

increased in frequency; the patient became drowsy; she refused her food; and finally, effusion having taken place into the bronchial tubes, she was suffocated on the 111th day of my attendance.

This case, which I have given at such length, was, I think, most interesting, and to me full of instruction. I believe that if I had seen the patient a fortnight sooner, I might have had a different issue to recount. I think that even under the circumstances I attended it, if on the eighteenth day I had been permitted to insert the issues I so strongly urged, she might yet have had a chance of doing well; but that four hours' mental strife was fatal to her recovery; and her brain, already seriously affected, never recovered from the worrying it got on that unlucky day.

I may, perhaps, be asked why I publish a case which ended unsuccessfully. Well, because I believe that we should recount not only our successful cases, but also our failures; for often these last will teach us even better than the former. I knew the power of mercury and the use of issues; but I never saw their value, especially of these last, so clearly exemplified as in this case: they were perfect indicators of the patient's state. When freely discharging, the patient did well; when not discharging, the patient was ill; and when they actually dried up, the last scene closed upon our labours. In the next number of this Journal I shall contrast this case with one of acute arachnitis, which also terminated fatally; but in which I had the advantage of a *post-mortem* examination, which I regret extremely that I could not obtain in this instance.

ART. IX.—*Plastic Operations on the Female Genito-Urinary Organs*^a. By THOMAS. E. BEATTY, M. D., M. R. I. A., F. R. C. S.; Honorary Fellow of the King and Queen's College of Physicians; Ex-Professor of Midwifery, Royal College of Surgeons in Ireland; Physician to the City of Dublin Hospital; President of the Obstetrical Society; Ex-President of the Pathological Society; Corresponding Member of the Obstetrical Society of Edinburgh, &c., &c.

THE subject of Plastic operations with metallic sutures has occupied so much attention during the last few years, that I am induced to hope the following cases may not be uninteresting. There is no doubt that the revival of the use of metallic su-

^a Read before the Surgical Society, March 9, 1861.

tures by Marion Sims was a very great boon to surgery; and although we may not be disposed to go the whole length with him, when he states*, "I declare it as my honest and heartfelt conviction that the use of silver as a suture is the great surgical achievement of the nineteenth century," we must acknowledge that to him and Dr. Bozeman we are indebted for vast improvements in the treatment of cases that formerly were considered hopeless.

Although, as Dr. Simpson has shown, these very eminent operators have been forestalled by Mr. Gossett, who, in "The Lancet" of November 29th, 1834, describes a case of vesicovaginal fistula cured by him by means of "gilt-wire suture," and the steps of whose operation bear a very striking resemblance to that of the American surgeons, we must still award the merit of working out and perfecting the process to the latter. It is just as the credit of the discovery of the Atomic theory in chemistry is awarded to Dalton, because he laboured hard, and with great skill and patience completed that theory; which did not originate with him, but was notoriously first promulgated by Higgins, then Professor of Chemistry in the Royal Dublin Society. In noticing the operations for vesicovaginal fistula, we should not forget that to Mr M. Collis, of this city, we are indebted for the first impetus given to these operations in this country.

His paper on the subject, read before the Obstetrical Society in May, 1856, and published in the "Dublin Quarterly Journal," details an operation differing from those that preceded it, in the proposal to split the edge of the fistula all round, instead of cutting off a portion of it; and then bringing the split edges together by means of quill-sutures. The first operation done by Mr. Collis in this manner, he was kind enough to submit to my inspection, and I found the orifice quite closed. I am inclined to think that this proposal of Mr. Collis to split the edge, instead of paring away tissue, might and ought to be adopted in cases where the opening is very large, and saving of substance is of importance. In most cases the tissue is sufficiently thick to afford of this being easily done; and when it is, there is less strain on the ligatures, of whatever material composed.

It will be seen that, in the following cases, some of the operations differed from that proposed by either Mr. Sims or Bozeman, and partook more of the modifications suggested and practised by Dr. Simpson, to whose lecture, illustrated by wood-

* Anniversary Discourse, New York, 1858.

cuts representing the different instruments employed, we are all so much indebted for accurate and useful directions. In one of them, the operation contrived by Dr. Battey, of Georgia, U. S., was for the first, and I believe the only time, performed in this country.

CASE I.—M. R. was sent up to me by Dr. Mackesy from Waterford, in the hope that some relief might be obtained from her present lamentable condition. She is a nice interesting person, twenty-six years of age, and two years married. She was confined on the 18th of January, 1859, of her first child. The labour was very severe, lasted twenty-four hours, and was terminated by the assistance of the forceps. During the operation the perineum gave way, and the rent extended through the spincter ani. She was confined to bed for three weeks, and recovered slowly. It is now five weeks since her delivery, and she complains that she cannot retain the contents of the bowels when at all liquid. If they are solid, she can pass them voluntarily but otherwise they escape without her knowledge. Flatus is, in like manner, unconsciously passed. She is still nursing her infant. She entered the private ward of the City of Dublin Hospital, under my care. To ascertain the extent of the laceration, I placed her on her back on a high table, with the legs bent, and the feet resting on the table in the lithotomy position; I then introduced M. Sims' duck-billed speculum into the vagina; and having it well held up towards the pubes, I got a full view of the back of the vagina and the torn perineum. I now found that, in addition to the perineum and anus, the rectum was split up for about an inch and a-half. The edges of the rent were quite healed; and the corners of the lower part, near the verge of the anus, were rounded off; just like the corners of a hare-lip. From the nature and extent of this injury, it was plain that two operations must be performed; the first with a view to close the rent in the rectum and sphincter ani, and the second, at a future time to restore the perineum. As it was of great importance to have the bowels in a quiescent state during the progress of the cure, after the operation, I had them well emptied by medicine, and the rectum well washed out by injections, for three days previously; and the day before the operation, a quarter of a grain of opium was given every fourth hour, to secure torpidity of the intestinal canal. Having made these preparations, I proceeded to operate on the 18th of March, 1859, in presence of Mr. Tufnell, Dr. Churchill, and Mr. Croly, house-surgeon to the hospital. The patient was placed on her

back, as already described, on a high table near a window, with a good light shining into the vagina, now well displayed by the speculum already mentioned, which was well held up by Mr. Croly. The first step in the operation was to pare the edges of the rent in the rectum. This was effected by sticking a hook into the lowest point of the torn sphincter at one side, and with a knife cutting off the edge from the bifurcation above down to the point, just as in the operation for hare-lip. This was repeated on the opposite side, leaving a Δ -shaped cut into the recto-vaginal septum an inch and a-half long. The edges were now brought together by means of iron-wire sutures, passed in the following manner:—A good-sized curved needle, holding in its eye a piece of iron-wire about six inches long, was firmly grasped at a right angle, near to the eye, by a strong porte aiguille, which was kept tightly closed on the needle by a slide run up on the blades. The point of the needle was then struck into the lining membrane of the vagina, close to the upper angle of the wound, on its left side, and at a distance of a quarter of an inch from the cut edge, and driven through the tissue between the rectum and vagina until the point appeared through the cut edge. The needle was urged across the gaping wound until it was made to enter the opposite cut edge at a point corresponding to that from which it emerged in the other; and being forced through the submucous tissue as before, the point was brought out at a quarter of an inch from the edge. When sufficient of the needle was passed through, it was caught by a strong forceps, and the slide on the porte aiguille being retracted, the needle was cast loose on the side where it had first entered, and was pulled out on the right side of the cut, carrying the iron-wire with it. This was now cut off with a pair of scissors near the eye of the needle, and so the first ligature was passed. In a similar way four other iron ligatures were made to traverse the gap in the septum, the last being through the edge of the anus. A thin leaden plate, an inch and a half long, and half an inch broad, with five holes pierced down the centre, was now prepared; and through the holes the ends of the wires were passed, beginning at the upper end, and so on to the last. The shield was then pressed down to the wound, while the ends of the ligatures were held on stretch in the left hand. This had the effect of drawing the cut edges into close apposition; and to secure them in that position, perforated shot were slid down over the ends of each pair of wires; and the shot, seized in a strong pair of forceps, was firmly forced down on the shield; and while the wires were drawn tight, the shot was strongly compressed, so as to hold

the wires securely fixed. This having been done for the five sutures, the ends of the wire were cut off near to the shot, and the ends of the cut wires were bent down on the shield. The operation being thus accomplished, the patient was put into bed, and a quarter of a grain of opium was given every third hour. Directions were given to have the bladder emptied by the catheter three or four times in twenty-four hours, so as to prevent the possibility of the urine coming in contact with the wound. This was strictly attended to by Mr. Croly, who watched the case with the most laudable care. No unfavourable symptom occurred until the 24th, the sixth day after the operation, when a pretty smart hemorrhage took place from the vagina, which lasted only a quarter of an hour, and was stopped by injecting cold water into the passage. On the 26th, the eighth day, the ligatures were removed, in the following manner:—The patient was placed in the same position as on the day of the operation; and the same speculum having been introduced into the vagina, the shield and lead buttons of shot were exposed. With a long pair of sharp-pointed scissors the wires were successively cut across, close to the shield, beginning at the outer one; and all the shot being thus removed the shield came away, leaving a perfectly healed cicatrix, with a surface and edges as smooth as if it had been pressed with a hot iron. An injection of warm water was now thrown into the rectum to soften the fæces, and the bowels were slowly relieved without any laceration of the newly-united parts. This constituted the first part of the operation. It was most successful in its results. The patient regained complete control over the bowels, and nothing escaped without her consent. She remained in hospital for ten days afterwards, when I advised her removal to the country for a short time, previous to any further operative proceeding. On the 27th of April, she returned; and on examination, I found the parts perfectly sound and solid; and so much contraction had taken place, that the gap in the perineum did not appear nearly so large as formerly, and it was quite manifest that a smaller amount of closure would be necessary than was expected. On the 2nd of May, I proceeded to finish the operation. This was done by paring about three-quarters of an inch of the edges of the torn perineum from the anus forwards, and then uniting the cut edges by means of three iron-wire sutures without a button. The ends of the wires were simply twisted together, and cut off about a quarter of an inch from the wound. The same precaution with respect to the urine was observed, as in the former operation. It was drawn off with the catheter every

six hours, and the bowels were kept quiet by opium. On the eighth day the sutures were removed, by clipping one side of the noose with a fine-pointed scissors, and drawing the wire through. The wound was found to be perfectly healed; and the patient left the hospital on the 6th of June, a much happier woman than she had entered it.

CASE II.—On the 28th of May, 1859, I was requested by Mr. Banon to see Mrs. H., who had come up to town from Limerick for advice, in consequence of incontinence of urine since her confinement. This had taken place on the 3rd of the month. Her labour was of her first child, twenty-four hours in duration, and very severe. No instruments were used in the delivery. She suffered a great deal of soreness afterwards; and on the sixth day the urine began to come from the vagina, and had continued to do so ever since. On examination, we found a large opening into the bladder from the vagina, of a size sufficient to permit a walnut to pass through; the edges of the opening were thick and fleshy, and in some places granular; the whole mucous membrane of the vagina was inflamed and raw. I expressed an opinion that it was a very favourable case for operation, and at Mr. Banon's desire I undertook the case. On the 31st of the month I proceeded to operate, in presence of Mr. Banon, Dr. Churchill, and Mr. M. Collis. The patient was placed leaning over the edge of a low bed, with her chest supported by pillows, and the buttocks turned towards a window, through which a good light came. The duck-billed speculum of Sims was introduced into the vagina; and being well held up, the aperture in the vagina was brought well into view. The edges were well pared all round. Considerable bleeding took place from the very vascular tissues; this was arrested by tincture of matico; and then five stitches were put in by means of the tubular needle, made by Mr. Young, the eminent cutler in Edinburgh. This needle was first described by Dr. Simpson, and it is figured in his lecture on vesico-vaginal fistula, in the "*Medical Times and Gazette*" for January, 1859. It is a most perfect instrument, does its work in superior style, and is easily managed. In the operation for vesico-vaginal fistula, the wound being made to close in a transverse direction, the stitches are introduced from before backwards, as the patient lies before us, and the tubular needle enables us to do that with the greatest ease. The wire, cut to the length required, is introduced into the tube, and pushed forward, until the end of the wire appears at the point of the needle; it is then withdrawn, until the end just

disappears within the tube; and having dipped the needle in oil, the point is driven into the membrane lining the vagina, half an inch from the cut surface; and being passed between the bladder and vagina, taking care not to penetrate the former, it is carried out through the raw edge, and then being pushed on, it is made to pierce the far side of the freshly-prepared border of the aperture; and being passed as before between the vagina and bladder, it is made to emerge through the wall of the vagina, at half an inch of the other side of the opening. When the point of the needle is seen well above the soft parts, the wire is steadily pushed forwards in the tube, and emerges from the point of the needle. The extremity of the wire is then seized with a long forceps, and pulled well downwards, while the needle is withdrawn over the wire, which it leaves thus safely lodged in its proper position. In this case five stitches were found to be necessary. They were fastened over a leaden shield, or button, differing from Boze-man's in this particular, that while his button has but one row of holes down the middle, through which the wires are brought (two through each hole), the button I used had two rows of holes parallel to each other, or rather five pairs of holes, instead of five single holes, as originally described by Dr. Simpson in the lecture already referred to. The object of this was to get rid of the perforated shot as a means of closing the stitches, and to close the wound by twisting the wires after they were brought through the double holes. The twister originally designed by Dr. Coghill, consisting of an iron rod five inches long, with two very short tubes a quarter of an inch long, attached on either side of its extremity through which the wires were passed, served to secure the stitches. The wires, being passed through the tubes, or rather holes, in the bulb at the extremity of the rod, were held firmly in the left hand; and the instrument, pushed down to the leaden button, was twisted three or four times, making a close and regular cord of the wires. It was gradually withdrawn as the twisting motion was given, and finally withdrawn over the wires; these were cut off within a quarter of an inch of the plate, and the other pairs of wires were treated in the same way, until the whole were secured; the cut ends were then folded down over the plate; a short gum-elastic catheter, with an Indian rubber bag attached to it, was secured in the urethra; the bag had a stop-cock at its other free side, to allow of its being emptied. The patient was placed in bed, lying on her face; a grain of opium was given, and she was ordered a quarter of a grain to be taken every third hour. A good nurse was put

in charge, and Mr. Banon and myself visited her every morning and evening. On our visit the second morning we were startled by hearing that the catheter had slipped out in the night, and that she had passed water by the urethra; no urine came through the vagina. The instrument was now firmly secured, and was removed every day, and washed. No untoward occurrence took place afterwards. On the eighth day I removed the stitches, by placing her in the position as on the day of operation, and displaying the apparatus by means of the same speculum. The stitches were removed by cutting one side of the loop with a sharp-pointed scissors, and drawing out the wire by a forceps. On the removal of the plate, we were gratified to find the whole wound perfectly healed, the cicatrix presenting a uniform smooth surface, as if it had been pressed with a hot smoothing-iron. The catheter was kept in for two days more, the opium was stopped, and the bowels were freed. After this she was allowed to get up; the urine came naturally by the urethra, and in a few days more she returned home. I have heard lately that this patient has been since safely delivered of a living child, and that she suffered no inconvenience of any kind during or subsequent to her labour.

CASE III.—Mary Nolan, aged twenty-three years, after first labour, which was very long and difficult, suffered great soreness of the vagina for some days, and then found a sudden burst of urine through that passage, which has continued to come in that way ever since. Her thighs and buttocks are excoriated. On examination in the position already described, a very frightful destruction of parts was discovered; in fact, the whole front of the vagina was gone, and one looked through the chasm into the cavity of the bladder. The gap extended from the vesical end of the urethra up to the cervix uteri, and to an equal distance transversely. It was nearly square, and measured two inches in every direction. The patient suffered severely from inversion of the bladder, which constantly took place when she stood up or walked, hence she was obliged to preserve the recumbent posture. Notwithstanding the unpromising nature of this case, I was unwilling to allow the sufferer to lose the chance of some relief, and I determined to make an effort to close this formidable breach. It happened that Dr. Battey, of Georgia, U. S., was in Dublin just at this time. He had designed and exhibited to me a modification of the operation of Sims and Bozeman, particularly calculated for this case, and I requested him to visit the patient with me in the hospital.

We agreed to try his operation, which I performed a few days after, in presence of Mr. Pirrie, the eminent Professor of Aberdeen, and author of the great work on surgery, who was on a professional visit to this city at that time, along with my colleagues in the hospital, and some other friends. The earlier steps of the operation were the same as those described; the paring of the edges of the opening, and the passing of the wires were the same. The great extent of the aperture made it necessary to place nine sutures *in situ*. All this was done, and now came the difficulty of closing such an enormous gap; and at this stage Dr. Battey's contrivance came to my aid. A bar of thin lead, two inches long, and one-eighth of an inch wide, perforated with nine holes to correspond with the nine sutures, was prepared; and instead of the second row of holes, as used in the plate in the last operation, nine notches were made in the edge of the plate, corresponding with the nine holes. Through each of the holes was now passed one of the distal ends of the wires, and then perforated shot was run down upon each of the wires, and closed on it by compression with a strong forceps. When all the nine wires were thus secured, the proximal ends which hung out through the anterior edge of the opening were grasped in the left hand and pulled strongly downwards, thus drawing the leaden bar into close contact with the distal side of the opening. The traction was continued and increased, and by degrees the upper edge was made to approximate the lower. This occupied a considerable time, and was much assisted by placing the end of a thin flat piece of wood, like a flat ruler, under the proximal wires, and pressing the end firmly upwards against the part perforated by the wires, while the leaden bar and the parts against which it was lodged were drawn down. By this means the raw edges were finally made to touch. The next point was to secure them in that position. This was done by turning up each wire in succession, and lodging it in the notch in the edge of the bar above described; and when safely lodged there, the edge of the bar was strongly compressed behind it by the point of a strong forceps, thus fixing the wire securely in its place, the distal end already secured by the perforated shot, the proximal end now firmly fastened in the corresponding notch; in this way the nine sutures were fastened. The ends of the wires were now, for further security, twisted by the twister. Some idea of the great difficulty of this operation may be formed from the fact, that three hours and a-half were occupied in its performance. The catheter was introduced and secured as usual, and opium was given as already described. My expectation of success, small

at first, was diminished on the fourth day, when urine was found trickling from the vagina. At the end of eight days the apparatus was removed; the wound was found apparently closed on the right side for a short way; but the strain had been too great on the left, and the wires had cut through the soft parts, leaving a large part ununited. I confess I was not disappointed at the failure in this operation. It was almost impossible to hope for a closure in such an enormous gap at the first trial. The patient remained for some time in hospital, and then went home to the country. She promised to return; and I intend, on some future occasion, to try another operation.

Prolapse of the uterus, when complete, is well known to cause very great inconvenience to the sufferer, and a variety of means have been proposed for its permanent relief; excision of portions of the mucous membrane; destruction of parts of the prolapsed surface by the application of strong nitric acid, &c., have been had recourse to. The latter has been followed by great success in many cases in which I have employed it; but the cure is spread over a very long time, owing to the number of applications that are necessary, and patients get tired of waiting through the long process and the numerous operations. The pessary is only a palliative, and requires looking after and arranging from time to time. The most effectual and speedy remedy for this displacement is that proposed by Mr. Baker Brown, consisting in a permanent closure of the vulva. Two cases were thus treated in the City of Dublin Hospital by me, with complete success.

CASE IV.—Mary Kelly, aged sixty-five years, was admitted on account of a very large prolapse of the uterus, with which she had been afflicted for many years. She was the mother of several children, and the prolapse commenced after the birth of the last child, twenty years ago. It had lately increased very much. It was permanently down, not returning when she assumed the horizontal position. The surface was dry, and covered with cuticle, except near the lower part, where some spots of ulceration existed, owing to the trickling of urine over it, and the friction to which it was subjected in walking. As she was a widow, past child-bearing, I considered this a suitable case for the operation of closing the vulva. The woman was kept in bed for some days; the prolapsed parts were returned within the vagina, for the purpose of accustoming them to their natural, but now unusual, position. The operation was performed in the following man-

ner:—The woman was placed on a high table in the lithotomy position, and securely held there close to a window, through which light fell freely on the vulva. I made an incision in the mucous membrane of the labia majora, near the line where it joins the common integument. This incision commenced on the right side, nearly on a line with the orifice of the urethra, was carried all down that side to the fourchette, and up the opposite side to a point corresponding with that from which the incision started. A similar incision, parallel to the last, was made all round at one-fourth of an inch within the vagina. When this was completed, the strip of mucous membrane between the two incisions was carefully dissected off, leaving a raw surface, one-fourth of an inch broad, all round the vulva. Double iron-wires were now passed from side to side by means of needles driven through the common integument, one-fourth of an inch from the cut edge, then through the middle of the raw surface, then across the vulva and through the opposite raw surface, and so out through the integument at a distance from the cut edge similar to that where it had entered. Four of these double wires were thus passed through, and the wound was closed by laying a piece of bougie of proper length along the right side, first between the wires as they emerged from the skin, and making four loops round it by twisting the ends of the four pairs of wires together, and a similar piece of bougie was laid along the left side between the wires; and the edges of the wound being strongly drawn together by pulling the wires, they were twisted together on that side also. A firm quilled suture was thus effected. In order to make the junction of the edges of the integument as complete as possible, three fine iron-wire stitches were made through the skin in the intervals between the deeper sutures. Opium was ordered, as in the former cases; and in order to prevent the contact of urine with the cut edges, the catheter was passed every six hours. On the eighth day I removed the sutures, and was gratified to find the vulva closed by a firm cicatrix, leaving a small aperture at the upper part corresponding to the orifice of the urethra.

CASE V.—R. Byrne, aged 60, was admitted in the City of Dublin Hospital, with a very large prolapse of the uterus, which had been down for many years. After preparing her for treatment as had been done in the former case, the operation, as just described, was performed. The same after-treatment was pursued; and, at the end of eight days, a similar happy result was found.

This is an operation that, I think, is only applicable to old

women. I am aware that Mr. Baker Brown proposes to treat younger and married women by an operation similar to that just described, but of less extent,—closing, in fact, only a portion (the posterior) of the vulva. I am afraid such a partial closure would not prevent the escape of enclosed prolapsed viscera; but that bit by bit, and by degrees, the bulk above would insinuate itself into the aperture, and finally escape from the pelvis, as before.

Case VI.—In October, 1860, I was requested by Mr. Banon to visit a patient under his care in Jervis-street Hospital. I found her labouring under the distress caused by vesico-vaginal fistula; and thinking it a very favourable case for operation, I placed myself and my instruments at his disposal whenever he thought fit to operate. This he did on the 15th of the month; and he has lately favoured me with the following letter respecting the case:—

“*Mountjoy-square, February 21, 1861.*

“MY DEAR DOCTOR,—I send you the particulars of the case of Catherine Ormond, on whom I operated on the 15th October, 1860, for vesico-vaginal fistula, assisted by you; and request you will have the kindness to read them, when bringing the subject forward at the Surgical Society. I take this opportunity of telling you that I had a few days ago a letter from Dr. Riordan, of Bruff, informing me that our former patient, Mrs. Hayes*, on whom you so successfully operated on the 31st of May, 1859, has recently been safely delivered of a full-grown child, without any injury whatever to the cicatrix of the fistula.

“I am very truly yours,

“A. BANON.

“Catherine Ormond, aged 19, was sent up to me by Dr. Seward, of Caherconlish, and admitted to Jervis-street Hospital, on the 29th of September, 1860. She states, that three months previously she was delivered of her first child, after a very severe and tedious labour, lasting three days; but she made apparently a good recovery, and found nothing wrong in passing water for nearly four weeks subsequently, when she lost all power of retaining it; and it continued to trickle through the vagina ever since, keeping her in a constant state of irritation and misery. On examination, an oval fissure nearly an inch in length, extending obliquely from left to right, was seen occupying the vesico-vaginal septum at its lower part, and having a portion of the mucous membrane of

* This was the patient of case No. 2.

the bladder protruding through it. On the 15th of October, the bowels having been previously emptied by a purgative enema, I proceeded to operate, assisted by Dr. Beatty, and in presence of my colleagues in the Hospital. First paring the edges, which I succeeded in doing by removing a complete ring of the circumference of the fistula without a break, five iron-wire sutures were introduced, and secured, in the manner described by Dr. Beatty, on the leaden plate. The patient was kept lying on her face for ten days. A No. 10 male catheter, fixed in the bladder by tapes, and daily changed, conveyed the urine by drops into a vessel suitably placed, so that no accumulation of this fluid could take place in the bladder. Occasional doses of opium were given, and the bowels fortunately did not act during the whole period. The vagina was daily syringed with tepid water. On the eighth day, the sutures and plate were removed, when the fistula presented a smooth appearance, and looked quite healed. On the tenth day, the catheter was removed, and the woman was allowed to get up. From this time she experienced no inconvenience whatever; and left the Hospital shortly afterwards, quite well, the fistula presenting an appearance of firm union. She was recommended separation from her husband for some months. She has recently written to me, expressing her gratitude for her cure."

ART. X.—*Cases in Surgery*. By EDWARD HAMILTON, M. D., T. C. D., F. R. C. S. I., one of the Surgeons to Steevens' Hospital, and Lecturer on Physiology in its Medical School.

Double Hare-Lip, which had been submitted to two previous operations without success.

JAMES BENTLEY, aged three years, a very fine little fellow, but most wayward and uncontrollable, presented the deformity of double hare-lip in a marked degree; the centre piece extending about half the depth of the fissure. On the left side the cleft was prolonged through the palate; the right alveolar arch was prominent, one of the incisor teeth projecting somewhat into the gap. The segments of the lip were adherent to the gum; the edges did not convey to the touch the usual soft feel, so characteristic of the red border of the lip. The mother states that he had been twice operated on for this deformity: first, at the age of six months, when, according to her account, in two days after the operation, "the needles burst out," leaving