

page 22, has collected 36 cases with 27 recoveries.

I would suggest that, in this operation, the cervical vertebræ be used as a guide instead of the trachea, which is necessarily drawn to one side by an assistant. After the skin and superficial fascia are divided, the vertebræ can be distinctly felt through the remaining tissues, and when their latero-anterior surfaces are exposed, the œsophagus is very readily found.

#### Nasal Intubation.

In a paper read before the Section in Laryngology and Rhinology of the New York Academy of Medicine, December 27, 1887, Dr. D. H. Goodwillie introduced a method of nasal intubation as a valuable aid in the treatment of intranasal disease; a method he has used for some years.

The *New York Medical Journal* gives the following: "My first efforts began by the use of pure rubber-gum tubing of different sizes and strength, and made applicable to each case by such impromptu means as I had at command. These experiments, after being carried on for some time, were so encouraging that I had the tubes made in soft rubber and platinum, or aluminium, from models that have proved by experience to be of practical application. These improved tubes, properly made, have given me such good results that I merely call your attention to them for your consideration.

These tubes are oval in shape, and of the same size, with the exception of the anterior end, that is shaped so as to fit the vestibule of the nostril, and by that they are retained in place.

They are made of different sizes,  $\frac{1}{4}$  to  $\frac{1}{2}$  inch in diameter, and in length from  $2\frac{1}{2}$  to  $3\frac{1}{2}$  inches, but may readily be cut to any desired length.

The metal tubes can be changed in their calibre by passing through them a core of the desired shape. The anterior end may be soft rubber, as it is more comfortable by its flexibility in the vestibule of the nose.

The small rubber tubes are made use of at the beginning of the treatment, and changed to larger ones until there is normal space, or the deformity has been corrected. Then the metal tubes may be used if so desired, as they allow freer respiration through them. The tube is put into the nostril by raising the end of the nose and gently passing it into the inferior meatus, then releasing the end of the nose and passing the anterior end into the ves-

tibule. They cannot be seen externally, and so can be worn and treatment carried on without any unsightly appearance, or even knowledge of their presence.

They can be readily removed by the patient for cleansing, and returned to the nostril. Some of my patients have worn them constantly for months without discomfort, and always with benefit.

I will simply refer to some of the nasal diseases in which they have been made use of, viz.:

1. Intranasal hæmorrhage.
2. Fractures of the nose, internal and external.
3. Deviations of the cartilaginous and bony septum after the necessary surgical operation of section or removal of exostosis.
4. After the removal of hypertrophic turbinated tissues or polypi, whether by the cautery or snare.
5. Hypertrophies of the soft tissues without an operation, when worn for a sufficient time to produce absorption.

#### A New Achievement in Surgery.

An editorial in the *American Practitioner and News* comments as follows:—

Since the day when McDowell conceived and successfully performed the first ovariectomy, the progress of surgery may be said to have been one triumphal march. The surgeon's hand has been made acquainted with almost every cavity of the body, tracing disease to its secret hiding-places in the most delicate vital organs, where the surgeon's knife and other appliances have been potent to remove it, arrest it, or mitigate its ravages. The abdomen, the pelvis, the thorax, and the cranium have repeatedly been the fields of well won victories, and now, through successful work in the spinal canal, is added yet another trophy to the conquest.

In the *British Medical Journal* of the 28th ult. is an account of the removal of a tumor from the spinal cord by Mr. Victor Horsley. The patient, an adult male, had complained for some three years of severe pain in the upper part of the chest, the point of greatest intensity being just below and to the inner side of the angle of the left scapula. Below the level of this point there was an absolute loss of sensation and motion in the body and limbs. The upper limit of the anæsthesia was in the region supplied by the left fifth intercostal nerve. On the right side though less accurately defined, the anæsthesia did not reach a higher level. The symptoms