

*Uva Ursi a Substitute for Ergot.*—Dr. E. G. HARRIS, of Fayette, Ala., calls attention (*Southern Med. and Surg. Journ.* Sept. 1853) to uva ursi as a substitute for ergot, in producing uterine contraction. Since December last, he has given it in five cases.

Dr. H. makes an infusion of two ounces of uva ursi in a pint of boiling water, one-fourth to be given, as hot as it can be drunk, every ten or fifteen minutes, until it has the desired effect.

*Cockle-Bur in Rima-Glottidis removed with Forceps.*—Prof. DUGAS, of Augusta, Ga., records (*Southern Med. and Surg. Journ.* Aug. 1853) the following interesting case:—

"York, a negro boy, twelve years of age, belonging to Mr. —, of Columbia County, was engaged, in November last, in removing cockle-burs from the mane of a horse, and put one of them in his mouth. By a sudden inspiration, the bur was carried down his throat, and he immediately experienced some difficulty in breathing, attended with frequent coughing. Medical aid was invoked, and an emetic administered without relief. The boy continued in this state several days, and was then brought to this city. We found that he breathed and coughed as though affected with oedema-glottidis or with membranous croup; his voice was extinct, and he spoke in a whisper; on walking briskly, he suffered for want of breath; he pointed to the thyroid cartilage as the seat of soreness; had some arterial excitement; nothing abnormal heard on auscultating the lungs, but a whiz was perceived on placing the stethoscope upon the larynx. By the most careful ocular inspection of the pharynx, the bur could not be seen. The finger being, however, carried down below the epiglottis, would feel the bur rise up against its extremity whenever the larynx was elevated by an attempt at deglutition. The cockle-bur was evidently situated vertically, with one end within the laryngeal aperture, and so securely fixed, by means of its minute hooks, into the mucous membrane, that its position could not be changed by such delicate touches with the finger as I thought it prudent to make during the momentary contact alluded to. A pair of oesophageal forceps being at hand, I made, in vain, repeated attempts to seize the bur, until the patient became very much exhausted. The continual movements of the larynx presented an insuperable difficulty. He was then allowed to rest, and an emetic of ipecacuanha administered in the evening, in the hope that the bur might be dislodged during the efforts to vomit. This also failed, as it had done before.

"On the following morning (Nov. 8), I provided myself with a pair of small curved polypus forceps, and carrying the index-finger of the left hand down below the epiglottis, forcibly drew this upwards, and at the same time glided the finger still lower, until its extremity rested in contact with the bur. The forceps were now with the right hand carried along the finger, and the bur effectually seized and extracted, after but one failure.

"In looking over the standard surgical authorities, we find no allusion whatever to the method adopted in this case, to bring the finger in contact with the larynx, and to stay its movements during the introduction of the necessary instruments. Some of those who treat at all of the removal of bodies lodged in the rima-glottidis, recommend, in general terms, their extraction with forceps, if possible, and when this cannot be done, advise immediate recourse to tracheotomy. Others make no mention whatever of the use of forceps, but resort at once to the knife. We have not had the leisure to examine *all* the written authorities at hand, and would therefore simply lay the subject before the profession, who may judge of its value as well as its originality. It may be sometimes difficult or impossible, in adults, to introduce the finger sufficiently far below the epiglottis to draw this forwards effectually, and to carry the finger to the larynx at the same time that its movements are prevented. But in children this can very rarely be the case."