In falling the chisel entered the right side of his neck, making a vertical wound a little more than an inch long, with its upper extremity just below and behind the angle of the jaw. He immediately withdrew the chisel, which was followed by a tremendous gush of blood. He grasped the side of his neck with his hand, and got up and walked down a flight of a dozen steps of stairs to where his comrade was working. The change of position and the pressure of his hand stopped the bleeding for the moment, but the neck swelled rapidly and the bleeding recommenced. When he reached his comrade he felt faint and giddy, and when he attempted to speak he found that "his voice was gone" and that he could only speak in a whisper. His comrade laid him down and tied a handkerchief tightly round his neck, but as this failed to stop the bleeding he applied pressure over the handkerchief with his hand. The Montreal General Hospital ambulance was telephoned for and arrived in a few minutes, accompanied by Dr. Kirkpatrick, of the hospital, who found that the patient had lost and was still losing a large quantity of blood. He took charge of the wound and controlled the hemorrhage by compression until he reached the hospital, when he was assisted by the medical superintendent and the other resident medical officers. I was immediately telephoned for, and on reaching the hospital I found him still losing a great deal of blood in spite of the well-directed efforts of the resident staff to control it by digital compression applied over the wound. The patient was weak and pale, and showed unmistakably the evidences of having lost a large quantity of blood. Having made the necessary preparations, I directed compression to be applied over the common carotid artery (which could be felt in the lower part of the neck, although the tissues higher up were much infiltrated with blood), and the compressing hand having been removed from the wound I hastily thrust my right forefinger into it. The performance of this act, although easily and speedily executed, was accompanied by an alarming gush of blood. I directed the wound to be compressed around and against my finger, which arrested the hemorrhage. The blood was apparently venous in character, although up to this time the lesion had been thought to be a wound of the carotid artery. I found that the wound extended upwards and backwards behind the sterno-mastoid muscle and along the base of the skull. I could feel the bodies of the upper cervical vertebrae, the styloid process of the temporal bone, and other prominent points about the base of the skull, but I could not put my finger upon the bleeding point so as to arrest the hemorrhage. As his condition was a very desperate one, and the permanent arrest of the hemorrhage seemed to be almost an impossibility, I sent for Dr. Fenwick in order to have his advice and assistance before removing my finger from the wound. I consequently retained my finger in the wound, and compression was applied against it, as already described, until Dr. Fenwick arrived. Dr. McClure then took my place and introduced his finger as I withdrew mine, the change being accompanied by a tremendous gush of dark venous blood. We then decided to tie the common carotid artery, thinking that although the gushes of blood were very dark and apparently venous in character, a large vein could hardly be wounded in this situation without some of the great arterial trunks being wounded at the same time, and that this operation would be a wise precaution as a prelude to further treatment. The patient was then etherized and the artery was tied below the omohyoid muscle, the infiltration of the cellular