

the dagger was fastened to a chain, which was passed over a cylinder turned by steam power. The pincers, used for drawing out tubes of copper, were so made that the more they were pulled the tighter they grasped. The man was then fastened to rings fixed in the ground, and the cylinder was gently set in motion. At the second turn the dagger came out. The blade measured ten centimetres in length, of which nine had entered the interior of the skull. The patient, who had submitted with the greatest coolness to these manœuvres, suffered no pain or inconvenience. Some drops of blood escaped, and a few minutes afterwards the man was able to walk away to a hospital, where he remained in bed for ten days, but without fever or pain. He then returned to his work, and the wound gradually healed. M. Dubrisay endeavoured by a post-mortem experiment to ascertain what parts of the brain had been injured. He drove the dagger into the head of a cadaver in the same situation, and to the same depth, and found that, without injuring the superior longitudinal sinus, it had passed into the cerebral substance just behind the ascending parietal convolution, and thus behind the motor zone; the point had not reached the base. The difficulty in extraction had been due solely to the fixation of the instrument by the edges of the wound in the bone.—*Lancet*, Nov. 12, 1881.

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*Salivary Colic: Expulsion of Two Salivary Calculi.*

DR. R. SAINT PHILIPPE reports in the *Journ. de Méd. de Bordeaux*, Août 7, 1881, the case of a man who was believed to have an abscess of one of the salivary glands: there was great pain in the maxillary, cervical, and temporal regions of the left side, with diffuse swelling under the jaw and on the floor of the buccal cavity. At the same time the masseter muscles were in a condition of contracture, preventing complete opening of the mouth. Digital exploration revealed the existence of a pocket on the left side of the frænum in the course of Wharton's duct: incision of this tumour was only followed by the escape of blood and saliva, but it produced considerable relief. Several hours afterwards the patient drew from his mouth two salivary calculi, about the size of a bean and pea. All the symptoms then disappeared, and exploration of the duct by means of a probe passed through the wound showed that no other calculus was present.—*L'Union Médicale*, Oct. 25, 1881.

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*Two Cases of Malignant Stricture of the Œsophagus in which Gastrostomy was Performed.*

At a meeting of the Clinical Society of London, on Oct. 28th, Mr. REEVES contributed a paper with the above title. After narrating the two cases, he pointed out how, having done gastrostomy in deference to the wishes of his colleagues, he should proceed to act in any suitable case of stricture of the Œsophagus. He said that the most recent information showed that malignant obstruction was most common in the upper part of the tube, occurring in that situation in about half the cases; and, although a much larger number of observations was needed to arrive at a correct conclusion, still there was sufficient justification for the rules he wished to lay down, which were the following: 1. Because of the great mortality after gastrostomy, and also because of the more frequent occurrence of malignant stricture in the upper portion of the tube, œsophagostomy was by far the preferable operation. 2. Even in cases where the stricture was situated as low down as the manubrium sterni (its depth rarely being very great), œsophagostomy was indicated as a preliminary or exploratory operation; and, if it were found that the little finger or sound could not be passed through the narrowing, gastrostomy might then be performed. 3. If it resulted