Two days afterwards the arm began to bleed again, the limb was somewhat swollen, the hæmorrhage was considerable, sufficient to make an impression on his system, and he felt faint. The doctor when he arrived at the house applied a bandage from the hand up to the axilla, and a tourniquet over the brachial artery, this had the desired effect of stopping the bleeding. He could not bear the pressure of the tourniquet very long, so that it had to be removed, this was followed by fresh bleeding after the lapse of some hours, which was again controlled by the tourniquet. This state of things was allowed to continue, successive bleedings occuring, and the man fearing the loss of his arm determined to apply for further advice and treatment, and came to the Montreal General Hospital.

September 24th—Passed a good night, rested well, complains of numbness in the fore-arm and hand, no pain nor bleeding, the limb is still suspended above the level of his body, he is confined to bed, and ice water constantly applied. The tourniquet is loosely retained over the situation of the brachial artery.

27th.—The patient is very comfortable, no pain, the numbness continues, no return of the hæmorrhage, no change was made in the treatment.

28th—This morning early while turning in bed he experienced a sensation of warmth about the arm, and noticed that he was bleeding freely. the tourniquet was at once tightened, which arrested further loss of blood. Dr. Fenwick received early intimation of this circumstance, and came to the hospital before the hour of visit, when he decided on cutting down and ligaturing the bleeding vessel at the point of injury.

The patient was removed to the operating theatre and placed under the influence of chloroform. The tourniquet was removed and also the bandage; the brachial artery was given to an assistant with instructions to exert pressure if necessary, and the operator commenced his incision from below upwards, bisecting the original wound, the incision extending from one inch above the wrist, and seven inches upwards, rather inclining to the ulnar side, and on slitting up the fascia, the palmaris longus muscle was observed to have been divided by the original wound. The finger of the operator was then introduced through the wound in the muscular structures, and he found that he entered a well defined aneurismal sac having a lining membrane, and the direction of which led upwards between the superficial and deep layers of muscles. To reach this and the interosseous space, the flexor sublimis digitorum was separated from the flexor carpi ulnaris, this was effected with the finger, the loose intermuscular septum yielding