

were held asunder, and the tongue hooked with a tenaculum, and pulled forward. In a few minutes the breathing was re-established, and then the pulse returned; and soon the patient was placed again on the table in the lateral semiprone position in which all my operations on the uterus are performed; and the operation was finished, but without any more of the anæsthetic.

These two cases comprise my personal experience with Nélaton's method in chloroform narcosis.

As the facts now laid before you fully explain themselves, it is unnecessary for me to indulge in any lengthened remarks on the subject. In my own country, the accoucheurs often use chloroform, and the surgeons mostly use ether. I believe there has not as yet been a single death from chloroform given during labour; while deaths from it in general surgery occur constantly, and for unimportant operations. There must be a reason for this. I believe that it can be explained only on the theory that death from chloroform is, as a rule, due to syncope or to cerebral anæmia. Now, we know that in active labour there can be no cerebral anæmia, for every pain throws the blood violently to the head, producing fulness and congestion of the blood-vessels, thereby counteracting the tendency of the chloroform to produce a contrary condition. It may be said that the recumbent position has some influence in determining the safety of chloroform in labour; and so it has, but it gives no immunity under other circumstances. Chloroform, given intermittently as in labour, is thought to be less dangerous; but patients in labour are often kept for hours under its influence with safety, and occasionally it is necessary to produce complete and profound narcosis in some obstetrical operations; and yet, I believe, I can safely reiterate what I have already said, that no woman has as yet died in labour from the effects of this anæsthetic. In puerperal convulsion, where the brain is believed to be overcharged with blood—and that, too, when the blood is known to be poisoned with urea—we formerly bled the patient, and we do so now sometimes; but our chief remedy is chloroform, which acts by arresting spasmodic movement, and by producing that very state of cerebral anæmia so necessary to a successful result. Whether puerperal convulsions are less frequent in labours under chloroform than in those without it, I do not know.

I believe that obstetricians may take a lesson from Nélaton's method of resuscitation, by adopting it in cases of threatened death from *post partum* hæmorrhage. Let us not be satisfied with simply placing the head low; but let us, in addition to the means usually adopted, invert the body, and throw what little blood there is left in it wholly to the brain. I have never seen a death from uterine hæmorrhage; but from recollections of the few alarming cases I have witnessed, I now feel sure that recovery might have been hastened if I had known and adopted Nélaton's method of inversion.

Whether death from chloroform is due to cerebral anæmia or not, it is at least safe to adopt Nélaton's method in all cases of supposed or threatened danger; but I think the safest plan is to relinquish the use

of chloroform altogether except in obstetrics. The frequent cases of death from the use of chloroform in surgical operations that have occurred amongst us, even of late, should warn us to give up this dangerous agent, if we can find another that is as efficient, and, at the same time, free from danger. Ether fulfils the indications to a remarkable degree; but, while it is safe, it is unfortunately unpleasant to the physician and bystanders, as well as to the patient. He who will give us an anæsthetic as pleasant to take as chloroform and as safe as ether, will confer the greatest boon upon science and humanity.

COLLES' FRACTURE OF THE RADIUS.

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I wish to offer a few remarks on Colles' fracture, in order to direct the attention of the profession to some points which are even at the present day often overlooked. On account of this neglect there is often left a permanent deformity in the limb, and both surgeon and patient have every reason to be dissatisfied with the result of the treatment.

Dr. Moore, of Rochester, N.Y., deserves great credit for the light which he has thrown on the pathology of this injury. That gentlemen found in his dissections that in a large proportion of these cases the styloid process of the ulna is dislocated underneath the posterior annular ligament. Where this is the case we cannot expect to obtain anything like a good result without first reducing the dislocation. In spite of his teaching, and in the face of the good results which have followed his plan of treatment, many practitioners yet adhere to the teachings of the past, and dress this fracture by simply carrying the hand forcibly to the radial side, and applying a pistol-shaped splint. The effect of this procedure, as will be apparent to all, is to thrust the ligament still farther underneath the process, and consequently aggravate the difficulty. Having liberated the imprisoned ulna, there can be no advantage in applying a pistol splint. The adherents to this mode of treatment claim that the pressure exerted over the lower end of the radius by the extensor ossis metacarpi pollicis and extensor primi internodii pollicis muscles, as well as the traction of the external lateral ligament of the wrist, will raise the upper end of the lower fragment from its bed, and thereby secure proper adaptation of the fragments. I do not believe that the amount of pain produced by the degree of force requisite to secure that end could be endured for any length of time; much less could it be borne three, four or six weeks, or until union had taken place. I doubt very much if the lower fragment is raised to any appreciable extent by this procedure. Moreover, should the fracture be a comminuted one, then certainly the pressure of the muscles over the lower end of the bone cannot exert their influence over every fragment.

What shall we do with the projection of the head of the ulna? My opinion is that we should proceed