she had always enjoyed good health, but that three days before, while at work in the field, she suddenly experienced abdominal pain, which gradually increased to such a degree at night that assistance had to be called. She had had no passage since the commencement of the attack. The patient presented all the symptoms of intestinal strangulation, with nausea, and the anxious expression of countenance, and on examination a tumor about the size of a hen's-egg was found at the site of the right inguinal canal. After giving morphine internally and making warm applications externally, and after an enema, taxis was repeatedly tried without success. The patient refusing an operation, taxis was again tried ineffectually on the following day, when the patient was almost collapsed, and stercoraceous vomiting had set in. The author then introduced a long elastic tube into the rectum as far as it would go, and began to inject air slowly. After a time, the intestinal coils could be seen through the very thin abdominal walls to become distended, and suddenly a peculiar rolling noise, as if the air had overcome an obstruction, was heard, after which the hernia was discovered to have disappeared. Air was then allowed to escape from the tube, and the latter was gradually removed. Half an hour later the patient had a large stool, and then slept; five days afterward she had entirely recovered.—*New York Medical Journal.*

Excision of the Scapula.—Mr. McCormac, of St. Thomas' Hospital, on May 10th, excised the scapula and outer end of the clavicle for a very large tumour of the former bone. The nature of the growth was a mixed enchondroma and myxoma. The operation was completed in twenty-four minutes. There was very little hœmorrhage, although the subclavian artery was exposed, and the subscapular had, of course, to be divided. After the operation, the flaps of skin fell together readily, although a good portion of the integument had to be removed with the growth. On May 19th, the case was doing extremely well, under antiseptic dressing.

Midwifery.

PROFESSOR BUCKINGHAM ON VERSION.

From the excellent "Notes of a Lecture" delivered by the Professor of Obstetrics at Harvard Medical School, and published in the *Boston Medical and Surgical Journal* for February 24, we extract some of the useful practical hints. Called to the patient and about to examine her, he says:—

"But perhaps the pulse is very feeble and very quick; her skin, which a few hours ago was moist and warm, has become cool, and she has had no pain for some time before you saw her. On the whole, then, it would be as well to wait for reaction to come on. If you interfere now, you may cut off the small chance which she still has. The doctor or midwife, who has been with her for hours before you came, has forgotten to feed her, and has neglected to see to her bladder. All he has been trying to do has been to hurry a case which would have done better if left alone. Give her any stimulant which she can take—wine, brandy, rum with milk, or broth, and if her depression be great let her have an opiate. 'An opiate,' you say, 'will put her to sleep.' Perhaps it will,—perhaps not; but I should hope for the former effect. If you can get her a few hours' sleep, she will wake with new strength, and you may go on with the turning or any other operation with much more probability of saving your patient; but if she is so very weak, the dose of opium which would produce ordinarily a long, and perhaps a suspicious or a fatal sleep, will simply stimulate her. Perhaps she cannot retain the opium; very well, throw under the skin an eighth or a sixth of a grain of morphia; and if in half an hour she is not positively warmer and more quiet, with a slower and stronger pulse, repeat it. As soon as this has been done, and before you begin to pass your hand, see to the bladder. Use a long gum-elastic catheter, and do not keep poking about under cover to find the meatus. Neither delicacy nor comfort requires this. See where your catheter goes. If you do not, you may put it up into the uterus in-