

There was nothing tight about the neck, nor was there anything in his appearance to lead one to think he was not a fit subject for the anæsthetic. He had a small receding jaw, and a short, thick neck, but no abnormal swelling of any kind which prevented his closing his mouth, as reported in *The Lancet* of the above date. An ordinary prop, attached to a strong fishing-line, was placed between the upper and lower central incisors. After taking three or four inspirations of nitrous oxide gas he took off the face-piece and said he felt nervous, but at his own request I proceeded to go on with the administration. His respiration was shallow but regular, and after taking about two-thirds of the ordinary quantity of gas, the tooth was extracted quickly and without any difficulty; the respirations at once became irregular and the patient became more cyanosed, his muscles rigid, and after three or four respirations, he ceased to breathe, but no danger appeared imminent. Breathing not continuing, the prop was at once removed, the patient taken from the chair on to the floor, and artificial respiration commenced within thirty seconds after the extraction. The tongue was pulled forward. The heart was beating regularly but not strongly, the body remained rigid, and there was no inspiratory effort. About two minutes after the tooth was extracted, two or three expirations took place, showing there was no considerable obstruction in the larynx. Nitrate of amyl was applied to the nose and mouth; but as no inspirations took place, it could not have affected the patient. A subcutaneous injection of ether was given over the præcordial region, as the action of the heart now became feeble. These measures failing, tracheotomy was performed within three minutes of the time the gas was discontinued to be administered; the position of the patient was awkward for the operation, and the extremely receding lower jaw, with a short, thick neck, made it somewhat difficult to perform, but as everything was at hand and ready assistance given, I fortunately made an entrance through the upper rings of the trachea without loss of time. The tracheal wound was kept open, and on resuming artificial respiration, a quantity of mucus (about an ounce) was forced out, nearly clear and only slightly blood-stained. Although one could hear air passing in and out of the opening in the trachea, there was no voluntary effort of breathing from first to last. The patient now became still more cyanosed, and the heart could no longer be heard beating. Artificial respiration was continued for twenty minutes longer, although there was little hope of its being of use. Micturition took place after the commencement of taking the nitrous oxide, a symptom which I have not infrequently noticed when cyanosis becomes well marked, and also in children. I will recapitulate shortly the methods adopted to restore respiration: (1) artificial respiration within half a minute after the patient ceased to breathe; (2) nitrate of amyl within one minute after