

four days the union of the wound was complete, and the patient swallowed with ease. On the 25th of August, he went out perfectly cured, with a very trifling deformity; a cleft fifteen lines long was to be seen in the situation of the vault of the palate; the uvula and velum palati were in their natural position; deglutition was free, and the patient could easily make himself understood.—*Dublin Med. Press*, Jan. 7, 1846, from *Walthur and Ammon's Journal für Chirurgie*.

44. *Compound Fracture of Os Frontis in a child 18 months old,—three pieces of Bone remaining in the Cerebrum during four months. Recovery.* By THOMAS INMAN, M.D.—Isabella Oliver, aged 18 months, was brought to the Infirmary in her mother's arms, having just received a kick from a horse. On examination, an extensive fracture of the right frontal bone was discovered, with great loss of substance. The little finger was passed through the opening into the brain, which was extensively lacerated, but no fragments could be detected. The child did not appear to suffer from the injury. A little lint, dipped in cold water, was laid over the wound, with directions to the mother to keep it constantly wet, &c.

In a few days the brain was seen to be (superficially) in a sloughing condition, but no bad symptoms appeared. Six weeks afterwards the slough separated, excepting at one spot, where it adhered pertinaciously, evidently having very deep connections. The rest of the exposed surface was covered by healthy, florid granulations. Four months after the injury four pieces of bone were found in the wound, and readily extracted; they were all rough and dry, as if they had been dead a long time, of different sizes, but in all sufficient to cover a half-crown piece.

In six days from this time the wound had cicatrized completely. The union, however, was membranous only, and the brain could be distinctly seen to pulsate through it. Considerable pressure could be borne at this part without producing any particular effect.

No untoward symptom occurred at any time after the injury, if we except a slight debility while the slough was separating, indicated only by the weakness of the cry.

No other treatment was adopted than an occasional powder to open the bowels, and the continuance of water dressing.—*Report of Liverpool Path. Soc., Edin. Med. and Surg. Journ.*, Oct. 1845.

45. *Fractures of the Ribs.*—M. Lisfranc has introduced what is said to be a modification in the treatment of this accident, the importance of which experience confirms. Pressure exercised on an oval body acts with more force in the direction of the longest diameter; and the transverse is generally greater than the antero-posterior diameter of the thorax. Accordingly, the pressure of a bandage, embracing the whole circumference of the chest, is greatest at the lateral parts, and thus must tend to press the ends of the bone *inwards*, instead of fulfilling the indication of directing them *outwards*. For the latter purpose compresses, about four inches wide, should be placed over the sternum; so graduated, that the antero-posterior not only equals but even exceeds the lateral diameter.

This principle of treatment is undoubtedly correct, and we believe it is admitted by Mr. Samuel Cooper and others; at the same time it is very seldom acted upon in this country, and perhaps in consequence of the omission, the bandages have frequently to be removed altogether, to obviate the pain produced in respiration by the fractured extremity of the bone.—*Ansell's Report in Ranking's Abstract*, vol. ii. from *Gaz. des Hôpitaux*, July 8, 1845.

46. *Amputation at the Ankle-Joint.*—Dr. HANDYSIDE, of the Royal Infirmary, Edinburgh, has forwarded us several papers containing cases intended to assist in forming an estimate of the relative merits of amputation below the knee and at the ankle-joint for caries of the joint and tarsus. He describes the method of operating by antero-posterior flaps, as practiced by Professor Syme, the soft parts of the heel being included in the posterior flap, and the flaps meeting transversely in front of the anterior margin of the lower end of the tibia; but Dr. Handyside recommends in preference a method by antero-lateral flaps. This operation is described as follows:—A strong bistoury was entered in front of the joint, and

midway between the malleoli. From this point an incision was carried forwards, over the side of the instep, in a semicircular direction, and then downwards to the middle line of the foot, terminating immediately in front of the ball of the heel. The extremities of this incision were met by another and a similar one on the outer aspect of the joint, the second one terminating where the first had been commenced. The flaps were then dissected backwards,—the tendo-Achillis was easily divided at its attachment to the os calcis,—and the separation of the foot was readily accomplished. The malleoli were removed by the saw, and along with them about one-eighth of an inch of the lower end of the tibia, although the cartilaginous surface of the latter was not diseased. The anterior tibial and external plantar arteries were tied. After the introduction of the sutures, which were five in number, the flaps covered the bone completely, and the flesh of the ball of the heel was situated, as in the antero-posterior flap operation, below the extremities of the bones. A bandage was then applied to support the stump. The flaps united almost entirely by the first intention, and a month afterwards the patient could rest his weight on the stump; the ball of the heel continued to form an excellent cushion beneath the ends of the bones; the cicatrix was situated vertically on the forepart of the stump; it did not exceed two inches in length; and the leg was only an inch and a half shorter than the other, so that the patient could walk easily with a high-heeled padded shoe.

This operation is inapplicable in some instances, as in severe injuries at the ankle-joint with extensive contusion and laceration of the soft parts, or acute gangrene of the foot, &c., and therefore it cannot entirely supersede amputation of the leg; still it has been performed in more than twenty cases in Edinburgh, all the patients, except one, recovering, and no doubt can be entertained that it is less dangerous to life. It has many advantages over Mr. Syme's method; the flaps meeting vertically in front—the facility afforded of incising the pad of the heel, if necessary, backwards from the point where the two antero-lateral incisions meet—there being no danger from sloughing, since the posterior tibial artery is not divided—the operation being much more easily and rapidly performed—and the readiness with which, should suppuration take place, the matter drains from the lower commissure of the flaps,—are particularly enumerated. In separating the malleoli, it is better to employ the saw than the cutting pliers, as a thin slice of the lower end of the tibia ought always to be removed.—*Ibid.*

47. *New Form of Varicose Aneurism.*—M. BÉRARD describes (*Gaz. Méd. de Paris*, June 7th, 1845), a variety of varicose aneurism in which the tumour, instead of forming a direct passage of communication between the two vessels, constitutes a sort of diverticulum on the parietes of the vein, at a distance from the artery, while a communication exists through the parietes of the vein contiguous to the artery into the latter vessel, as in the aneurismal varix. The case of a man whose brachial artery was wounded in bleeding is given. After having emptied the sac of the fluid blood and clots which it contained, M. Bérard placed a ligature on the artery two centimetres above the point whence the blood escaped at the bottom of the wound. Still, blood continued to flow,—black when the artery was compressed, both arterial and venous when the compression was removed. It was now ascertained that deep down the artery presented on its anterior parietes a large wound, nearly transverse, more than half way across the vessel. The posterior parietes of the vein presented a wound exactly corresponding with that in the artery. On the anterior parietes of the vein a third wound was discovered, exactly similar to the two former, and in the front of the vein there was an aneurismal sac. Thus the sac received the blood of the artery, mediately. Adhesion between the vein and artery below the puncture rendered it necessary to include them in the same ligature, when all hemorrhage instantly ceased.

M. Bérard believes this form of varicose aneurism exists much more frequently than that intermediate between the vein and artery, although not hitherto described.—*Ibid.*

48. *Early operation for Hare-lip.*—In the No. of this Journal for July, 1842, p. 188, we gave an abstract of a communication made to the Surgical Society of Ireland, by Dr. Houston, the object of which was to show the expediency of ope-