

ing in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute œdema and not by phlegmonous inflammation. In the mouth was some ropy mucus tinged with blood, but there was no repulsive odor. While examining these appearances it was suggested that the child had the mumps. There was no swelling, however, about the temporomaxillary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in their being any foreign body in the child's throat but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. Then the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manœuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four

hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover, but, as is often the case in children when the exhaustion and the enfeeblement of the nerve centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

## FRACTURE OF THE LOWER END OF THE RADIUS.

BY R. J. LEVIS, M.D., PHILADELPHIA.

The correct nature and mechanism of the ordinary form of fracture of the lower end of the radius is now, after much controversy, generally admitted and properly comprehended. With this proper understanding the indications of treatment become rational and decisive. In the usual and very characteristic fracture of the carpal end of the radius the primary line of the fracture is, with little tendency to deviation, *transverse* in direction. Associated lines of fracture are generally those of comminution of the lower fragment, and are caused by the upper fragment being driven vertically into it and splitting it, usually in directions towards its articular surface. The displacement of the lower fragment is towards the dorsal aspect of the forearm, and its articular surface is inclined in the same direction, abnormally presenting backwards and upwards.

The mechanism of the fracture is its production by falls upon the palm of the hand, which, with the carpus, undergoes extreme extension, and the fracture is caused by an *act of leverage* or *transverse strain*. This direction of force has also been called *cross-breaking strain*. In this fracture, actual displacement of the lower fragment may not exist at all, or it may be to the extent of complete separation from contact with the broken surfaces, varying with the amount of force applied and with the retaining influence of the surrounding dense structures.

The first essential of the treatment of fracture of the lower end of the radius is *the complete reduction of the displacement*. The action of replacement must be directed to the lower fragment itself. The reduction of the fracture can usually be thoroughly effected, under anæsthesia, by *strong extension applied to the hand, associated with forced flexion of the wrist, and with pressure applied directly on the dorsal surface of the lower fragment*. Unless vertical splitting or comminution of the lower fragment