collected and about a pint was wasted. Air entered the chest freely. When I introduced my finger through the ribs, I could not reach the lung for at least half an hour after the incision was made. When the lung did expand the surface of the pleura was found to be quite rough. A tube four inches long was inserted downward and backwards, and I applied a small dressing of boracic lint soaked in mercurial solution. Within an hour the heart sounds were to be heard under the left breast. Friction was heard posteriorly as soon as the pleural surfaces were apposed. The friction gradually appeared from above downwards, as the expansion of the lung was very gradual, and when I left it had not fully expanded at the base, which I proved with my finger. The pulse tracings, taken every few minutes, were very interesting. Before the operation it was a slight deviation from a straight line, being so feeble. Soon after the operation the pulse wave expanded, getting larger and fuller until there was a full, sharp, apex systolic wave with a marked dicrotic wave, showing low arterial tension, due to the relaxation of the arteries and the removal of the pressure on the heart and main vessels.

6th.—Temperature 101°; pulse 120; respiration 32. The wound was dressed under the spray. There was a free serous discharge through the tube, and air enters with inspiration. The physical signs of pleurisy are well marked.

7th.—Temperature 101°; pulse 120; respiration 26. Wound dressed and tube removed. I inserted my finger to feel the pleura. It felt rough and spongy, like the placenta. I passed my finger round, separating the adhesions of the two surfaces, and it reminded me of a case of placenta prævia. It was the adhesion of the surface that determined me to remove the tube.

8th.—Temperature 101°; pulse 108; respiration 26.

10th.—Temperature 100°; pulse 98; respiration 24. Wound dressed. Very little thin serous discharges. Physical signs normal over both lungs. I could not trace the cause of the slow fall in temperature. The patient, though very weak, is doing well, considering that she was at death's door before I operated.

15th.—Temperature 99°; pulse 90; respiration 20. Wound dressed, and healing satisfactorily. Before the operation I measured each side of the chest from the anterior to the posterior mesial line just below the mammæ. The right half was 16 in., the left 17½ in. To-day, five days after the operation, each side measures 16 in. alike. The spine is perfectly straight, and the left chest is not shrunken. These results could not be attained by aspiration, however skilfully done. The patient was soon restored to perfect health.

Leytonstone.

A CASE OF SUPPOSED FRACTURE OF NECK OF SCAPULA.

BY G. Y. EALES, M.R.C.S. ENG., L.R.C.P. ED.,
HOUSE-SURGEON, TORBAY HOSPITAL; LATE ASSISTANT DEMONSTRATOR OF ANATOMY AT ST. GEORGE'S HOSPITAL; AND SENIOR ASSISTANT-SURGEON, SIRHOWY IRONWORKS.

LAST September R. B——, aged fifteen, a spare, delicate-looking lad, came to me with an injury to the left shoulder. He was playing with several boys, butting at each other with folded arms, when he was knocked over and fell on his left shoulder. On examination I found the following points of observation:—1. Considerable bruising of the deltoid. 2. The acromion process prominent, with depression underneath, and outer third of the deltoid flattened. 3. Arm lengthened about an inch and a half, and drawn away slightly from the side. 4. A rough object high up in the axilla in the neighbourhood of the neck of the scapula. 5. Humerus rotated freely and smoothly, and with but little pain. 6. A round projection in front and below the shoulder, which proved to be the head of the humerus on rotating that bone. 7. On raising this projection upwards, outwards, and backwards, crepitus was produced; the contour of the shoulder was restored, with disappearance of the deformity. 8. Slight increase of vertical measurement around the joint. 9. Great freedom of passive motion, with but little pain.

Owing to the bruising I was unable to manipulate the coracoid process; I therefore put the arm up with a pad in the axilla, with the elbow raised and bandaged to the chest. Five days afterwards, the bruising and swelling having partially subsided, I took off the bandages and found the same condition of things as when I first saw him, but much more plainly. On raising the head of the humerus all the symptoms disappeared, accompanied by loud bony crepitus audible to the bystander; and on removing the reduction force all the above-named symptoms again appeared. I was struck with the ease and comparative absence of pain with which the fracture could be reduced, also the readiness with which it became displaced on removing the reduction force. The rough object in the axilla was now more distinct, and disappeared on reducing the fracture, and was apparently the scapular neck. I now noticed also that the coracoid process did not appear to move on reducing the fracture.

Remarks.—The noteworthy features of the case were (1) the ease with which the fracture could be reduced, together with the ensuing deformity on removing the reduction force; (2) the great freedom of passive motion; and (3) the striking resemblance to dislocation into the axilla. With regard to this latter, the lengthening of the arm, the freedom of passive motion, and the easy reduction of the deformity in the way I have mentioned were sufficient to exclude simple dislocation into the axilla. The other lesions which this injury simulates appear to be (1) dislocation of the humerus into the axilla, with fracture of its neck; (2) separation of the epiphysis of the humerus; and (3) dislocation of the humerus into the axilla, with fracture of a portion of the glenoid cavity of the scapula. The lengthening of the arm and the movement of the head of the humerus on rotation are against the first two. Holmes, in his System of Surgery, states that it is the opinion of most modern writers on surgery that a simple fracture of the anatomical neck of the scapula never occurs, and that Malgaigne has shown that the symptoms of the supposed lesion are identical with those of dislocation of the humerus into the axilla, with fracture of a portion of the glenoid cavity of the scapula. In another place Holmes admits that the two lesions are indistinguishable during life. I hardly dare to express an opinion in the face of such high authority; but why should not a simple fracture of the anatomical neck of the scapula occur as readily as the more complicated injury? because the force to produce either must be of the same nature and very considerable. It appears to me that the symptoms of this case are so analogous to those quoted by Dr. Lotzbeck of Munich[1] and that recorded by Spence,[2] and bearing in mind the fact of the coracoid process being apparently stationary, that I feel justified in saying that in all probability this was a case of fracture through the anatomical neck of the scapula.

The lad having passed from my care and observation for treatment by another surgeon, I am unable to give any details of the progress of the case, but I afterwards ascertained that he eventually gained very good use of the arm.

Torquay.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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.

WEST LONDON HOSPITAL.

ABSCESSES OF THE NECK AND BEHIND THE PHARYNX, ALMOST CAUSING DEATH FROM SUFFOCATION.

(Under the care of Mr. WAINWRIGHT.)

ABSCESS at the back of the pharynx is a very formidable disease, as is illustrated by this case, and requires the most prompt surgical treatment. The chief danger is that of suffocation, either from œdema of the glottis or the mechanical effect of the swelling. In this case the relief afforded by incision of the external abscess made it probable that the post-pharyngeal abscess communicated with it, but the subsequent progress of the case negatived this view.

[1] See New Sydenham Society's Biennial Retrospect for 1867-8, p. 240.
[2] Edinburgh Medical Journal, 1863.

Simple incision with a guarded knife is usually sufficient to relieve the symptoms; but occasionally tracheotomy may be required, as in a case which was recently under our observation, where the flow of pus from the abscess was so copious as to stop respiration. For notes of the following case we are indebted to Mr. R. Lake, house-surgeon.

On May 10th, 1886, an adult, G. H——, was admitted into the hospital suffering from attacks of dyspnœa. His voice was low and harsh, his face very anxious, and the breathing distressed, with frequent attacks of dyspnœa. On examination of the neck a large fluctuating swelling was found beneath the trapezius on the right side, and on looking into the mouth the pharynx was found bulged out on that side and pushed towards the left. There was much swelling in the right submaxillary region. He gave the following history: The swelling with pain began six weeks previously, and there had been gradually increasing dysphagia, so that for the last seven days he had only been able to swallow fluids. He had had syphilis five years previously, and some months ago a general eruption of rupial character broke out, from which he is still suffering.

An incision was made into the abscess under the trapezius, with antiseptic precautions, and about two ounces and a half of pus let out. This relieved the breathing, and it was hoped that the other abscess would be emptied through this. He was given ice to suck.

May 4th.—At 1.30 A.M. he had become much worse; the breathing stopped entirely for a few moments, and it required artificial respiration to bring him round. An examination was now made with the laryngoscope, and there was found to be a large amount of œdema of the right side of the pharynx and tongue, and a swelling on the same side involving the whole of the right side of the pharynx, and projecting beyond the middle line. This was incised, and about two ounces of fetid pus escaped. The symptoms were at once relieved, and when the patient spoke it was with a voice which was now full and clear.

12th.—A mixture containing ten grains of iodide of potassium was ordered, and he was placed on a diet of meat, and allowed stout. He was able to take solid food for the first time during nine days.

14th.—The incision in the pharynx had closed, and so was reopened, two ounces of glairy fluid escaping.

17th.—The dose of iodide of potassium was increased to twenty grains.

20th.—Much better. There is only slight discharge from the incisions.

27th.—The abscesses are quite healed, and the eruption on the body is rapidly improving under large doses of iodide of potassium.

STROUD GENERAL HOSPITAL.

TWO CASES OF EXTERNAL URETHROTOMY.

(Under the care of Mr. STORRY.)

CASE I.—Walter W——, aged twelve, was admitted on Feb. 26th, 1886. The boy gave a history of having fallen, some sixteen months ago, on some stone steps, the sharp edge of one step having caught him in the perineum. There was at the time of the accident considerable bruising and swelling of the perineum, and blood issued from the meatus on attempting to pass urine. He was unable to micturate, and a medical man was consequently sent for, who passed a gum-elastic catheter, and repeated this operation in a week's time. From this time up to the date of his admission the boy had not sought further advice.

On admission, the urine passed in drops, the boy crying out and straining severely; he complained also of a smarting pain at the back of the perineum. Several attempts were made by Mr. Storry and the house-surgeon to pass an instrument, but without success. External urethrotomy was therefore decided upon, and on March 2nd the patient was etherised with one of Clover's small inhalers; and before operating Mr. Storry tried again to pass a catheter, but this was impossible. Mr. Wheelhouse's grooved straight staff, with the beak turned up as a blunt hook, was passed down to the stricture; the urethra was opened upon the staff, and the sides of the divided urethra being held apart with forceps, the small probe-pointed director was after considerable difficulty passed into the bladder. The strictured portion of the urethra was then divided, and the tapering probe-pointed gorget introduced above the director into the bladder; a No. 8 silver catheter was passed through the meatus upon the gorget into the bladder, and the catheter tied in. This catheter was left for ten days, when a No. 9 silver was passed, the perineal wound having healed by this time. After this a No. 8 silver was passed daily, which after a time was changed for a No. 9.

The boy was discharged on April 12th, a No. 10 silver catheter being passed the same morning. He was told to return in three or four days, but failed to do so until a fortnight afterwards, when a catheter could not be then passed, so he was readmitted for a day or two, and was taught to pass for himself a No. 7 gum-elastic catheter.

July 19th.—He passes easily a No. 7 gum-elastic catheter every morning before going to work at a stick-mill in his neighbourhood.

CASE II.—Thomas W——, aged sixty, was admitted April 7th, 1886. The patient had gonorrhœa in the year 1855. He was for three months under treatment. He says "it gathered" at the time in three different places in the spongy portion of the urethra. After this he had no other attendance until 1886 when he suffered from retention and œdema of the penis and scrotum, and was admitted as an in-patient of this hospital. He then had catheters passed. For three years, at the least, he has had a fistula in the perineum and one at the inner part of the right thigh, and for two years he has had another fistula by the side of the frænum preputii.

On admission, the last three inches of the spongy portion of the urethra was of a cartilaginous hardness. Urine came only from the three fistulæ, none by the meatus. There was a deep cicatrix involving the lips of the meatus, through which a No. 1 silver catheter could be passed about a quarter of an inch.

April 13th.—The patient was placed under ether and a way into the urethra was attempted by the meatus, but a very fine probe only reached about a quarter of an inch. An attempt was then made to get at the urethra by means of the fistulous opening by the side of the frænum preputii, but this failed also. An incision was now made in the central line of the perineum through tissues which cut like cartilages, and after great difficulty the proximal end of the urethra was found, but after half an hour's searching the distal end could not be seen or reached. Mr. Storry then prolonged the incision in the left lateral lithotomy line and entered the bladder. The hæmorrhage was very slight. The patient was then taken back to bed, the urine for four or five days passing by the lateral incision. Several attempts were made to pass a catheter by the meatus, and at last one was passed about four inches.

27th.—The house-surgeon was successful in passing a No. 9 silver catheter, after having introduced several smaller ones through the meatus into the bladder. This was tied in for twenty-four hours, and the following day a No. 4 silver was passed and tied in, but this had to be removed on account of the pain and irritation it caused. For three days no instrument was passed; but on the 4th of May a No. 8 silver was passed pretty easily; a day or two later it was passed again, and the patient himself was instructed to pass a No. 5 gum-elastic for himself. The wound in the perineum by this time was healing rapidly, and no urine flowed by the fistulæ.

June 7th.—The sinus on the inner side of the thigh was laid open and scraped; the incision in the perineum has nearly healed, and the patient passes for himself a No. 6 gum-elastic easily.

21st.—The sore on the inner side of the thigh has healed, the fistula by the side of the frænum also is closed, and there is only occasional slight weeping from the perineal fistula. The patient was discharged to-day, being able to pass for himself easily a No. 7 gum-elastic catheter.

MATER MISERICORDIÆ HOSPITAL, DUBLIN.

CASE OF SPONTANEOUS CURE OF OVARIAN TUMOUR.

(Reported by Mr. C. H. CALLANAN, clinical assistant.)

MARY C——, aged twenty-nine years, was admitted on May 21st, 1886, suffering from ovarian tumour, which caused her great inconvenience, and had been undermining her health for some months past. She had been married two years, but had no family. Three months ago she consulted Dr. Duke, of Steevens's Hospital, for a swelling over the right ovary. It was excessively tender and painful, and gradually increased in size unt it extended over the