The swelling had existed six or seven months, but had not increased much in size for several months, although at first it grew very rapidly. A history of syphilis was obtained, and the exciting cause was attributed to "striking." On the same leg in the middle third was an ulcer (specific?), three inches by three inches, and unhealthy in appearance. No treatment other than absolute rest was employed for twenty-four hours, after which Carte's compressors were placed alternately on the external iliac and common femoral arteries, the patient himself attending to the instruments. The aneurism not having improved by the use of this procedure, a bag of shot, as suggested by Bellingham, of Dublin, was placed over the common femoral at 11.15 A.M. on Nov. 7th, and on the following morning the pulsation was less; the tumour was deemed to be harder. On Dec. 4th the bag of shot was omitted because the glands in the groin had become swollen and painful. No marked benefit had resulted from its use. Up to this time also the patient's diet had been restricted to the limits advised by Tufnell, but he was now ordered the usual hospital fare. The wound on the leg was also on this day grafted, but without success. For a few days diarrhœa was present, and controlled by compound kino powder.

On December 31st, at 11.15 A M., Esmarch's bandage was applied firmly over the foot and leg; less so over the aneurism, which was now about the size of an orange; and firmly, again, on the thigh; the strong india-rubber tourniquet encircling the limb at its upper edge. Much pain was suffered, and opium was given to relieve it. The tourniquet was removed at 1.30 P.M., and the shot-bag used to control the vessel. The measurement of the thigh in circumference before the application of the bandage was 15¾ in. on the affected side, 12¾ in. on the unaffected; but on removal of the bandage at 2.30 P.M., on account of the lividity of the toes and pain, the circumference was 16⅝ in. in the left thigh. The tumour was firm, with very little pulsation at the highest point of aneurismal dilatation, and the whole limb was dusky and cold. The leg was raised and enveloped in cotton-wool. Throughout the night the bag of shot was kept on the femoral at Poupart's ligament; and at 12.30 on Jan. 1st all pulsation had ceased, the measurement having increased by ⅛ in. (16¾ in.). Towards evening, however, pulsation returned, and was to be felt very feebly up to the morning of the 4th. Pressure on the common femoral was discontinued on the 5th. The temperature rose to 101°, probably as a result of enlarged and painful swelling of the inguinal glands. The ulcer, which had bled and had gone back somewhat by the application of the bandage, soon returned to a healthy condition, and on the 5th was healing.

In this case, the patient was not placed in the erect posture, as advised by Mr. Wagstaffe, before covering in the aneurism with the bandage; neither was any padding placed between the surface of the tumour and the bandage. The omission was an oversight.

HÔPITAL DE LARIBOISIÈRE, PARIS.

INFRASPINOUS LUXATION OF THE HUMERUS.

(Under the care of M. TILLAUX.)

THE following case of infraspinous luxation of the humerus is worthy of record, partly from the extreme rarity of the lesion, and partly because its mechanism was established by the patient in the clearest manner. The descriptions given of this dislocation are often very meagre. Malgaigne, in his "Traité des Luxations," gives a short account of two cases. Sir Astley Cooper relates six other cases; in all his cases reduction was extremely easy. Later on, M. Sédillot, in the year 1834, presented a case of infraspinous luxation of the shoulder to the Academy, which had been mistaken for a fracture of the scapula. Another case came under the care of M. Tillaux in the year 1867. Most authors are agreed as to the mechanism of this dislocation. Sir Astley Cooper regarded it as determined by the contraction of the muscles situated in the infraspinous fossa, together with a shock on the anterior portion of the shoulder. Nélaton admits the possibility of its production by direct violence from before backwards. M. Tillaux is of opinion that it may be produced by torsion.

R. J——, aged fifty-nine, a mechanic, was admitted on December 26th, 1876, for an abscess situated under the pectoral muscle. On examination, a deformity of the right shoulder was at once detected. In the month of February, 1870, the patient was going upstairs, when he met some one who was coming down at the same time. He prepared to place himself in such a manner as to let the person pass, but in so doing his foot slipped, and he fell against the border of a step, striking the anterior part of the right shoulder. Under the right arm he was carrying a parcel, and in order not to let this fall he flexed his arm violently and brought it firmly against the thorax. This movement naturally tended to thrust the head of the humerus directly outwards. The weight of the body completed the luxation, by carrying the head directly backwards. Two hours afterwards, not being able to make use of his arm, he consulted a surgeon, who placed the arm in position by means of bandaging, but the patient could not say whether the luxation was reduced or not. Be this as it may, at the present moment there exists an infraspinous luxation of the humerus, which the patient can reduce at will by means of simple muscular contraction, and which the surgeon can reduce with the greatest facility. But the displacement returns as soon as the muscular contraction ceases. The signs are as follow. In front the infraclavicular depression is effaced. The shoulder is brought nearer to the median line, and is lowered. The anterior wall of the armpit is diminished in its vertical measurement. Outside, there is a prominence formed by the acromion, with a depression underneath. On the posterior surface of the shoulder the head of the humerus projects under the spinous process, and forms a rounded tumour. The inferior angle of the scapula is farther from the spinal column on the right side than on the left. The head of the humerus can no longer be found in the armpit. The patient has been able to make some use of his arm, having continued to carry on his occupation, but the movements are extremely limited. Elevation of the arm is impossible, but he can draw the arm to the thorax. The chief movements of this arm are situated at the elbow, and these permit of the patient making use of his limb to a certain extent.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

THE ordinary meeting of this Society was held on Friday, Jan. 26th, Mr. Callender, F.R.S., the newly-elected President, in the chair. The business of the evening included the President's opening address, and a discussion on subcutaneous section of the neck of the femur, raised by cases brought forward by Mr. Brodhurst and Mr. Croft. The attendance was fair, the surgical element being predominant. Some cases of skin disease were shown by Mr. Squire, but no remarks were made upon them.

PRESIDENT'S ADDRESS.

Gentlemen,—If an earnest desire to promote the exact observation of clinical facts should largely influence me as a member of this Society, that earnestness should be intensified by the responsibility I have incurred in venturing to accept office as your President—intensified by the knowledge that your friendly judgment has placed me in a position which demands that by precept and example I should plead for precision in clinical research. If I had only to speak to you in words of thanks, my duty would soon be ended, for I can but say that I value most highly the honour you have conferred upon me. In recalling your confidence, I shall be encouraged in the endeavour, so far as I can, to do it justice. It has, however, become a custom of the Society that your Presidents should venture from time to time to offer suggestions as to how the objects we have in view may be best promoted; a custom which it grows more difficult to observe as its novelty wears off, and yet—having in mind changes in the grooves of thought, in the