continued attempts to expectorate. These attempts were so violent that the patient, three or four times during the operation, expelled the canula with the sputum. It was found impossible to remove the larynx by at once cutting it free from the trachea below and the hyoid bone above, and the process had to be suspended several times to allow the patient to relieve himself by coughing up the mucus and blood, which escaped into the trachea notwithstanding all the care that was used to prevent it. Several arteries, especially the two superior laryngeal, were tied, and the galvanic cautery was applied to others.

The subsequent history of the case shows that on the 11th erysipelas set in, but disappeared by the 21st, from which time the patient's temperature did not exceed 98.9° F. and the pulse 80. He was on the latter day able to swallow fluid and semi-fluid food; the paroxysms of cough had become rare and slight; the wound had healed, for the most part by the first intention notwithstanding the erysipelas; he slept fairly well at night; and altogether his condition was promising.

No account was given of the nature of the disease for which the operation was performed; but Dr. Martelli intimates that a complete account of the case will be published by Professor Bottini.—*Gazzetta delle Cliniche*, March 9, 1875.

Thus of the five operations three are known to have terminated fatally, and in the remaining two the operations are too recent to know the final result.

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38. *Removal of a Foreign Body from the Pharynx by Pharyngotomy.*—Mr. W. J. Wheeler detailed to the Surgical Society of Ireland March 19, 1875, a successful case of removal of a foreign body impacted in the pharynx by the operation of pharyngotomy, performed, for the first time in that country, by him in the City of Dublin Hospital. He remarked that the majority of surgical writers say little or nothing of pharyngotomy, and appear to confound the operation with œsophagotomy. Foreign substances when extracted otherwise than by the mouth have almost in every case been removed by œsophagotomy, and no account is given of the performance of pharyngotomy before the cases graphically detailed by Mr. Cock in *Guy's Hospital Reports*. The steps of the two operations are different, the same structures are not engaged, the parts to be avoided are not similarly situated, and there is not the same readiness in getting at the pharynx as at the œsophagus. The difficulty of pharyngotomy is increased also by the much greater proximity of the common carotid, the danger of wounding the thyroid gland, the almost absolute necessity of dividing the insertion of the omo-hyoid muscle, and the danger of wounding the inferior thyroid artery. The case in which he operated was that of a man aged 45 years, in robust health, who had accidentally swallowed a needle. The patient endeavoured to withdraw it by pulling at a thread which hung from it, but as it had slipped down eye foremost it became impacted. The laryngoscope showed the needle somewhat obliquely situated, with its eye buried in the left palato-pharyngeus muscle, and its point in the left arytenoid cartilage. On endeavouring to extract it with the forceps it appeared to slip through the blades. Similar attempts next day with different kinds of forceps proved unavailing, and the patient suffered so much laryngeal distress that he was allowed rest three or four days, after which it was found so firmly imbedded that all attempts to depress or dislodge one end of the needle were unsuccessful. As the patient then became pale, thin, and haggard looking, continued unable to swallow solid food, and occasionally suffered considerable pain, which prevented sleep, it was determined, after due deliberation, to remove it by pharyngotomy. The patient having been put under the influence of chloroform, Mr. Wheeler made an incision on the left side of the neck from the body of the os hyoides to the superior margin of the cricoid cartilage, through the integument and fascia. A small vessel, probably the sterno-mastoid branch of the superior thyroid artery, required to be ligatured. The layers of fascia were taken up and cautiously divided on a director, until the common external and internal carotid arteries, the superior thyroid body, and superior laryngeal nerve, with some descending filaments of the ninth nerve, were exposed to view. The attachment of the omohyoid muscle was then separated, and the chloroform discontinued. A staff passed into the mouth was caused to bulge in the left

side of the pharynx, and an incision sufficient to admit the top of the index finger made down on it. The staff being removed, the opening was enlarged upwards and downwards, and a finger passed behind the ala of the thyroid cartilage, but the needle could not be felt. A small forceps was next passed in on the palmar aspect of the left index finger, but it did not catch the needle. Mr. Wheeler then passed his forefinger upwards towards the mouth, and brought the thread from the mouth through the wound. On following the course of the thread he found the needle imbedded in the soft structures, and had to scrape with his nail until he came upon it, whereupon by slight traction on the thread and grasping the needle with the forceps the foreign body was removed. During the operation the patient suffered great dyspnœa, the face was congested, the eyes protruded, and perspiration poured off his face. No sutures were put in the gullet; the edges of the wound were approximated with carbolic sutures, and lint soaked in carbolic oil was laid over the wound. A bread and milk poultice was placed over the abdomen, and renewed in four hours; nutritive enemata were given, and a sponge soaked in iced milk was occasionally squeezed into the mouth or given in teaspoonfuls, and though some came out through the wound the greater part followed the natural course. The second day after operation the edges of the wound were slightly inflamed, and an abscess in the vicinity discharged through it, as the edges had not, in anticipation of such result, been drawn together. After eleven days fluid ceased to come through the wound, and the patient was discharged cured after the lapse of a further fortnight. Mr. Wheeler directs attention in the performance of such an operation to the immediate arrest of hemorrhage from the small vessels necessarily divided, so that none of the parts may be obscured; to having the vessels well retraced; to having a staff put into the pharynx from the mouth; not to pass a knife into the pharynx to enlarge the opening up and down, as recommended by Mr. Cock, and so avoid producing hoarseness and wounding the filaments of the nerves; not to mistake the thyroid gland for the gullet; and to operate on the left side as being more convenient than the right, unless contraindicated by position and size.

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39. *Traumatic Popliteal Arterio-venous Aneurism successfully treated by Ligature of the Popliteal Artery and Vein.*—Mr. THOS. ANNANDALE reports (*Lancet*, April 24, 1875) a very instructive case of this. The subject of it was a boy aged 10, admitted into the Edinburgh Royal Infirmary October 28, 1874, who three months before admission had received a wound in the popliteal space from the point of a pair of scissors. The hemorrhage was stopped by a compress and bandage. After a few days the boy was allowed to go about. A swelling was observed in the popliteal space, and when admitted it had acquired the size of an infant's head, was of an irregular shape, pulsating, "and when the hand was placed over it, the characteristic aneurismal expansion could be felt on all its aspects. No peculiar thrill could be felt in the swelling. Pulsation was absent in the anterior and posterior tibial arteries at the ankle. At one point the swelling was very prominent, and the skin over this point was thinned and discoloured.

"The case being diagnosed as one of traumatic aneurism of the popliteal artery, it was decided to treat it by laying open the sac and tying the artery above and below the wound.

"On the next day—the 29th of October—I proceeded to operate in the following manner. A tourniquet being applied to the femoral artery in the upper part of the thigh, I made a small incision into the centre of the sac, sufficiently large to admit my forefinger. My reason for making this limited opening in the first instance was, that I could, if necessary restrain any hemorrhage until the finger had made an examination of the sac and separated any adherent clots. I learned the value of this practice in assisting the late Mr. Syme in most of his serious operations on large aneurisms. Having searched the sac with my finger, I gradually withdrew it so as to lay the whole cavity open, but on doing so free bleeding took place, and, as it seemed probable that this hemorrhage was coming from the distal end of the wounded artery, an elastic ligature was applied round the upper part of the leg, the finger being kept in the wound as