

seemed slightly better. Mercurial inunction was had recourse to, as we thought it possible that some specific affection of the larynx might be causing the hoarseness and spasms. On January 31st the spasms were more frequent, and there was greater difficulty of breathing. Assisted by Dr. Beatson, I opened the trachea, with immediate relief to the urgent symptoms. There was no swelling about the throat, and no special difficulty in performing the operation. One of the late Dr. Foulis's tubes was used, and the breathing was perfect until the inner tube was inserted, when a spasm immediately took place, so that it (the inner tube) was removed. The child progressed favourably for three days, when suddenly an abscess burst into the trachea and death took place. When the nurse was dressing the child after death, she noticed something sharp and prominent at the left side of the neck, an inch below and to the outer side of the wound, and drew my attention to it. On introducing my finger into the tracheal wound, I found behind it the outline of a foreign substance, not in the trachea, but evidently between it and the œsophagus. Cutting down on the external sharp point, a pin was extracted measuring two inches in length, and from its appearance it was evident that it had belonged to a brooch or safety pin. I was allowed to examine the throat, and found that an abscess existed between the trachea and gullet, which had burst into the windpipe and caused the fatal result. The larynx and trachea were quite healthy, there being no evidence of any affection of the vocal cords.

Remarks.—On explaining the cause of death to the child's mother, she stated that three months previously, while from home, a brooch was found without the pin, which had been broken, and, like many other children, our little patient often put beads, pins, &c., into her mouth, and while in the country she may have swallowed the brooch pin. It is quite possible for a pin to remain in the œsophagus for a considerable time without causing any irritation, especially if it is fixed perpendicularly. Some displacement takes place and an abscess gradually forms, pressure on the trachea causing spasm, which in the present case necessitated tracheotomy; finally the abscess burst and displaced the pin into the position in which we found it. This case illustrates the importance of bearing in mind the possibility of foreign bodies in the larynx, trachea, and œsophagus producing spasm and difficulty of breathing, even where there is no history of such being swallowed to guide us. An examination of the larynx with the laryngoscope might have aided us, but as we felt certain that we were either dealing with an inflammatory or specific affection of the windpipe, we deemed it unnecessary to give the child chloroform for that purpose.

PARALYSIS OF THE ABDUCTORS OF THE VOCAL CORDS.

BY A. LEGGE ROE, L.K.Q.C.P.I., L.R.C.S.I.,
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I READ with much interest the paper by Dr. Gordon Holmes in THE LANCET of the 22nd and 29th ult. During the last few weeks I have had under my care at the Hull and Sculcoates Dispensary two well-marked cases of this somewhat rare disease. The first was a man aged forty-five, who complained of marked inspiratory difficulty, which laryngoscopic examination proved to be caused by bilateral paralysis of the abductor muscles. Careful examination of the chest gave negative results. Unfortunately, being pressed for time, a complete history was not then obtained, and the man on being informed of the serious nature of the affection ceased to attend, and has been lost sight of.

The second case, a woman aged fifty-eight, is at present under treatment. She gives a most clear history of an attack of laryngitis twenty years ago, which was shortly followed by difficulty in breathing, most marked on exertion or when she had a cold. This difficulty has remained ever since. Laryngoscopic examination revealed complete paralysis of the abductor muscles; the vocal cords do not separate more than two millimetres on inspiration, and on forcible inspiration are almost driven together by the in-rushing air. Voice unaltered; sonorous inspiration present during quiet respiration, very loud during sleep. No enlarged glands, tumour, or other cause of pressure could be discovered.

This case is of interest on account of the clear history of the great length of time the paralysis has existed without

calling for operative interference. The cold from which she was suffering when she first presented herself caused great inspiratory difficulty. This has now passed away, and the respiration is comparatively quiet.

Hull.

CASE OF SUPERFŒTATION.

BY B. G. GODFREY, L.R.C.P., M.R.C.S.

I WAS called on Aug. 17th of the present year to Mrs. H—, aged twenty-nine, to attend her in her fourth confinement. She stated she was seven and a half months gone and had been in pain all night, with considerable loss. On examination I found a three and a half months' foetus in the vagina, which came away without difficulty. The uterus was large, rising about two inches above the umbilicus, and I could distinctly feel the movement of another foetus. The placenta did not come away, and all pain ceased. I then left her, as there was no hæmorrhage or pain, and returning in an hour and a half found things *in statu quo*. This state of affairs continued for four days, when the pains returned, and the breech of a child was born before my arrival. I immediately removed the child, still-born, though the nurse informed me that the legs moved after their delivery. The child must have been quite seven months, as the nails were commencing to form and its weight was $4\frac{1}{2}$ lb. The placenta of the second child came away naturally, but was followed by a great deal of hæmorrhage; there was no sign of a second after-birth attached to it. Traction on the smaller cord failed to detach its placenta, so I introduced my hand into the uterus and removed it piecemeal; it was completely adherent and attached to the upper zone on the right side, measuring about 3 in. across; it was not putrid. All the bleeding immediately ceased, and my patient made an excellent recovery, without a drawback.

Balham.

DISLOCATION OF THE FIRST PHALANX OF THE INDEX-FINGER BACKWARDS.

BY E. M. HARRISON, M.R.C.S., &c.

A DISLOCATION similar to that recorded by Mr. Miller in a recent number of THE LANCET lately came under my observation, and may be worthy of a brief record.

A servant girl came to my surgery one morning, stating that in moving a heavy box her hand had slipped, the palmar surface of the proximal end of the phalanx coming into violent contact with the edge of the box. Since the accident, which happened about a quarter of an hour before I saw her, the finger had been immovable and very painful. There was no difficulty in recognising a backward dislocation of the first phalanx on to the metacarpal bone. This was easily reduced with the thumb of the left hand pressing on the displaced bone and traction on the finger with the right hand.

Willowmore, South Africa.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. MARY'S HOSPITAL.

TWO CASES IN WHICH THE OPERATION FOR THE RADICAL CURE OF STRANGULATED INGUINAL HERNIA WAS PERFORMED, AN ATROPHIED TESTIS BEING REMOVED AT THE SAME TIME; RECOVERY; REMARKS.

(Under the care of Mr. EDMUND OWEN.)

THE question of excision of an atrophied testis in cases where operation for strangulated hernia is performed must be left to the discretion of the operator. By the removal of the testis and cord the canal would appear to be more effectually blocked, whilst the removal of the wasted and presumably useless organ does not add materially to the severity of the operation. The best kind of suture to be