After the second fit, I procured some tincture of Indian hemp, thirty drops of which, with a small quantity of water, was with difficulty swallowed; but no more was taken, as he was unable to get it down.

On my fifth visit to him that day, he was seized with his third severe spasm, the first having occurred eight hours previously. The attack was of short duration. The pulse, which at its commencement was readily felt, gradually became indistinct, and the respirations gasping; and it would be difficult to say which terminated first, had not a slight gasp occurred a few seconds after I believed he was dead. During the last fit, the muscles of the face were relaxed; the thighs and legs flexed, but motionless; the arms bent; the hands clenched. Immediately after death, his countenance resumed a quiet aspect.

The next morning, I examined the body externally, and observed that the face was mottled, and showed signs of rapid decomposition. The legs were straight, and the back without any bend in it; the fingers were clenched, but easily opened. An anatomical inspection was refused, until some relations at a distance could be consulted: the body was then too far advanced in decomposition to render an inspection satisfactory; indeed, it was obliged to be buried forty hours after death.

ON AMPUTATIONS.

By JOHN RUSSELL, Esq., Merthyr Tydfil.

In hazarding suggestions respecting the common operation of amputation, I fully expect to have been anticipated in my ideas, as practice would be likely to give rise to them with others as well as with myself. My object is to draw the attention of the more inexperienced in this branch of surgery to the very great difference between amputation performed on one limb shrunk from disease and inaction, and on another in a state of health and development. I have searched the most recent and high works of authority on operative surgery, with the expectation of finding the point touched upon; but I have not succeeded.

A young operator, whose only experience has been on the dead subject, should he be called upon to operate upon a limb in the first condition above described, would find an absence of all elasticity of skin, cellular tissue, and muscle; and he would find no unequal retraction of parts, and probably no natural separation or retraction of them: and, should he have followed strictly the directions laid down by authorities, he would find the result correspond with his previous practice on the dead subject, and his operation would necessarily be followed by a flattering stump.

But, in the case of a limb in the opposite condition, he would find circumstances very different, and be very likely disappointed at the result; as, in such a case, all structures would be found in the highest degree elastic, and the retraction of them very unequal. The skin would retract most, and the muscles (each layer) less and less towards the centre of the limb, thereby causing somewhat of a convex instead of a concave flap.

The contrast between these two conditions has appeared to me so striking, that it surprises me so little notice has been taken of it. I have looked through Liston's, Skey's, and Erichsen's works on operative surgery, for suggestions applying to the different cases; but the only one bearing upon the point is the plan proposed by Mr. Skey in amputations (I believe?) in general: viz., that of pressing up the muscles under the protection of the bone with the flat hand before transfixing, preparatory to making the posterior flap. I have not tried this plan. It appears to me, however, that, in so doing, the surgeon must sacrifice skin as well as muscle, although not in the ordinary proportions. And I fear that the palm of the hand, and more especially the ball of the thumb, must be inconveniently near the knife.

My own plan has been to make two lateral incisions through the skin; then to grasp a fold of it between the finger and thumb (similar to the fold seized when lifting a dog by the nape of the neck), before transfixing for the posterior flap; and to carry the hand down, keeping pace with the knife, until sufficient flap has been secured; then to cut out. By this plan there is great gain of integument, and sacrifice of useless muscle; and the operator's hand is safely out of the way of the knife. The sacrifice of muscle will be found of great advantage; and the limb should be transfixed close to the margins of the drawn skin. It is hardly possible to save too much skin; for, however bag-like and unseemly it may look at the

time, it will eventually contract to the dimensions of the stump. The occasional difficulty of securing the vessels, after amputation of the leg, suggests the plan of carefully passing the knife perpendicularly and square to the plane of the bones, a short distance below the intended site of sawing through them, and then cutting up a short way close to each; thus leaving a tongue of muscle and ligament between the bones which would contain the vessels.

When mention is made, in the JOURNAL of November 13th, of the use of silver sutures in King's College Hospital, as imported from America. In reference to this, I beg to say that, in 1835, as dresser at Guy's Hospital, I assisted the late Mr. Morgan in a case of amputation of the leg, in which he used silver sutures. As if to test their utility, secondary hæmorrhage came on in the evening. But the pain caused by the angles of the untwisted wire seemed to be an objection to its use. Besides this, the wire across the wound very much interfered with the search for the bleeding vessel. Wire may, nevertheless, be found useful in other cases.

A point much overlooked in operative surgery is the use of warm instruments. Of this I had a striking illustration the other day. A patient had a bubo opened by a cold lancet. A short time afterwards, another abscess formed, and discharged its contents by forming a communication with the first opening, which was about an inch and a half distant. I slit open the canal of communication, having carefully warmed the director and bistoury. The patient ridiculed the dread which he had entertained previously to the operation: he said that the pain was trifling, compared with the former operation of lancing; and immediately assigned the reason himself. The practice of warming tooth instruments is very common, and is a great comfort to patients.

ANALYSIS OF FIVE HUNDRED CASES OF LABOUR.

By FREDERICK COLLINS, M.D., Wanstead.

COMPLYING with the hint given in the JOURNAL of November 27th, I have pleasure in forwarding an analysis of the midwifery cases I have attended within the last few years.

Every cases I have attended within the last few years.					
Number of cases	.	.	.	.	508
Twin cases	.	.	.	.	8
Total number of children {	Males	280	}	508	
	Females	228	}		
Presentations :—					
Natural (the membranes being expelled entire)	.	.	.	.	484
in 4 cases)	.	.	.	.	
Face towards pubes	.	.	.	.	6
Breech	.	.	.	.	9
Foot—including 4 cases of turning	.	.	.	.	7
Arm	.	.	.	.	2
Still-born :—					
Putrid	.	.	.	.	6
Premature	.	.	.	.	13
Craniotomy	.	.	.	.	2
Other cases	.	.	.	.	8
29					
Funis round the neck : in several cases three times	.	.	.	.	96
Placenta partially presented	.	.	.	.	2
Placenta adherent : in one instance extremely ossified	.	.	.	.	5
Forceps cases	.	.	.	.	3
Labour induced at seventh month : mother and child	.	.	.	.	1
did well	.	.	.	.	
Acephalous fœtus	.	.	.	.	1
Six fingers and toes on each hand and foot : said to	.	.	.	.	1
be hereditary on the male side	.	.	.	.	
Slight <i>post partum</i> hæmorrhage	.	.	.	.	9
Mothers died from causes unconnected with labour :—					
On fourth day, from disease of the heart with	.	.	.	.	1
anasarca	.	.	.	.	
A few hours after delivery, from cholera	.	.	.	.	1
On twelfth day, from confluent small-pox	.	.	.	.	1
Three hours after labour, from inanition : not from	.	.	.	.	
hæmorrhage, but caused by insufficient nourishment during pregnancy. This was her	.	.	.	.	1
twelfth labour	.	.	.	.	
4					