

movement without pain, although within all but its extreme range its movements may be free and painless.

In these, among many cases, chloroform or ether may help in diagnosis. In the real disease, as in the mimic, while the patient is utterly insensible, the joint may be moved as widely as in health, unless, indeed, there be such changes in its structure as might alone have proved its disease; but commonly you will observe that, in the real disease, the muscles become alert, and restrain the movement of the joint before the patient has regained consciousness; while in the mimic disease there is no restraint till consciousness is completely regained. The test is a delicate one, but I think I may be sure that it is a true one, and fit to be relied on, whenever the chief sign of disease of the joint is a restraint of movement on account of pain and the guarding action of muscles.

Closely allied with this pain on movement of an inflamed joint is its stiffness, with contraction or other set posture, dependent on muscular action; for this posture, whether it be due to choice or to reflex movement, is the posture of greatest ease, or of safest guard against weight or shock or other causes of pain. The absence, therefore, of the fixed or nearly fixed posture usually observed in a diseased joint may always suggest the suspicion of mimicry. It would be rather strange to see a hip or a knee extended after many weeks of such pain as would be felt in an acute arthritis, unless, indeed, they were rheumatic or gouty, with exaggerated pain, or had been carefully maintained in good position. It would require the presence of many other signs of real disease to counterbalance the absence of this sign; for diseased joints, left to themselves, will be habitually or always in the position easiest to the patient.

But the reverse of this is not true. Very commonly a joint mimicking disease assumes the posture of disease—assumes and maintains it stiffly in even an extreme degree. This may be seen even when there is no objective pain in the joint; but much more, when the joint is a little really painful, as often a blow or strain, the nervous condition of a patient may either make this pain so intense as to demand the position of greatest ease, or may bring about this position for the relief of even a little pain. Especially the posture of hip disease is apt to be imitated by the drawing up of one side of the pelvis and rotating it, so that the limb looks shortened.—[Lancet.

(To be Continued.)

THE GALVANIC WIRE IN SURGERY.

Do British surgeons avail themselves sufficiently of this mode of bloodless section? This may be doubted, and when we seek for the reason we shall soon find that it lies principally in the trouble with which the wire is connected. Now, however, that bloodless operations have become popular, it behoves all those who are conversant both with galvanic apparatus and surgery to devise means of simplifying this operative measure. A few days ago Prof. Boeckl, of the faculty of Nancy, showed, at a meeting of the Surgical Society of Paris, an apparatus with which he can

graduate the force of the current, and remove tumours without shedding a drop of blood. M. Trélat, at the same meeting, spoke in favour of the instrument, but found fault with its complicated appearance, and brought forward one made by M. Trouvé, and modified by M. Onimus, which is simple and acts very satisfactorily. There are a great number of operations in which the wire cautery should be used, so as to save the patient loss of blood. As Esmarch's method can only apply to the limbs, we ought to see that operations on the head or trunk be performed, when advisable, by the galvanic cautery, which promises to be almost as saving of human blood as Esmarch's proceeding.—[Lancet.

MR. GUTTERIDGE'S METHOD FOR LITHOTOMY.

Mr. Gutteridge, of Birmingham, who has made lithotomy a specialty, and who employs instruments of peculiar construction, and is very rapid and dexterous in his manipulations, made a demonstration of his method at St. Peter's Hospital, in London, on Nov. 3rd, on the person of a lad of seventeen, in the presence of some fifty gentlemen, with complete success. The Lancet says of it:—Mr. Gutteridge repeatedly demonstrated the method of using his instruments in the Museum of King's College, at the recent meeting of the British Medical Association in London. It is essentially Cheselden's lateral operation performed on a staff which has the peculiarity of having its groove roughened, so that the surgeon can feel the knife grate along the staff into the bladder. Mr. Gutteridge performed the operation in the kneeling position, and with a scalpel, to the handle of which a cystotome is attached, so as to avoid changing the instrument if enlargement of the incision is required. A large director fitting the forefinger is used as a blunt gorget to guide the forceps into the bladder, and the stone is extracted with forceps the peculiarity of which is a second pair of handles attached by watch springs, by which effectual traction can be made with the left hand while the stone is merely grasped by the right, thus avoiding undue pressure on a very friable calculus. Mr. Gutteridge's success has been great—we believe, and he has been singularly honest in his avowal that he has three times cut a patient without finding a stone. He purposes to embody his experience in a work.

ON LARYNGEAL GARGLING.

It has long been believed, and many physicians still believe, that the epiglottis protects so effectually the cavity of the larynx, that nothing can penetrate as far as the glottis; and yet, in the case of simple catarrh accompanied by hoarseness—that it is to say, expressly implicating the vocal apparatus, they do not hesitate to prescribe local emollients, such as tisanes and demulcent gargles and success encourages this kind of treatment which is of every-day frequency. The fact ascertained and the cure obtained, they do not stop to seek the explanation, or they confine themselves to putting the question if there be not a therapeutical action on the intralaryngeal

mucous membrane exerted from the distance and by continuity of tissue, by means of the mucous membrane of the deep parts of the mouth.

The laryngoscope, by allowing a view of the vocal organ, gives the key of this mystery. I give it here as I demonstrated it to the members of the Académie des Sciences and the Académie de Médecine of Paris (and recently before the Clinical Society of London). The essence of the demonstration is to show, by means of the laryngoscope that a fluid can pass the epiglottis, and that it then bathes the glottis itself and all the portion of the vocal cords accessible to view in the laryngoscopic image during the act of closure of the glottic aperture.

The experiment is made with a small quantity of fluid so calculated as to fill pretty exactly only the subepiglottic cavity. I take then a small quantity of water into the mouth, and throwing the head slightly backward, I let it drop by its own weight into the laryngeal or subepiglottic cavity. I introduce the laryngoscope, and the liquid is very easily seen, subjacent to the epiglottis, which is or may be dry; the fluid may be seen to bubble in the supraglottic cavity under the influence of little bulles of air, which I expire through the glottis. If the fluid be transparent such as water the white colour of the contracted vocal cords may be seen through it.

This very easy experiment causes me no unpleasant sensation, and it may be prolonged throughout the whole period of a long expiration, or, indeed, as long as I can hold my breath. It proves that it is possible to apply medicated fluids in the form of a gargle to the mucous membrane of the larynx. But it does not follow because a thing is possible that it is easy to generalise it, and it might be possible that practice and skill peculiar to myself permitted me to realise an exception. I have easily ascertained that others can like me gargle the larynx; and, if I have found that by some the performance of this act is at first not easily attained, I have a much greater number who, when properly instructed, have been able to gargle in the most natural way in the world as far as their glottis. At Canterets, where a number of bathers gargle every year with the sulphurous waters of the these important springs, I have been able to repeat them on a large scale, and to establish a method for facilitating the use of this useful ablutation even for the least skilful.

To gargle effectually the pharynx and the larynx, it is only necessary—

1. Slightly to raise the head;
2. To open the mouth moderately;
3. To protrude the chin and the lower jaw;
4. To emit or to form the intention of emitting the sound of the double vowel æ.

The simultaneous and concordant action of these four movements open largely the back of the mouth; lift the velum palati and uvula, separate the base of the tongue from the posterior wall, and allow the liquid to gravitate into the cavity of the larynx.

Thus gargling lasts throughout the whole period of a long expiration, and inspiration is ini-