placed on his side in bed with the head resting on a low pillow.

Results.—Up to the present we have used the above apparatus in 60 consecutive cases of nose and throat operations where a general anæsthetic of some duration was required; 43 were in hospital and 17 in private practice. Of the above—

- 7 were for submucous resection of the septum only.
- 4 were for submucous resection and removal of posterior ends.
- 22 were submucous resections of the septum with removal of one or both middle turbinates.
- 7 were submucous resections of the septum with removal of adenoids.
- 6 were for submucous resections of the septum with removal of tonsils, and in some cases adenoids as well. In one of these the tonsils were enucleated by dissection.
- 6 were for ethmoidal disease, and in one of these the antro-nasal wall was also removed.
- 5 were for middle turbinectomy, with removal of tonsils or adenoids as well.
- 2 were for œsophagoscopy.
- 1 was for excision of a malignant growth of the pharynx by external incision. In this case anæsthesia was maintained for one and a half hours through a tracheotomy opening. The patient, a woman aged 69, returned to bed with a pulse of 80, and made an excellent recovery.

In three of the cases a preliminary injection of morphia and atropine was not made, but it was found that much more ether has to be used to maintain anæsthesia, and the increased secretion of mucus and consequent cough were undesirable. The ages of the above patients varied between 14 and 69 years; 36 were males and 24 females. All types of patient were represented; 4 were asthmatics.

Where chloroform has been the anæsthetic employed it was our experience that post-operative vomiting frequently occurred, but in the majority of the above cases there has been no vomiting at all, and in no case has it lasted for more than one or two hours after operation. There have been no post-operative lung complications.

In conclusion, we would like to point out the following advantages in the above method:—1. Its greater safety in comparison with chloroform, especially when adrenalin has been applied. 2. The ease with which a light and even anæsthesia can be obtained. 3. The good colour and strong pulse maintained throughout the operation, and consequent freedom from anxiety. 4. Less post-operative vomiting. 5. Less after-shock. 6. The use of the foot bellows leaves the anæsthetist's hands free to adjust the head, or in other ways to assist the surgeon.

THREE CASES OF INFANTILE CONVULSIONS.

By JAMES GILROY, M.B., C.M. GLASC.

THE first case is that of a girl aged 3 years, to which I was hastily called on July 31st. The history is as follows. The patient was put to bed well the night before, but on awaking at 7 A.M. she went into a fit. Medical assistance was sent for and arrived at 10 A.M., while she was still in that condition. I saw her at 1.30 P.M. I was informed that the child had had hot baths, &c. She was still unconscious, the breathing being jerky and rapid. The temperature was 102° F. and the pupils were widely dilated. The jaws were not clenched, so that the tongue could be looked at, but the thumbs were inverted and all the signs of clonic spasm were present. Acting on the success attending another anterior case, I injected a solution of sulphate of magnesia into the rectum. This had no effect, and was followed by a hypodermic injection of 1/100th gr. of hydrobromate of hyoscine. Cold cloths (not ice) had been persistently kept at the head. A third medical man arrived about 3.30 and advised cold pack, which was done. I noted that about 2.30 the breathing altered, becoming very rapid, strongly expiratory, and coma deepened momentarily, after which the convulsive spasm seemed to ameliorate, but consciousness did not return. About 3 P.M. I took a few ounces of blood from the right median basilic vein. Normal saline was later injected into the rectum. The child lingered till 6.30, when she died.

The next case contrasts strongly with the one indicated above. A little girl of South African nationality, aged 3 years, residing here on holiday, had a fit after being in strong sunshine. I happened to be in the neighbourhood and at once attended the case. The spasm was so marked that I placed a piece of wood between the jaws, and the rectal injection

of sulphate of magnesia seemed at once to terminate the seizure.

The third case was that of a boy, aged 2 years, who had a severe seizure in bed at 11 P.M., and another practitioner and myself saw him repeatedly during the night, administering chloroform, injecting chloral and bromide of potassium, and wrapping in hot steaming blankets, all to no purpose. He died about 6 A.M. in the most severe fit I have witnessed, grinding his teeth incessantly, his veins prominent, and no sign of returning consciousness.

In giving a little careful thought to these very similar cases I have wondered if trephining the skull, carefully incising the membranes and raising them gently and letting away cerebral fluid, would not succeed. I go on the analogy of a case of stertor and profound coma in an adult where that procedure was so successful that consciousness returned before he was removed from the operating table. In these infantile cases there appears to be effusion—something that no drug can reach. The brain seems firmly gripped by some extraneous force. Why should trephining not be done? I should be grateful for an expression of opinion in this matter. Infantile convulsions is a condition we have too little real knowledge of. There is a stage in the respiration in these and many other cases I have seen where it gets, it would seem, out of all control by the brain. It runs away, so to speak, and cases will last for days in this state. Are we to stand helplessly by?

Ecclefechan.

OVARIAN CYST EXPOSED PER VAGINAM DURING DELIVERY BY A MIDWIFE.

By D. C. KEMP, M.R.C.S. ENG., L.R.C.P. LOND.,
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THE patient, a Tamil Mahomedan woman aged 30, was delivered of a full-term foetus on the morning of her admission to hospital, but actually before admission. The midwife relates that just before the child was born, the membranes being already ruptured, there appeared a membranous, as it seemed, presentation beside the head. She thought it was a second membrane. Whether she actually interfered with it or not is in question, or whether it was a thinned vaginal wall or not is uncertain, but the result came about that the "bag" suddenly protruded out of the vagina and was found to have a pedicle about an inch thick, the "bag" being of the size of a smallish cocoanut. The child immediately after was born and the placenta came away naturally, but the "bag" remained attached by its pedicle to the inner parts.

The patient was then brought to hospital in this state. Only a very superficial examination, and owing to the tender state of the vulva and vagina a minimum of handling of the parts, was made; it was seen that a cystic tumour was present in the appearance of a "bag." The pedicle, two and a half inches in length, could be felt to extend to as far as what seemed the anterior wall of the vagina or cervix (an erroneous conclusion), and a very patulous state of the cervix, as it was afterwards ascertained to be, gave the impression that a further cystic condition was internally extending beyond the pedicle.

The patient's general state of health being very good considering she had just been delivered, and there being no indication for immediate interference, the cystic tumour was supported on towels and wrapped around in aseptic gauze dressings to be later more carefully dealt with. Gentle irrigation with iodine solution was ordered to be given at a spot behind the tumour, where it was felt there was free egress to the fluid. The condition at this time was not diagnosed, but the possible view was that the tumour seemed to be an unusually large fibroid of the uterus or vagina (possibly), and it had become cystic to so great an extent that it was one "bag" of fluid, which had a wall so thin that at one part it had almost ruptured, and looked at this part like the very fine dark inner membrane of the tunica vaginalis in a hydrocele which one operates on and exposes just before stripping it from the scrotum.

Two or three days later, the patient being in the meantime in no pain or distress, and with no temperature or other morbid sign or symptom, the tumour was very closely examined under an anæsthetic. It was then recognised