

was passed upward, through the opening in the trachea, to the larynx, and the tracheal tube was passed through the place prepared for it in the end of the laryngeal tube.

Subsequently, after several experimental tubes had been made the laryngo-tracheal tubes, shown in Fig. 3 were constructed. Although somewhat larger in caliber than the rubber tube, the first of the silver tubes made had proven too small, and a tube, the caliber of which was about two millimeters greater than that of the rubber tube formerly worn had to be procured. Owing to the contraction of the trachea about two inches below the opening, whenever the tracheal tube was left out for fifteen or twenty minutes, it was necessary to make the silver tracheal tube long and formed, at its lower extremity, like the Durham tube. This silver tube the patient wore comfortably and with it was able to talk naturally. The author thought that the patient would be obliged to wear the tube the remainder of her life, because of the elastic stricture of the trachea about three inches below the glottis.

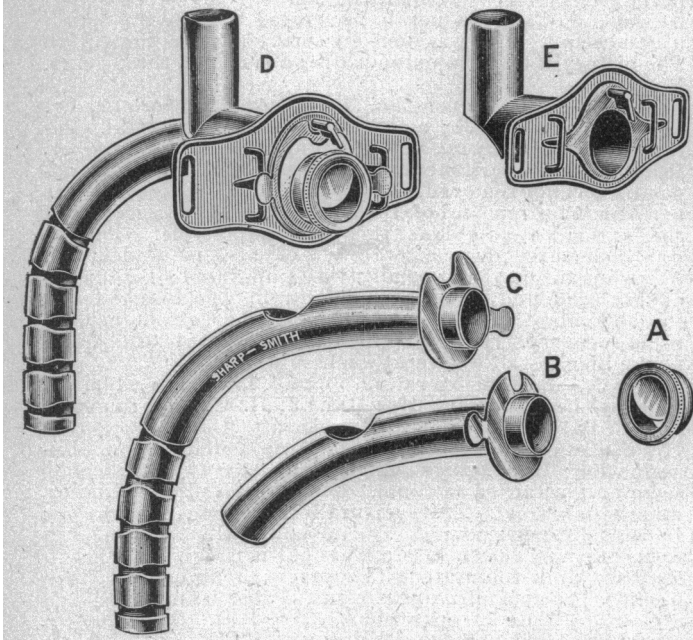


Fig. 3.—Ingals' laryngo-tracheal stenosis tubes (two-thirds size) A, cap with valve to prevent the escape of blast of air during phonation. B, middle tube. C, inner tube. D, instrument complete, all parts in position. E, outer tube.

In the discussion which followed, Dr. Wm. E. Casselberry referred to an interesting case which had been presented to the American Laryngological Association by Dr. Cohen, where the patient was able not only to speak, but to sing, although no air whatever could pass from the trachea to the mouth; and he inquired of the author of the paper especially regarding the voice in the case reported.

Dr. Ingals stated that the patient was unable to speak even in a whisper that could be understood; though by sucking air into her mouth before attempting to speak she could make some sounds with her lips, but the nurses and physicians at the hospital were unable to understand more than one word in ten; her friends, however, had learned to understand her by the movements of the lips.

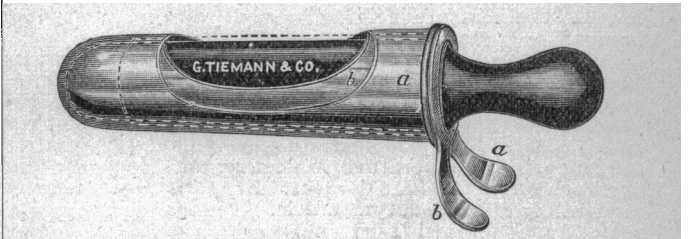
Several months after the operation the patient was wearing the silver tracheal tube and speaking naturally.

A NEW RECTAL SPECULUM.

BY N. H. HENDERSON, M.D.
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While one would think after examining the various rectal specula now on the market that there would be no room for another, experience has demonstrated

that there is. The new rectal speculum as shown in the cut below is sure to find a place in the hands of those who are giving attention to diseases of the rectum. By rotating handle, B, one-half, we completely close the opening, in which position the instrument should be when introduced. As will be observed, when the handle, B, is rotated directly over handle, A, we have a large opening, exposing almost one-half of the caliber of the rectum.



After introducing the speculum the handle, B, is to be rotated little or much, to expose little or much of the field as may be desired. In using the speculum in this way the plug is not necessary, but is only designed to be used in a rectum small enough to indicate a smaller sized speculum; in which case the inner speculum should be withdrawn and used with the plug. We now have two complete instruments capable of a great variety of adaptations.

It is not claimed for this instrument that it takes the place of all other rectal specula, but it will be found on trial, specially valuable in the management of diseases of the rectum. I claim for this speculum some advantages which others do not possess. Many patients present a redundancy of tissue just within the anus, so that when a bi-valve speculum is introduced the field of observation is obscured.

This speculum overcomes this, by supporting the entire circumference of the anus to a depth of three-fourths of an inch. It also holds back from the field of observation any fecal matter that may be in the rectum, which no other speculum does.

This instrument was made for me by Geo. Tiemann & Co., New York, and is also manufactured by Chas. Truax, Greene & Co., Chicago.

APPENDICITIS; WITH ORIGINAL REPORT AND ANALYSIS OF ONE HUNDRED AND FORTY-ONE HISTORIES AND LAPAROTOMIES FOR THAT DISEASE UNDER PERSONAL OBSERVATION.

Read before the Pan-American Medical Congress.

BY J. B. MURPHY, M.D.

CHICAGO.

PROFESSOR OF SURGERY, AND CLINICAL SURGERY, COLLEGE OF PHYSICIANS AND SURGEONS, CHICAGO; PROFESSOR OF SURGERY, POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL; ATTENDING SURGEON TO COOK COUNTY HOSPITAL; ATTENDING SURGEON TO ALEXIAN BROTHERS' HOSPITAL; CONSULTING SURGEON TO HOSPITAL FOR CRIPPLED CHILDREN, ETC.

(Continued from page 308).

Case 21.—Date of operation July 24, 1890. Operator, Dr. E. W. Lee. N. C., aged 34 years; female. Present sickness commenced July 16; complained of chills, fever, vomiting, and abdominal pain, latter more pronounced in ileo-cecal region. July 18, pulse 120, temperature 103 degrees. Slight tenderness in ileo-cecal region. July 21, pulse 124, temperature 102.5 degrees. Great pain over whole abdomen. Tenderness over ileo-cecal region marked and induration present. Operation: Appendicectomy. Appendix large, swollen, and tortuous; no perforation. Appendix contained enterolith in which was imbedded a small spicula of bone. There