the rubber tube, the first of the silver tubes made had proven too small, and a tube, the caliber of which was about two millimeters greater than that of the rubber tube formerly worn had to be procured. Owing to the contraction of the trachea about two inches below the opening, whenever the tracheal tube was left out for fifteen or twenty minutes, it was necessary to make the silver tracheal tube long and formed, at its lower extremity, like the Durham tube. This silver tube the patient wore comfortably and with it was able to talk naturally. The author thought that the patient would be obliged to wear the tube the remainder of her life, because of the elastic stricture of the trachea about three inches below the glottis.

Fig. 3.—Ingals' laryngo-tracheal stenosis tubes (two-thirds size) A, cap with valve to prevent the escape of blast of air during phonation. B, middle tube. C, inner tube. D, instrument complete, all parts in position. E, outer tube.

In the discussion which followed, Dr. Wm. E. Casselberry referred to an interesting case which had been presented to the American Laryngological Association by Dr. Cohen, where the patient was able not only to speak, but to sing, although no air whatever could pass from the trachea to the mouth; and he inquired of the author of the paper especially regarding the voice in the case reported.

Dr. Ingals stated that the patient was unable to speak even in a whisper that could be understood; though by sucking air into her mouth before attempting to speak she could make some sounds with her lips, but the nurses and physicians at the hospital were unable to understand more than one word in ten; her friends, however, had learned to understand her by the movements of the lips.

Several months after the operation the patient was wearing the silver tracheal tube and speaking naturally.

A NEW RECTAL SPECULUM.

BY N. H. HENDERSON, M.D.
SURGEON LAKESIDE HOSPITAL, CHICAGO.

While one would think after examining the various rectal specula now on the market that there would be no room for another, experience has demonstrated

that there is. The new rectal speculum as shown in the cut below is sure to find a place in the hands of those who are giving attention to diseases of the rectum. By rotating handle, B, one-half, we completely close the opening, in which position the instrument should be when introduced. As will be observed, when the handle, B, is rotated directly over handle, A, we have a large opening, exposing almost one-half of the caliber of the rectum.

After introducing the speculum the handle, B, is to be rotated little or much, to expose little or much of the field as may be desired. In using the speculum in this way the plug is not necessary, but is only designed to be used in a rectum small enough to indicate a smaller sized speculum; in which case the inner speculum should be withdrawn and used with the plug. We now have two complete instruments capable of a great variety of adaptations.

It is not claimed for this instrument that it takes the place of all other rectal specula, but it will be found on trial, specially valuable in the management of diseases of the rectum. I claim for this speculum some advantages which others do not possess. Many patients present a redundancy of tissue just within the anus, so that when a bi-valve speculum is introduced the field of observation is obscured.

This speculum overcomes this, by supporting the entire circumference of the anus to a depth of three-fourths of an inch. It also holds back from the field of observation any fecal matter that may be in the rectum, which no other speculum does.

This instrument was made for me by Geo. Tiemann & Co., New York, and is also manufactured by Chas. Truax, Greene & Co., Chicago.

APPENDICITIS; WITH ORIGINAL REPORT AND ANALYSIS OF ONE HUNDRED AND FORTY-ONE HISTORIES AND LAPAROTOMIES FOR THAT DISEASE UNDER PERSONAL OBSERVATION.

Read before the Pan-American Medical Congress.

BY J. B. MURPHY, M.D.

CHICAGO.

PROFESSOR OF SURGERY, AND CLINICAL SURGERY, COLLEGE OF PHYSICIANS AND SURGEONS, CHICAGO; PROFESSOR OF SURGERY, POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL; ATTENDING SURGEON TO COOK COUNTY HOSPITAL; ATTENDING SURGEON TO ALEXIAN BROTHERS' HOSPITAL; CONSULTING SURGEON TO HOSPITAL FOR CRIPPLED CHILDREN, ETC.

(Continued from page 308).

Case 21.—Date of operation July 24, 1890. Operator, Dr. E. W. Lee. N. C., aged 34 years; female. Present sickness commenced July 16; complained of chills, fever, vomiting, and abdominal pain, latter more pronounced in ileo-cecal region. July 18, pulse 120, temperature 103 degrees. Slight tenderness in ileo-cecal region. July 21, pulse 124, temperature 102.5 degrees. Great pain over whole abdomen. Tenderness over ileo-cecal region marked and induration present. Operation: Appendicectomy. Appendix large, swollen, and tortuous; no perforation. Appendix contained enterolith in which was imbedded a small spicula of bone. There