The temperature was not taken, nor was the urine examined for albumen.

Remarks.—I believe the foregoing to be very interesting, as the presence of Scarlatina in the hills, and indeed in the plains, is denied by many medical men in India. At the time it occurred, there were, I was informed by a Civil Surgeon at the station, very many *exactly similar cases in* the station. I find in the *Indian Medical Gazette* for 1st July, 1870, a case of "Erythema Scarlatinaform" by Dr. Garden of Saharunpore, in which the symptoms are almost similar to those of the case above given, and in his remarks, Dr. Garden asks, "in an epidemic of scarlatina, would not this case be accepted as a fairly typical case of the mild form? Scarlatina, however, is, as far as I am aware, an unknown disease in India, and the case moreover wants one of the chief factors of that disease, *viz.*, *contagiousness.*" In my case certainly no one in the same house took the disease, though some of the servants in the adjoining compound had "fever and sore throat." but I was informed by the Civil Surgeon, there were several similar cases at the time in the station. I have since learned that other cases occurred at the same station (in children) were well marked, but did not prove contagious. I have, however, seen very severe cases in England, notably two, each of which occurred in the midst of large families, where the disease was not taken by those in immediate contact with the sufferer. Bearing in mind the difficulties which had only recently to be overcome in establishing the presence of typhoid fever in India, and which is now admitted by all, I think we should be careful how we call and classify such cases as the above, and the one described by Dr. Garden; as though probably the disease at present only exists on the country in a mild or modified form, it may nevertheless at no distant date assume the severe type it is so well rceognized by at home.

AMPUTATION AT THE LOWER THIRD OF THIGH, BY A LONG ANTERIOR FLAP.

By Assist. Surgeon J. CLEGHORN, *Civil Surgeon, Jounpore.*

SHEOBUX, *Lohar*, aged 35 years, was admitted into the Dispensary on the 18th May last, with a compound comminuted fracture of both bones of the left leg, at the middle third. The bones at the seat of fracture were broken into numerous fragments, the muscles destroyed, and the only connection between the upper and lower half of the leg was a narrow piece of skin. The upper portion of the tibia was dead, and entirely denuded of pericsteum. Sinuses burrowed in all directions underneath the skin, and sensation was lost up to the lower edge of the patella.

The injury was caused by the patient falling from a tree, one month previous to his admission. He had been treated in his own house by a Hakim, but as it was evident that the limb could not be saved, he was brought to the Dispensary by his friends to have it removed. Amputation was performed at the lower third of the thigh, on the 20th May, by the long anterior flap operation, a modification of Teales rectangular flap, introduced by Professor Spence of Edinburgh, and invariably practised by him in the surgical wards of the Royal Infirmary. Instead of a large rectangular flap, requiring accurate adjustment and nicety of operation, Mr. Spence rounded off the corners of the anterior flap, and thereby is not retarded in his cutting, by a fear that the edges and corners of the flaps will not be in accurate adjustment. The length of the anterior flap ought to be one-half, and the posterior flap one-fifth or rather less, the diameter of the limb at the point where the amputation is to be performed. In the present case the anterior flap extended to nearly the lower edge of the patella; its lower half was formed entirely of skin, and its upper by cutting obliquely through the muscles up to the point where the limb was to be amputated. The posterior flap was formed by a sweeping cut of the knife at right angles to the bone. The femoral artery was divided by this cut. There was little bleeding, and the vessels were easily secured. The cut surfaces were washed with carbolic acid lotion, and the flaps brought together by horsehair sutures. No bad symptoms supervened. And on 19th July, the patient was walking about with the aid of a crutch, and was discharged with a well-healed and useful stump on the 25th July.

The advantages of the above method of operation over others are as follows. In disease of knee-joint and special forms of injury in its neighbourhood, amputation can be performed lower down than in the circular or flap operations, and therefore danger to life is diminished. Dressings are light and easily applied. The line of incision is posterior and dependant, and discharges readily escape.

The end of the bone does not correspond to incision, but to the middle of anterior flap; there is, therefore, no danger of the bone protruding between the flaps by their retraction. The cicatrix is well behind the end of the bone, and the latter rests on a pad of connective tissue, fat, and skin; pressure is well borne, and when an artificial limb is used, a great portion of the weight of the body can be supported on the end of the stump

The same form of operation may be employed in all amputations through the extremities.

DEATH FROM CHLOROFORM.

By W. P. DICKSON, *Civil Medical Officer, Dhurmsala.*

ON the 2nd of April, 1870, I operated on a female named Tali, Hindoo Choomar of Kullu, for the removal of two large tumours growing from the organs of generation. The chloroform was administered by Native Doctor Noor Khan of the Dhurmsala Dispensary, who states positively that he commenced the inhalation with a very small quantity (♏ xl); she soon became insensible (in less than five minutes), and the tumours were immediately removed. I should say ten minutes after the inhalation was commenced, I noticed the woman's countenance become ghastly pale, and found no action of the heart or lungs, Artificial respiration was commenced, the woman being rolled over from her back on to her face, and back again; in this way only one lung was operated on, but after five minutes she began to give evidence of attempting to respire, although before to all intents and purposes she was dead. The artificial respiration was kept up for a quarter of an hour till she was breathing fully and regularly, and then the arteries were tied, and the sutures put in.

It was noticed that, though the woman's respiration was fully established, and the resonance of both lungs normal, there was a certain amount of dyspnœa; this continued for the next four days, and was accompanied by the expectoration of a large amount of yellow mucus. She died, *suddenly*, on the morning of the 6th April, and I believe the cause of death was the plugging of the left or both branches of the pulmonary artery by a clot, which had formed during the time the woman was in a state of syncope, caused by chloroform. The woman never recovered her voice, but spoke in a whisper, and complained of a painful constriction about her throat. The husband refused to allow a *post-mortem*. The value of artificial respiration was deeply impressed on my mind; but care should be taken that Dr. Marshall Hall's rules be followed in their entirety, and that the body be turned over on the face, from one side to the other, and back again, like a log of wood.

I doubt if I should have published this case, incomplete as it is, were it not for Dr. Fayrer's suggestive remarks on *thrombosis*, at page 29 of the June number of the *Indian Medical Gazette*. This woman was an inhabitant of the Kullu Valley, which, like that of Kangra, corresponds to the Terai. I should question whether a single individual in either of these valleys escaped an attack of intermittent in any single year, and it is the invariable rusult of an operation on one of these people to produce a well-marked paroxysm. The tumours have been sent to Calcutta.

THE INDICATIONS FOR TRACHEOTOMY IN CASES OF LARYNGITIS AND DIPTHERIA.—By *Dr. George Johnson*, Kings' College Hospital.—When the symptoms of laryngitis, whether in a child or in an adult, continue and increase and threaten life, or when, in a case of diphtheria, the extension of the disease to the larynx causes the same threatening symptoms, we ought to have recourse to tracheotomy; and by this operation we may not unfrequently save a life which must otherwise inevitably be lost. The operation is more frequently successful in cases of simple laryngitis than in diphtheria—for the reason that, in the latter disease, the exudation often extends into the trachea and bronchi; so that an artificial opening in the windpipe does not counteract the cause of the apnœa. It is more frequently successful in adults than in children, and more frequently in older than in very young children. In adults, I have rarely failed to save life by the timely performance of tracheotomy; but in children I have rarely succeeded. In very young children, the trachea is so small that it is scarcely possible to introduce a metal tube; and the operation is, therefore, impracticable. The youngest child that I have seen saved