

A NEW METHOD OF MANIPULATION FOR THE REPLACEMENT OF THE LOWER JAW WHEN DISLOCATED.

BY FELIX ROTH, M.R.C.S., L.R.C.P.

THE patient is seated in an ordinary cane-bottomed chair ; the operator stands before him with one foot placed slightly to the right side and the other just in front of the patient and in the middle line. The operator is thus on a firm basis, with the legs well apart and fully extended. He then flexes himself at the hips and asks the patient to lean forwards and to place his forehead in the middle of the sternum of the operator's chest (but this position varies with the size of the patient's head). The operator now flexes his head so that his chin grips the patient's head about the upper part of the occipital bone ; he thus acquires a firm hold and has the head well under control between his chin and chest. The thumbs, protected in the usual manner, are placed in the patient's mouth and the fingers of both hands grasp the lower jaw. In this position reduction is facilitated, and the advantages over the ordinary methods are as follows : (1) The operator has the head under perfect control and perfectly fixed ; (2) the line of force exerted by the operator's hands acts in the same line as the resisting force exerted by the operator's chin ; (3) the operator's elbows being well flexed, he can exert a greater power by the force acting through the thumbs being close to the shoulders, and it will be found that he has greater power of muscular action in the terminal phalanges of the same ; (4) the patient's head is also in a better position for replacing a dislocated jaw ; (5) the operator needs no assistant and does not inconvenience his patient by the excessive pushing and pulling about of the head during the reduction.

George-street, Portman-square, W.

ULCERATIVE TUBERCULOUS AFFECTION OF THE LOBE OF THE LEFT EAR,

WITH ANÆSTHESIA OF THE SAME SIDE OF THE FACE, COMPLICATED WITH SCABIES.

BY W. GILMORE ELLIS, M.D. BRUX., M.R.C.S., L.S.A.,
MEDICAL SUPERINTENDENT, GOVERNMENT LUNATIC ASYLUM, SINGAPORE.

A PORTUGUESE Eurasian lad aged twelve, fairly well developed, mulatto coloured, hitherto healthy, was brought to me on Dec. 16th, 1892, suffering from ulceration of the lobe of the left ear, the affected part itching considerably. The lobe was swollen, livid and nodulated, ulcerated in places, and discharged a sanious fluid of a peculiarly disagreeable odour. The patient stated that fifteen days previously he had been bitten upon this ear by a mosquito, that the puncture had caused excessive irritation, and the above described condition had rapidly ensued. He also complained of almost complete anæsthesia of the left half of the face above the level of the angle of the mouth, and added that he had noticed this loss of sensation for about a year. The boy was stripped and thoroughly examined, but nothing further abnormal could be discovered. As I had a suspicion of leprosy, two of the nodules on the ear were compressed until they were anæmic and then pricked with a needle, and cover-glass preparations were made of the clear serum that exuded. These were double-stained by Ehrlich's method, as recommended by him for staining the bacilli of tubercle. The preparation first examined showed under a quarter-inch object glass two female acari scabiei, and under a one-twelfth homogeneous oil immersion lens numerous bacilli lepræ, some of which were apparently within one of the acari, although it is possible that they were above or beneath it. Many bacilli lepræ were also to be seen about the legs and body of the acari and in other parts of the field. Large numbers of similar bacilli were present in the other preparations and in preparations of the sanious discharge from the ulcerated portion of the ear, some lying free, some in cells about the nuclei, and some in small masses resembling little balls. No bacilli were to be found in blood from the diseased ear nor in serum from the anæsthetic patch, and although careful search was made no more acari could be discovered. The bacilli seen were very like the bacillus tuberculosis, but somewhat smaller, straighter and less rounded at the ends. The

family history of the boy was bad : his mother suffered from advanced pulmonary tuberculosis, and her father, uncle and grandfather died of lung mischief ; her brother also, but a few months ago, had severe hæmoptysis. The father of the lad denied having had syphilis. None of the members of the family have ever been known to be leprosy. The boy himself, however, had been in the habit of playing about an old leper's house, although he denies ever having entered the house or having had any contact whatever with the man. I saw the patient again on Jan. 13th, 1893. The anæsthesia was more marked and the lobe of the ear was thicker, but the ulceration was tending to heal. Some slight thickening of the second toe of the right foot—which had lost its nail—was noticed. There has been no itching since the removal of the acari. Mercurial ointment to the ear has as yet been the only treatment. Crowds of bacilli were again found in the discharge from the ulcer and in serum from the nodules.

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Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. BARTHOLOMEW'S HOSPITAL.

TWO CASES OF LAPAROTOMY, ONE FOR RUPTURE OF THE FEMALE BLADDER AND THE OTHER FOR ACUTE LOCALISED INFLAMMATION OF THE ASCENDING COLON.

(Under the care of Mr. HOWARD MARSH.)

IN commenting on this case Mr. Marsh remarks that, as rupture of the urinary bladder has as yet been treated in comparatively few instances by laparotomy and suture, it seems desirable that for the present every example should be recorded. Each must afford useful information in regard either to the course which these cases take or the different steps of the operation itself. In the present case the operation was performed eighty hours after the rupture had occurred. This is probably the longest period that has elapsed in any instance between the accident and the operation. It is needless to say that such an interval must in itself render success almost hopeless. In the majority of cases the period has been under thirty hours. In Mr. Heath's case, however, it was forty-two hours and a half and in Mr. McGill's sixty-six hours. Both patients died. In the present instance the abdominal cavity had become distended with urine mixed with blood-stained serum. This composite fluid had, however, apparently undergone but little putrefactive change ; it was not ammoniacal and had no odour of decomposition. The intestinal coats were somewhat thickened and injected ; but no lymph effusion was present, so that peritonitis, though it had been already developed, had not been intense, nor had it reached an advanced stage. It was, in fact, a matter of surprise to notice how comparatively little the peritoneum had suffered from its long immersion in urine, and also how slight a degree of decomposition the urine had undergone. It seemed doubtful at the time whether it might not be wise to introduce a glass drainage-tube into Douglas's pouch. It was determined not to do so, as the peritoneum had been thoroughly irrigated and sponged dry.

CASE 1. *Rupture of the female urinary bladder ; laparotomy eighty hours after the injury ; fatal peritonitis.*—A woman aged thirty-four while intoxicated was kicked in the abdomen and otherwise very roughly used on the evening of Aug. 2nd, 1892. It was difficult to obtain the facts, but no immediate symptoms seem to have been developed. On the 5th the patient applied to a surgeon and said that she had passed only a teacupful of urine since the injury. A catheter was passed and only two ounces of blood-stained urine were withdrawn. On her admission immediately afterwards she looked ill and distressed and presented several bruises about the abdomen and other parts