ness, and in the position of the apex-beat. We must then rely upon the prominence of the præcordia; the enlarged triangle of dulness, with its base below: the absence or altered position of the apex-beat; the distant and feeble character of the heart-sounds; the displacement of the anterior border of the lungs; and the extreme disturbance of circulation and respiration. It is true that an enlarged and dilated heart has been mistaken, and has even been tapped, in mistake, for a distended pericardial sac. But a searching investigation into the history of the case—the fact that the apex-beat, however feeble, is on the lowest level of præcordial dulness the shape of the area of dulness, which here also is triangular, but with its base upward and to the right; and the character of the heart-sounds, which, though, feeble, are much less distant and obscure than in large pericardial effusions—all of these will combine to enable a correct diagnosis to be made. Again, a solid, mediastinal tumor has been mistaken for a distended pericardium; but I am confident that close attention to the diagnostic points I have given would prevent the commission of this error. —*Med. News and Library.*

BLOODLESS TRACHEOTOMY.

Everyone who has been called upon to perform tracheotomy upon a young child suffering from threatening asphyxia, where the venous plexuses of the neck are engorged, and each touch of the knife may flood the wound with blood, will appreciate any method of operating by which this danger can be avoided, and tracheotomy added to the list of the bloodless operations. The attempt to accomplish this has been several times made. In 1872 M. Verneuil employed the galvanic cautery instead of the bistoury in several cases with success; but this method is evidently ill-adapted for general use, as the necessary apparatus is cumbrous, and only to be found at hospitals. More recently Mons, G. Poinsot, of Bordeaux, has used Paquelin's thermo-cautery with excellent results, and his example has been followed by other French surgeons. The skin and soft parts quite down to the trachea should be divided by successive light touches of the point of the cautery, heated to a dull red color, and when the trachea has been exposed it should be opened with the knife, and the tube inserted in the usual way. The cautery must be used lightly, or its action will be too extensive, and a thick eschar be formed; and if it be used too hot, as is well known, it loses its hæmostatic power. The cautery is not suited for opening the trachea, because the radiation from its hot point introduced into the air-passage would be harmful, and there is some risk of burning its posterior wall; while in adults it is difficult to sever the firm rings with it, and particularly if they are at all ossified, and the loss of substance that an eschar necessarily involves might cause trouble from narrowing of the air-tube. On the other hand, as the use of the knife for this purpose does not cause hæmorrhage, it is free from objection. In fat subjects the wound may become filled with molten fat; this is readly removed with a sponge. In addition to the bloodlessness of this mode of operating, Mons. Poinsot claims for it two other advantages—the spontaneous retraction of the edges of the wound, rendering unnecessary the aid of assistants for this purpose, and giving a funnel-shaped opening down to the trachea; and the protection of the wounded surfaces from the contagion of diphtheria. Slight secondary hæmorrhage has followed this operation in several cases, but in no case has it been severe, yielding readily to simple treatment. Although the wound gapes widely at first, the resulting cicatrix contracts to a small size, and has not given rise to any unpleasant symptoms in any recorded case. This appears to be one of the most useful applications of this recent addition to the surgeon's armamentarium. It promises to change tracheotomy from an operation which is always anxious and often very trying into a safe and simple proceeding; and we may hope that it will, in this way, add to the value of the operation by leading to its more frequent and earlier adoption in obstructive diseases of the larynx.—*The Lancet.*

RAPID CURE OF ANEURISM OF THE ANTERIOR TIBIAL BY ESMARCH'S BANDAGE.

For the notes of this interesting case we are indebted to Mr. G. W. Rigden, house-surgeon, Taunton and Somerset Hospital.

A young agricultural labourer, aged twenty, was admitted into the hospital with the following history:—During the last week of August he wounded his right leg with a scythe. He lost a large quantity of blood at the time, but the wound healed after he had been in bed about a month. When he began to get about he noticed that his foot dropped on that side, and for this he came to the hospital for advice.

On admission, it was found that he could not raise his foot on the affected side, but there was no stiffness of the joint, the whole foot being perfectly flaccid. The cicatrix of the wound was noticed, about the middle of the outer side of the leg, and beneath this was found an ill defined tumour, deep in the muscles of the leg, which exhibited a distinct pulsation synchronous with each beat of the heart, and on listening with a stethoscope a distinct bruit could be heard.

After he had been kept at rest in bed a few days, the tumour became much more defined; it was less in size, but the margin of it much more distinct; it was very deep and appeared about the