

times a day) prescribed. On May 5th the wound had healed, and the patient appeared as in Fig. 3. Phonation had greatly improved. The patient was discharged, with directions to continue dilatation of the nostril, which showed a tendency to contract.

Remarks.—There was no clear history of syphilis on the parental side, and the case was sent to St. John's Hospital as one of lupus. The absence of lupus on the face, and the limitation of the rapidly destructive processes to the nose and naso-pharynx, rendered such a diagnosis inadmissible. The good effect of iodide of sodium in full doses (forty-five grains a day) was well illustrated in this case. Whether the syphilis was inherited, or acquired accidentally in childhood, I am unable to decide.

Hereford-square, South Kensington, S.W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

WHAT IS THE AVERAGE LAPSE OF TIME BEFORE THE RETURN OF CANCEROUS DISEASE AFTER OPERATION?

By FRED. A. A. SMITH, M.D.

We all know how difficult it is to get patients the subjects of cancer to submit to an operation before the disease has made such progress that life becomes unbearable. Then, and not till then, will they submit to an operation which for obvious reasons is too often only palliative, with the consequence of an early return of the disease and death. My reason for writing these few lines is to show in a small way how great the boon might become would patients only submit to early operation. Even should the tumour be found after excision to be innocent, a constant source of mental discomfort is clearly removed, and tumours of all descriptions are unsightly and troublesome. The subjoined case was operated upon by me in 1868, and until a few weeks ago the lady has had no return of the disease, when she observed two small tumours in the cicatrix of the former operation, with constant pain.

In 1868 a lady, aged forty-one, consulted me about a painful tumour in her right breast. It was the size of a large walnut, smooth, and movable in all directions. She was advised to submit to an early operation, and after a few weeks' consideration consented, the consequence being that for nearly nineteen years no return of the disease took place. After excision, well-marked cancer cells were observed under the microscope. I should like to know whether many such cases have been observed, and whether an early excision of the secondary growth is not equally advisable, because the lady does not wish to have the tumours removed. At present they are small, smooth, and movable, but may rapidly enlarge at any time.

Cheltenham.

A READY METHOD OF REMOVING FOREIGN BODIES FROM THE ANTERIOR NARES.

By T. OSBORNE-WALKER, M.R.C.S.

I HAVE many times been called upon to remove peas, buttons, and various substances from the nostrils of children, who have themselves introduced them there. The last case occurred to a little boy, whom his mother brought to my surgery on Aug. 1st with a boot-button tightly impacted in the angle between the vomer and os nasi at the bridge in the right nostril. Ineffectual attempts at extraction had evidently been made, as shown by blood oozing from the nostril, and some, coagulated, adherent to the button, partially concealing its outlines from view, and also by the button being fixedly jammed in. As is my practice in such cases, I first confined, to prevent struggles and interruption, the child's arms, hands, and legs, by folding tightly round these and the body a long, clean white apron, which the mother was wearing, and then, placing the child on his mother's lap, facing a window, while I stood behind the patient, and,

bending over and depressing with two fingers of my left hand the apex of the nose, to admit as much light as possible upon the object to be removed, I introduced with my right hand very carefully, to avoid its descent into the pharynx or larynx, the spoon end (with the concavity directed forward) of an ordinary pocket-case director, with which I ejected at once the button with a simple lever movement or jerk.

By attention to the following points the removal is instantaneously effected: The close confinement of the hands, arms, and legs by a shawl, blanket, or apron; a good light; a reliable person to securely hold the child; the position of the operator behind the patient; depressing well the apex of the nose to obtain a good view of the object; and lastly, getting the concave face of the spoon of a director fairly behind the body before making the forward lever movement.

Crick.

IMPERFORATE ANUS.

By JAMES DALGLEISH, M.B., C.M. EDIN.

THE following case is, I think, worthy of consideration as showing how much may be left to nature in the repair or growth of the tissues in very early infantile life.

My attention was called to the fact that an infant, otherwise quite healthy, at the fourth day of its life had not had any motion of the bowels. On examination I found the anus apparently normal. The appearance was, however, deceitful, as on entering my digit I discovered that it terminated in a *cul de sac* about an inch deep. I pierced the mucous membrane forming its floor, through an ear-speculum, with a tenotomy knife, but was disappointed to find that no meconium appeared, and that evidently there was more abnormal than the septum of mucous membrane I had expected. The child was being well nourished and showing little sign of discomfort. The next day I operated. Without enlarging the natural external aperture, which was dilatable enough to admit my forefinger, I found by cutting through an amount of cellular tissue, which occupied the place of the rectum, that the bowel terminated as high up as my finger could just reach with an effort—i.e., about three and a half inches. With my finger, carbolised, I broke down a clear passage to this point, and, pushing my knife on the flat along my finger, I freely incised an opening in the gut, when there was a most plentiful flow of meconium, and presently the ordinary faecal discharge. Beyond instructions towards the greatest possible cleanliness, I took no more pains in the case, and now, two months later, there has evidently been a downward growth of the mucous membrane to form a rectum. The child has regular motions, and, as far as the *prima vie* are concerned, has never shown a bad symptom. The reservation I make simply refers to an attack of bronchitis from which it has since suffered.

Trowbridge, Wilts.

CASE OF SUPERFETATION.

By GEORGE GILES, L.S.A.

As there has been a great diversity of opinion upon the possibility and probability of the above subject, the following facts may be of interest.

On Aug. 6th, 1887, Mrs. H—, who had gone to visit her mother in Holbeck, was suddenly taken in labour, and Dr. Mann (Messrs. Mann and Woodcock) attended, and delivered her of a foetus at half-term about 8 P.M. Being compelled to go to another case about 11 P.M., Dr. Mann requested me to call and see if it was not a case of twins. I did so, and on external manipulation found another foetus, and which I got away alive (the first being dead), about fourteen inches long, weight about four pounds, and which appeared about seven months and a half old, although very livid. This child lived from two to three hours. The placenta were quite distinct (the second placenta being of a large size). The liquor amnii was also separate. It is quite evident that when gestation had progressed from two and a half to three months, in the case of the elder foetus, that a secondary conception undoubtedly took place, the second ovum becoming developed independently of the first. I have preserved the first foetus, the second having been interred before I called again. The question of bifid uterus I did not ascertain, but up to the present the woman is doing well. Playfair says it is probable; Galabin does not make any note of it.

Leeds.