it in the first instance; and after effusion of lymph has taken place, no good can be expected from the proceeding.

When the operation is decided upon, it becomes a question whether the larynx or the trachea is to be opened; under some circumstances cutting into the crico-thyroid membrane will answer the purpose. In cases where there is obstruction at the rima glottidis, as where swelling has followed a scalding of the parts, the high operation may answer; and in cases where a foriegn body is lodged in the ventricle of the larynx, an opening in the crico-thyroid membrane may suffice, and in that case should be preferred, as being more simple than tracheotomy. It may be accomplished with any pointed instrument, as a penknife, and without any great incision. This operation will also answer exceedingly well in cases of suffocation caused by the impaction of a foreign body in the œsophagus, and many persons have been thus saved. But in the majority of cases tracheotomy is to be preferred, whether it be impaction of a foreign body in the lower part of the trachea, or in cases of œdema and other diseases of the glottis; for by this operation you get a free opening, and one at some distance from the seat of the disease, which is a point of some importance.

The operation itself is not attended with much danger, as the incision into the windpipe can be made without involving any vessel of consequence. There are sometimes large arterial branches running across the windpipe, but not often; the chief obstacle is the presence of the thyroidal veins. The wound heals with great rapidity; too fast indeed in some cases; for when the operation has been performed for the extraction of a foreign body, blood will sometimes be extravasated, or drop into the trachea and cause suffocation. The best plan, therefore, is to put a bit of lint between the edges of the wound, and cover its surface with a pledget dipped in cold water and frequently renewed. After the incision has been made six or eight hours, the edges may then be brought together, and will speedily unite.

There is little difficulty in getting down to the windpipe in an adult patient, if he is steady, and willing, as they generally are, to be relieved from impending suffocation. The patient is placed in a chair, and an assistant bending back the head, an incision is made from the top of the sternum upwards towards the cricoid cartilage, fully an inch in length, and going through the skin and subjacent tissue. You expose at once the sterno-hyoid muscles and cut through them, the veins and the isthmus of the thyroid body are then pushed on one side, and a clear space is thus exposed for making the opening into the trachea. The patient is then to be desired to swallow his saliva, and while the windpipe is raised by this act, the knife is to be pushed into it, and two or three rings to be cut across. If this has been done in consequence of the presence of a foreign body, this will generally fly out the moment the incision is made, and in consequence of the relief to the respiration and the cessation of struggling, the bleeding, principally venous, will cease of itself. Should it happen, however, that there is hemorrhage from an arterial vessel, it must be secured. In cases of permanent or long continued obstruction at the top of the windpipe, it will be necessary to introduce a tube. There is no sound objection to this instrument. Mr. Liston states that he has tried it more than twenty times, and that it does not cause irritation. He condemns the curved canula and trochar as unsurgical.

The operation is far more difficult in children than in the adult, as the neck is shorter and more laden with fat. The patient, if a child, must be well secured, and the operation is then to be performed as above described, with this exception, that as we cannot get the child to swallow its saliva, the larynx must be raised with a sharp hook. The time for which it is necessary to wear the canula varies according to the nature of the disease for which the operation is performed, the only precautions necessary, in connexion with it are to keep it clean, and to cover the orifice with some loose texture, to prevent the admission of cold air.

[In a late number of the *Medical Gazette*, Mr. Cock speaks in very favourable terms of the curved canula and trochar in the operation of opening the trachea. Its principal advantages over the ordinary method, as stated by him, are a saving of time, which in some cases is a matter of great consequence; and the power it gives to the medical attendant of dispensing with assistance. The method of using the instrument, is first to cut boldly down to the larynx, and then to introduce it as in the ordinary operation for hydrocele, the concavity of the instrument of course looking downwards.]—*Half yearly Abstract of Medical Science.*

MIDWIFERY.

EXTIRPATION OF THE UTERUS.

BY M. MOLLET.

Annales de Therapeutiques Jan. 1845.

The subject of this operation was a woman of feeble constitution, æt. 47, mother of three children, who had experienced obscure pains in the uterus for the first time in 1831. The case was supposed at this time to be one of incipient polypus. At the end of 1843 bloody discharges occurred at short intervals, and in the course of the next year became more frequent and abundant. Her general health becoming much impaired she placed herself under the care of M. Mollet.

On the 25th of October the patient suddenly perceived something pass per vaginam, which upon examination proved to be the uterus, completely inverted (?).

It now became a question, what proceeding was to be adopted? Reduction was impossible; therefore the only chance for the patient was either to leave the disease to nature, or to remove it by operation. In the former case, everything was to be feared from the prolonged contact of the air, urine, &c. In the other, a considerable risk had, no doubt, to be encountered; but facts were not wanting to attest the possibility of success. As the patient became daily more and more exhausted, and ulceration with fetid discharge had commenced, the operation was at length decided upon, and performed in the following manner.

At the time of the operation, 11 a.m., the patient was in the following state;—pulse small and feeble; skin soft, without coldness. The tumour was of a grayish white colour, seven inches in length, three and a half in breadth. On the hypothesis that the case was one of total inversion of the uterus, it was agreed that as several important parts, such as the fallopian tubes, ovaries, fundus of the bladder, &c., might be dragged within the concavity of the organ, that an exploratory incision should be made, in order to ascertain what parts had become involved in the misplacement. This was done, after certain precautions had been taken to prevent serious hemorrhage. The bistoury plunged into a somewhat lardaceous tissue; but as no cavity was displayed, it became evident either that the tumour was not the uterus at all, or that that organ had been totally converted into scirrhus. Under these circumstances, it was considered safe to amputate at once by a circular incision. In this manner, the whole of the diseased parts were removed without hemorrhage, the operation lasting only thirteen minutes.

On examination of the parts, it was discovered that the diagnosis had been erroneous; that the uterus was not inverted, as was supposed, but merely dragged downwards by an enormous polypus, which had developed itself on the os tincæ. The patient died on the fifth day. [Appended to this case are some valuable practical remarks on the diagnosis of uter-