melon; and on handling, a peculiar boggy elastic feeling is communicated. An impulse is perceived in each variety of this hernia on the patient coughing or otherwise making forced expiration. I have never read of any other affection simulating this disease; and the following case, as affording an instance, may therefore interest.

A child, about five or six years of age, had suffered from fever, believed to be typhoid; but, during the convalescence, a small tumour appeared at the umbilicus, accompanied with pain, tenderness on pressure of the abdomen, and sickness.

I found, on being called in, a protrusion at the umbilicus exactly resembling umbilical hernia; it could not be returned, and was accompanied with great tenderness of the abdomen, pain, sickness, and constipation. It looked to me a case of strangulated umbilical hernia; and, as the objective and subjective symptoms were so unfavourable, relief by operation seemed a forlorn hope. In no long time, the tumour became discoloured, gangrenous, and sloughy; and within a few days from its first appearance, gave way; but, instead of stercus, there issued pus, and this in large quantity, without admixture. The case was now explained to be abscess bursting at the umbilicus; and my fears respecting artificial anus or faecal fistula were dissipated, as no connection with the intestine had been formed. Pus continued to issue from the opening for two or three weeks; it then ceased; the child's health became restored; he grew well; and is now a robust adult.

I believe the case was one of secondary abdominal cellulitis following fever. I have found this externally in the sheath of the rectus; and there seems no reason why it might not occur within the abdominal walls, and probably in the fascia propria; that it was not glandular abscess, seems clear from the subsequent history of the patient.

It is generally recommended to treat simple reducible umbilical hernia in the child by applying compresses of wood, lead, or lint, kept in place by plasters or bandages; or by elastic bandages with conical projections of India-rubber, or balls inflated with air, to make pressure at the umbilicus; the whole of which I deem to be very unsatisfactory. As many months, or even a year or two, may be necessary for the cure, the employment of plasters for such periods on the delicate skin of the infant, I hold to be hardly possible, reflecting on the irritation and filth which must occur, and, moreover, that the warmth of the child's skin in this situation is continually loosening the most adhesive preparation. Ordinary bandages will shift position with the multitudinous movements of the child, notwithstanding the greatest care in their application. The wide elastic bandage, with a cone to press on the umbilicus, will sometimes fit and keep in position, but as frequently it will not; it is questionable, however, whether it be advisable to have conical pressure exerted in this disease, lest it retard the contraction of the umbilical aperture. Another objection to the elastic bandage is, that it will not wash; a matter of consequence where an article is required to be worn on the body of a young child for months, and even years. Feeling these objections, I designed a little apparatus, which I have recommended to my patients for a great many years, and which I will briefly describe.

An abdominal support is to be made of two layers of thick calico; it is to be open behind, where some strings or a lace should be placed; the body must have several cords of stout bobbin drawn between the layers from top to bottom, to prevent folding; and, in the part which covers the umbilicus, a pocket of about two and a half inches square, opening in-

wards, is to be formed, which is to receive a square of gutta percha, about the thickness of moderately stout tapping leather, with the edges pared or rounded by a file; a few stitches may then be made to keep the pocket closed. There should be shoulder- and thigh-straps to keep it in place; and it then may be worn either on the outside or within the child's linen. The warmth of the abdomen moulds the gutta percha into shape, which thus effectually covers the umbilicus, and repels the hernial protrusion. It is well to have at least two abdominal supports of this kind for each patient; a soiled article can thus be replaced by a clean one, the gutta percha being removed from the one to the other. In this way, the case is managed effectively, and with due attention to comfort and cleanliness.

Obstruction, or strangulation of this hernia, may occur in the adult, as I have myself seen; but in respect to infantile umbilical hernia, I never saw, heard, or read, of a case of strangulation. A very large proportion of the cases are never placed under professional treatment; and being left to nature, with the assistance of the support afforded by the usual dress of the infant, do well. I knew a practitioner of large experience who left these cases to the care of the parents, with the assurance that they would be cured, and no untoward results were known to follow. The assistance of the surgeon may, therefore, be rather an aid than a necessity—valuable in expediting, rather than ensuring, the recovery of the patient.

DISLOCATION OF THE HEAD OF THE RADIUS.

By HENRY HARE, M.D., Great Baddow.

THE following case, which occurred in my practice on September 28th, may be considered of interest.

A boy, about 10 years of age, was thrown from a donkey, pitching on his hand. When he came to my surgery, I found the left arm hanging down by his side; the hand being in a state of pronation. I could easily bend the forearm upon the arm, and also extend it fully; and that without giving pain. I could effect supination and pronation, with the infliction of little uneasiness. The head of the radius could be felt on the outside of the external condyle of the humerus. It was perceived and felt to move under the finger on effecting supination and pronation. The ulna was normal in its position; and without fracture. There was no fracture of the radius. The appearance of the forearm that struck me most, was that of a depression behind, beneath the olecranon, along the margin of the ulna, making the whole of that bone prominent, brought out, as it were, in relief, when the hand was in a state of pronation. The tendon of the biceps muscle felt somewhat tense. The depression appeared less, when the hand was put in the state of supination; but did not disappear altogether. I diagnosed dislocation of the head of the radius outwards.

I made an unsuccessful attempt at reduction by extension; grasping the boy's hand with my right, and his arm with my left hand. I afterwards put my knee in the bend of the elbow, and flexed the forearm; the head of the radius immediately returned to its normal position with a snap.

When I saw the boy next morning, the arm appeared quite normal, with the exception that behind, the margin of the ulna remained somewhat prominent; and there was a slight appearance of depression (a muscular effect, I imagine) about the middle, along the margin of the ulna.