lines long," and Travers strongly recommends a similar practice. I am however of opinion, notwithstanding these high authorities, that too much importance is attracted to the suture; when we consider the anatomical structure and tendency of the parts to closure as above shewn, the rapid effusion of the lymph, and equally rapid organisation, if judicious efforts to diminish the peristaltic action be used, union will, and must follow. Under all these circumstances I think with Dr. Fremont, that fœcal effusion, in the case of Corrigan, took place at the moment of receiving the injury; otherwise, it was not of so extensive a character as to have precluded the probability of its closure by adhesion.

Quebec, 28th February, 1856.

ART. XL.—*Observations on the treatment of Aneurism of the Arteria Innominata, by ligature of the right common Carotid Artery*, with a Case. By Wm. Wright, M.D., L.R.C.S.E., Professor of Materia Medica, McGill University, &c.

(*Continued from page* 420.)

The characters that chiefly distinguish the preceding case from its fellows are as follows:—the situation of the external tumor—the resemblance of the latter to an abscess—the modification of its direct symptoms—the initiatory redness—the inadequacy of the acoustic signs derived from the chest—the slightness of the remote symptoms—the anatomical difficulties of the operation—the external opening of the aneurism—the fistula to which it led—the symptoms of deranged cerebral circulation as witnessed in hemiplegia, ushered in by pseudo-coma, and varied before death by intercurrent stupor and vigillium—and, lastly, the subsequent discovery of abscesses in the brain, and of a peculiarly constructed aneurism. Each of these calls for a few remarks.

I. The situation of the tumor appears peculiar when contrasted with that of others, before quoted, in which this circumstance is precisely stated. Of 8 cases of innominatal aneurism treated by carotid deligation: in five it was directly above the right sterno-clavicular articulation, or inner extremity of the clavicle, and behind the lower end of the sterno-mastoid muscle; when large it projected so as to be visible on both the tracheal and outer borders of the muscle. In one it proceeded outward about one-third along the right clavicle. In another it was still more external, and was seated over the middle of this bone. And in the last it is described as "immediately above the sternum, bounded laterally by the trachea and tracheal margin of the sterno-cleido-mastoid muscle." All these exhibit a lateral position. In the case I have described, how-