

his ordinary diet with a view to improve his general condition. On Oct. 18th he was placed under the influence of the anæsthetic mixture, and Mr. Davy, who kindly assisted me, introduced his rectal lever and compressed the right common iliac as a precautionary measure in case of the elastic band slipping. Contrary to expectation, the pulsation in the aneurism, though much reduced, was not entirely controlled by this, the probable explanation being that the middle sacral had become a considerable factor in conveying the blood to the limb after ligation of the external iliac. I need hardly point out the significant value of such a demonstration, affording, to my mind, a sufficient argument against the ultimate success of applying a ligature to the common iliac, had we contemplated such a line of treatment. The next step consisted in raising the limb and applying an elastic bandage firmly from the toes to the aneurism. Esmarch's elastic tourniquet was then wound tightly round the limb as far above the tumour as possible, close up to the hip-joint, and kept from slipping down over the aneurism by means of a loop of tape passed round the coils of indiarubber on the outer side, held taut by an assistant, and drawn upwards. The bandage was then removed, and the limb was thus rendered bloodless. Having washed the parts thoroughly with a 1 in 20 carbolic lotion, the spray was turned on, and I made an incision seven inches in length over the centre of the tumour in the longitudinal axis of the limb, and exposed the sartorius, which was expanded over, and its deeper fibres apparently incorporated with, the sac. I reflected the bulk of the muscle to the outer side, and carefully dissecting through the dense and thickened fascia, opened into Hunter's canal and exposed what appeared to be healthy artery about an inch below the aneurism. After placing two catgut ligatures upon the vessel, I divided it between them and, using the fingers and handle of the knife, with an occasional touch of the edge, lifted the aneurism intact from below upwards. During this proceeding the femoral vein was opened, but this could scarcely be avoided, on account of its intimate connexion with the sac. The long saphenous nerve lay behind, and, though flattened by the pressure of the aneurism, was easily dissected clear. In this way the upper portion of the neck of the sac was reached, and, having secured it with a strong thick catgut ligature as close up as I could get under the indiarubber bands, I cut through the structures half an inch below, and the tumour was free. The Esmarch tourniquet was loosened slowly and removed, and then the rectal lever. The bleeding was insignificant, one or two small vessels divided in the dissection requiring ligature. The wound was brought together with carbolic silk sutures, a medium-sized drainage-tube inserted, and the usual antiseptic dressings applied, the limb being wrapped in wool and bandaged with flannel. The patient made a rapid recovery. The result is a firm healthy cicatrix, with complete obliteration of the external iliac and superficial femoral arteries. The patient is in good health, the limb is as strong as the other, and he returned to his work twelve months ago.

One of the most interesting points in this case is the explanation of the recurrence of the aneurism after complete occlusion of the external iliac. My belief is that, in consequence of the rapid formation of an anastomotic channel through the branches of the internal iliac with those of the profunda, a reverse current was established in the latter vessel, causing return of pulsation and rapid increase in size of the aneurism. The aneurism was no doubt of idiopathic origin, the man's account of it being misleading. It must have existed before he fell, but was probably increased by the injury, rendered painful and so attracted his attention. Lastly, I would lay great stress on the immense value of the bloodless method of Esmarch in such a case. By its means the operation was practicable, and, indeed, comparatively easy; without it the difficulties would have been increased by the welling up of blood into the wound, and the sac would most probably have been opened either by accident or design. I believe, therefore, that in cases where we may reasonably consider the neighbouring arterial tissue healthy, we have in the bloodless method, where applicable, a powerful aid in the treatment of aneurism not hitherto sufficiently appreciated.²

² The patient and aneurism were shown at the Medical Society.

A JAPANESE student has been appointed assistant to the Professor of Anatomy at Berlin.

CEREBRAL HÆMORRHAGE IN A YOUNG SUBJECT.

By WALTER FERGUS, M.D.

ON the afternoon of Nov. 17th I was informed that a youth, sixteen years of age, had been found in a state of insensibility. From inquiries that were made it appeared that the boy had been in his class till one o'clock, that he had done his lessons well, and finished top of his form. Soon after half-past one he went to dinner. He had not sat long before he complained to the boy next to him of not feeling well. The boy advised him to go out into the air. When he attempted to walk he found that his legs were unsteady, and he felt giddy. Two boys then assisted him, and he crossed the court and supported himself against a pillar, where he was found by his house-master, who, finding him unable to walk, carried him into the sick-house, where he was laid on a bed. He told the matron that he had a bad headache, and that he had come out of the dining-hall. A very few minutes afterwards I saw him. He was then perfectly unconscious, and he made no sign when spoken to in the loudest voice. The pupils were strongly contracted, the eyeballs being half open. The teeth were separated about a quarter of an inch, and the jaws were rather rigid, resisting an effort to examine the interior of the mouth. The countenance was slightly suffused and expressionless. The breathing was regular, without stertor or sighing. The pulse was weak and slow, ranging from fifty to sixty-four beats per minute. The temperature was 98.5°. After he was in bed coldness of the hands and feet, and of the nose and ears, came on. A consideration of the circumstances and symptoms led to the conclusion that there must be extensive effusions and pressure at the base of the brain, and treatment seemed to promise little. A blanket bath restored the external warmth, and induced a genial perspiration over the surface; but there was not the smallest improvement in the symptoms. He was unable to swallow from the first, a spoonful of liquid trickled down upon the larynx, where it excited violent coughing and convulsive efforts of breathing. There had been no general convulsion throughout. Death took place about nine hours after the seizure, the breathing becoming laboured and spasmodic during the last half hour of life.

An examination of the head twenty hours after death showed an extensive hæmorrhage, first seen on the sides of the pons, near to the olivary bodies. The fourth ventricle was completely filled by a large dark-coloured blood-clot. The blood extended forward, and both of the lateral ventricles were filled with it. On the right side there was a large clot, entirely filling the ventricle and descending into the cornua. The left ventricle had a good deal of blood in it of a semi-fluid consistence, without any firm coagulum. The brain was large for the size and age of the boy; the brain tissue was of good consistence. There appeared to be a laceration of the side of the fourth ventricle, but no cyst was found. The calvaria presented a remarkable appearance. When the scalp and periosteum were removed the skull was found to be reddened in various places from an injection or extravasation of blood in the diploe. One patch of redness was almost the size of the parietal bone, in which it was situated. This condition of the bones of the skull may have existed for a considerable time, as it had no appearance of being recent. The previous history of the boy is that in early life he suffered from chorea, and that on one occasion he had fallen suddenly down on the floor of the room where he was, but did not lose consciousness. He was a small boy, and ill-developed for his age.

Marlborough.

ON A MODE OF IDENTIFYING THE UPPER AND LOWER ENDS OF ANY GIVEN PIECE OF SMALL INTESTINE.

By R. FRANK RAND, M.B.

It is confessedly difficult to determine the course, as between duodenum and cæcum, of any portion of the small bowel which may present when an opening is made into the abdominal cavity; as, for example, in a section made for the relief of intestinal obstruction. Operators have ere this