accomplished." * * * "At the end of six weeks or two months we usually allow the patient to get up, but he is always provided with a patellar apparatus before so doing, to prevent flexion of the knee." * * * "If an apparatus be not at hand a gum and chalk, or plaster of Paris case will serve the purpose quite as well. I usually advise our patients to wear the apparatus for six months; and then, if the knee feel strong, to throw it aside." Mr. Hutchinson is not an enthusiast as to the advantages of bony union, and says that those who have fibrous, and even ligamentous union, often walk better. He also points out that decided atrophy, and sometimes contraction, of the quadriceps follows not infrequently. Apropos of this Mr. Christopher Heath, of University College, says: "Agreeing fully with Mr. Hutchinson in his view, I have carried the treatment of these cases further than he seems to have done, and do not hesitate to aspirate the knee-joint in cases both of fractured patella and injury of the joint." * * * "If the knee-joint be aspirated within a few hours of the accident, the blood is still fluid, and can be readily withdrawn." * * * "Having emptied the joint, or, still better, having the patient in charge before effusion has taken place, I do not hesitate to apply at once plaster of Paris over an envelope of cotton wadding, and to make the patient get about as soon as the plaster is dry." He says in this way the muscles retain their tone and atrophy does not ensue. He suggests that the reason why ligamentous union is often more satisfactory than a close or bony union, is the probability that the patella contracts adhesions to the external condyle, thus limiting the motions of the joint.

OAKLEY ON COMPLETE POSTERIOR DISLOCATION OF THE KNEE-JOINT, WITH LIFE-LONG USE.—Mr. J. Bagnall Oakley reports and figures a case of the above injury in the *Lancet*, Jan., 1882, p. 53. The patient, aged 70, when seen, stated that, when nine months old he, fell and damaged his knee-joint, causing complete posterior dislocation. He has worked at brick-making all his life, and has never beeen laid up on account of his knee.—*London Medical Record.*

CASE OF EXCISION OF A STRICTURE OF THE DESCENDING COLON THROUGH AN INCISION MADE FOR A LEFT LUMBAR COLOTOMY: WITH REMARKS.

BY THOMAS BRYANT, F.R.C.S.

Mr. Bryant read the record of a case of stricture of the descending colon, in which he excised the diseased segment of bowel through the wound made for a left lumbar colotomy, the patient recovering. The operation was performed on a lady aged 50, who had suffered from complete obstruction for eight weeks, and was very feeble. The stricture could not be felt from below. The bowel was removed through the oblique incision made for left lumbar colotomy, by simply pulling the segment strictured through the wound, and stitching each portion of the bowel, with its two orifices as divided, to the lips of the wound. The stricture was of the annular kind, and involved about one inch of the bowel; it was so narrow as scarcely to admit the passage of a No. 8 catheter. The preparation was exhibited with microscopical appearances of the growth in section, as made by Dr. Goodhart. Mr. Bryant said he believed the operation he had performed was a new one, and that it was applicable to not a few of the cases of stricture of the descending colon. It had suggested itself to his mind from seeing cases of localised or annular stricture of the bowel which were free and movable, both in operations of colotomy as well as in the *post-mortem* room; but the case read was the first in which he had put the suggestion into practice. He pointed out how these annular strictures were generally local diseases, and consequently how desirable it was that they should be removed where possible. He suggested that the question of excision of the diseased growth should be entertained as soon as the diagnosis of the case was made, and that, in every case of colotomy for chronic obstruction of the descending colon, the possibility of being able to remove the diseased bowel by operation should be considered before the bowel was opened for a colotomy operation. He then showed how desirable it was that the question of excision or of colotomy should not