the fluid extract of ergot every four hours, until the patient gets entire control over his bladder. Until this is accomplished, I continue to relieve him with the catheter every twelve hours. As his power of urination is restored I diminish the frequency of the medicine, and gradually end in giving a dose every night. A gentleman who died last month, at the age of ninety-two, was exceedingly ill in August, 1872, in consequence of retention of urine from enlarged prostate, and had to be regularly catheterized for relief. He was placed upon the above treatment, and in a few days was able to do without his catheter. His urinary organs were kept in a good condition by taking a dose of ergot every night, and he enjoyed much better health in consequence, and died recently of old age. I mention this case in particular, because a post-mortem examination proved to me that the prostate had been diminished in size by the treatment.

In these cases it is very common for sedimentary deposits to accumulate in the bladder, which becomes a source of irritation and discomfort, and if the organ should fail to expel its contents entirely, it is best every few days to introduce the catheter to remove them.—*New Orleans Medical and Surgical Journal.*

DISLOCATION OF MUSCLES (*The British Medical Journal*, July 13, 1878).—Mr. George W. Callender, after detailing some interesting cases of this injury, concludes as follows: "If, then, you come across a case in which sudden or unusual movements of the body have been followed by pain,—local in its character,—made worse by certain movements, or preventing certain movements, and epecially if such pain be referred to the site of muscular digitations about the spine or to that of long comparatively slender muscles, as in the forearm, it is at least worth your while to try the simple measures which we may use for reducing the dislocation of a muscle. First, guided by the pain, decided as to the muscle or digitation of a muscle probably the seat of the trouble. Secondly, relax this muscle so far as you can. Thirdly, by firm manipulation, such as by rubbing with the hand or by kneading with the thumb, endeavour to replace it. Fourthly, if this fail, make pressure over the part whilst you bring the muscles into action or put it on the stretch; and, if the less painful measures have failed, it is almost sure to bring the muscles into position. All this has to be done without the employment of an anæsthetic. We need guidance from the patient; we require action in the muscle. Some amount of pain is inseparable from the treatment of these dislocations."

FOREIGN BODY IN THE SIGMOID FLEXURE: SUCCESSFUL REMOVAL.

A rare and curious case is related by Dr. Studsgaard of the Communal Hospital in Copenhagen, in a recent number of the *Hospitals-Tidende*. A man, aged 35, introduced into the rectum, with the open end uppermost, a preserve-bottle nearly seven inches long, for the purpose of stopping a diarrhœa. The next morning, he complained of pain in the abdomen; chloroform was given, and the bottle, which could before this be felt in the rectum, passed higher up, and he was brought to the hospital (January 10th). The bottle could be felt through the abdominal wall, lying in the middle line, with the bottom close to the horizontal ramus of the pubic bone. In the afternoon, he was deeply narcotised, and the posterior linear rectotomy was performed, and an attempt was made to reach the bottle, but without success. Abdominal section was therefore performed, under antiseptic precautions, in the linea alba. An incision having been carried four inches downwards from the umbilicus, a loop of intestine, apparently a portion of the sigmoid flexure, was protruded with the neck of the bottle. The bowel was then divided over the mouth of the bottle and a little way down the neck, and removal was effected slowly. The neighbouring parts were protected by sponges and compresses from the escape of fæces; and, after the bowel had been cleaned, twelve or fourteen catgut sutures were applied to it, each being, for safety, tied with three knots. The bowel having been replaced, the wound in the abdominal wall was untied by eight silk sutures. The operation lasted an hour. Recovery was slow, and the prognosis was for a time doubtful in consequence of local peritonitis and the formation of abscesses, which opened partly through the incision in the abdominal wall and partly through the rectum; the patient was, however, discharged quite cured on April 16th,—less than fourteen weeks after the operation. The bottle was 17 *centimètres* (6.8 inches) long, 5 *centimètres* (2 inches) in diameter at the lower end, and 3 *centimètres* (1.2 inches) at the upper end. In commenting on this case, Dr. Studsgaard refers to three others of a similar character; one related by Ogle, in which recovery followed spontaneous discharge of the foreign body (a stick); one by Closmadeuc, where the patient died of peritonitis, without operation; and one in which laparo-enterotomy was successfully performed in 1849 by Reali of Orvieto.