

"As the point of the foot was still drawn considerably inwards by the contraction of the tendon of the flexor longus pollicis, this was divided, and extension afterwards kept up.

"In about ten weeks after the date of the first operation, the form and mobility of the foot left nothing to wish for; and the boy could move about with the greatest facility.

"The fourth case occurred in a youth 19 years of age. The foot was turned inward, so that the point of support in standing was on the metatarsal bone of the small toe. The result of the operation and of the subsequent treatment was so successful, that the deformity was quite removed (*das entstellende eubel war ganz gehoben.*")

53. *Section of the Sterno Mastoid-Muscle, for the cure of Wry-Neck.*—This operation has been performed by M. AMUSSAT. The patient, a man 53 years of age, stated that seven years ago, while carrying a heavy weight on his back, he suddenly felt a sharp pain on one side of the neck, and that this pain lasted for the following fortnight or three weeks; that some time after all uneasiness had ceased, he began to experience, chiefly at night, a stiffness of the neck, and a tendency to incline it to the left side; that on awaking one morning, he found that he had a very painful wry-neck; that this attack however speedily abated; but that ever afterwards the stiffness of the neck and its turning to the left side were much more troublesome than they had been before, and that these symptoms soon increased so much, that he was forced to resort to the expedient of steadying his head, when engaged at his work, by fixing a packthread to his front teeth, and securing it to one of his thighs! This expedient, however, proved insufficient; and in the course of ten months, the malady had increased so much that he was forced to discontinue altogether his employment as a shoemaker. The left sternomastoid had become larger and thicker than its fellow. A variety of remedies, including blisters, acupuncture, electricity, &c., had been tried without avail. M. Amussat therefore advised him to submit to the division of the affected muscle. Pinching up the skin, about an inch above the insertion of the muscle into the extremity of the clavicle, he divided the fold with a sweep of the bistoury; he then severed the muscle, layer of fibre after layer, permitting one to retract before dividing the other, until the entire substance was fairly cut through, with the exception of a few of the outer, or clavicular fibres. A few arteries sprung; but the hemorrhage from these was easily arrested, by twisting their bleeding extremities. The wound was then dressed with simple cerate. The wryness of the neck was unexpectedly quite as great after, as it had been before, the operation, and continued to be so for at least three weeks. As the cicatrization of the wound advanced, the deformity was observed to decrease; and, by the end of the sixth week after the operation, when the wound was quite healed, the normal position of the neck was perfectly recovered.

The most interesting features of the present case are, first, the long continuance of the malady; it had existed for seven years; secondly, the cure obtained without the use of any apparatus, either during or after the section of the muscle; thirdly, the permanence of the cure—it is now upwards of a twelvemonth since the date of the operation; and lastly, the proof which is thus established of the efficacy of the treatment recommended by the older surgeons, and which of late years had fallen into unmerited desuetude.

The point at which M. Amussat divided the muscle, was that usually indicated in surgical works. M. Malgaigne has, in his *Manual Operatoire*, suggested that the division should be made higher up, with the view of more effectually avoiding the large blood-vessels in the neighbourhood, and also because the muscle is less bulky. With respect to the former of these motives, it is founded on an anatomical mistake; for M. Amussat shews that the sterno-mastoid is as close to the blood-vessels higher up in the neck, as it is lower down; and moreover, that at this latter point, the omo-hyoideus being interposed between the muscle and the vessels, secures the latter in some degree from the risk of injury. —*Med. and Chirurg. Rev. from Gazette Médicale de Paris.*

54. *Radical cure of Varicose Veins and of Hernia by Acupuncture.*—M. BONNET, Surgeon in Chief of the Hôtel Dieu at Lyons, has treated eleven cases of

varicose veins by introducing pins through their cavities, and allowing them to remain there for some time. Nine of these cases were cured. He has applied the same treatment to herniary sacs; and the following is a short account of his method, and of the success which he has obtained from it. He passes three or four pins through the herniary coverings close to the inguinal ring, and in order that they may exert a certain degree of compression, as well as of irritation, on the sac, he twists upwards their points and heads, so as to give them a circular direction.

Caution is necessary not to injure the spermatic cord. The inflammation and pain commenced usually on the third or fourth day after the operation, and the pins were removed a few days afterwards. M. Bonnet has treated four cases of inguinal herniæ by acupuncture. In two of these, the herniæ were small, and three weeks sufficed for the cure. The third was more troublesome. It occurred in an old man 67 years of age; and in him the hernia descended to the bottom of the scrotum, and was with difficulty kept up by a truss. Six needles were used. After a month's treatment, this patient could walk about, without any tendency of the viscera to descend. In the fourth case, the hernia was of 30 years' standing; no truss could keep it up; the inguinal aperture was large enough to admit the introduction of five fingers, and the tumour descended a considerable way down the thigh. Five weeks were necessary for the cure. We are assured that all these patients could cough and walk about freely without any escape of the bowels, and that the inguinal ring was so plugged up, that it could no longer be distinctly recognised.—*Ibid.*

55. *Dissection of an Old Dislocation of the Thumb, with Remarks and Experiments.* By J. ADAIR LAWRIE, Professor of Surgery, Glasgow.—I am indebted to Dr. Hunter, Andersonian Professor of Anatomy, for permission to examine and make public the following case:—A female subject was brought into Dr. Hunter's dissecting rooms during the course of last winter, with an unreduced dislocation of the phalanx of the right thumb, on the back part of the metacarpal bone. It was ascertained on inquiry, that the dislocation had existed for three years, and that several unsuccessful attempts had been made to reduce it. The motions had been partially restored and performed without pain. Previous to dissection, the phalanx was seen to be thrown back, with an anterior and posterior prominence. The thumb shortened, the second phalanx not bent on the first, and the articulation between them capable of free flexion and extension. There being no swelling, the nature of the accident was obvious.

*Dissection.—Bones:* the end of the phalanx was thrown on the back and inner part of the metacarpal bone, to the distance of at least an inch. The circumstance of the phalanx being placed on the inner side of the back part of the metacarpal bone is worthy of notice, as I believe that it is almost uniformly so situated in this dislocation. The end of the metacarpal bone projected forwards to a distance corresponding with the displacement backwards, free from muscle or ligament.

*Ligaments.*—The anterior ligament torn from metacarpal bone; the posterior pressed back, but apparently nearly entire. The anterior portion of external lateral torn; the posterior portion stretched, thrown back and across the metacarpal bone; the internal entire. New ligamentous connexions had formed between the displaced bones.

*Muscles.*—Extensors thrown back, and somewhat stretched over the end of the phalanx; of these, however, I cannot speak with certainty; as they were cut before I examined the preparation minutely. Abductor thrown back, and a little stretched. Opponents a little changed. Flexor brevis: on this muscle, and the flexor longus, the alteration of position was most remarkable. Dr. Hunter thought that the brevis was not torn, but that the end of the metacarpal bone had passed between its two portions, one of which was on each side of it, grasping it firmly. Further examination induces me to think that the greater part of the outer head was torn, the end of the metacarpal bone having passed through its fibres, and that the inner head was uninjured, having slipped to the inner side of the metacarpal bone. The tendon of the flexor longus lay on the inner side of the metacarpal bone, along with the inner head of the brevis, pressing on the abductor, and pushing it back, which last muscle, with this exception, was unchanged.

*Nerves.*—The first, or external digital nerve, is thrown to the inside of the