downwards, through the skin only. Retracting the skin on the left side about one inch, an incision was made through the sheath of the rectus, and the fibres of the muscle split parallel to their direction. The peritoneum was not then opened, but was separated with the finger over an area of about four or five inches laterally and longitudinally. It was then incised horizontally at the upper portion. I checked the great rush of fluid with a sponge, and about five minutes was allowed for emptying the abdominal cavity. While still half full, I introduced my hand, and finding that the omentum was retracted and high up, I gently drew it down. A large portion was brought out through the opening in the peritoneum and spread out behind and in contact with the muscles. With fine catgut stitches I attached it to the recesses of this extra-peritoneal pouch. During this time the cavity had drained nearly dry, partly through a medium-sized trocar inserted at the lower end of the wound. The muscles were then sutured with chromic gut, and the skin with silk. The whole operation took twenty minutes, and only two drachms of chloroform were administered. There was slight shock when the fluid first escaped, and this was combatted by a rectal injection of hot water with a teaspoonful of brandy, and by a hypodermic injection of strychnine. He quickly recovered from the anæsthesia, and expressed himself as feeling comfortable.

His progress was free from complications; the temperature never rose above 98°. On the fourth day I found him out of bed, the ward attendant having only left him a minute before. He said that he only got up to urinate. The abdomen filled as rapidly as previously, and to prevent tension on the recent wound I tapped him on the 24th October. On November 12th he was again tapped, and went home on the 17th—thirty-seven days after the operation. Since then he has returned to us and been twice tapped. So up to the present the operation has not effected any cure.

CASE OF PYONEPHROSIS WITH CALCULUS.

KASHMIR MISSION HOSPITAL.

UNDER THE CARE OF A. NEVE, F.R.C.S.E.

A WOMAN aged 30 was admitted on April 4th, 1903, with a history of pain for some months. A large hard swelling was felt in the right hypochondriac region, extending downwards to near the crest of the ilium, and forwards to within three inches of the umbilicus. The dulness could be marked off above from the liver. The fever and anæmia of the patient indicated suppuration.

Being sure that adequate adhesions must have formed, an incision was made over the most prominent part, and at no great depth pus was tapped. On exploring, a stone was felt, and withdrawn with narrow bladed forceps. It was not firmly imbedded. It was a black irregular calculus, about the size of a water chestnut.

The wound was drained with a rubber tube 3 inches long, and for the first fortnight the suppuration was free, and the temperature several times went over 102, but later on she made good progress. After a month the temperature remained normal, and there was very little discharge, although a sinus remained. She was dismissed on the 18th of June.

CASE OF LARGE GOITRE; EXCISION THYROIDISM: RECOVERY.

BY E. F. NEVE, F.R.C.S. (EDIN.),

Kashmir Mission Hospital.

FATAH, *æt.* 23, male, was admitted on September 8th, 1903, suffering from a large bronchocele. The tumour, which was the size of a small cocoanut, was on the right side. The isthmus was flattened out and pressing on the trachea. The left lobe was also somewhat enlarged. As a general rule, Kashmiris are well satisfied with the result of the action of the biniodide of mercury ointment, which has a great reputation, and for which they frequently ask. Consequently, unless the goitre is giving considerable discomfort, they decline operative interference. The following day, I removed the tumour with the kind assistance of Dr. H. T. Holland of Quetta. The operation presented no special difficulty, but was tedious and involved the ligature of an enormous number of vessels, although we were working well beyond the limits of the capsule. And the isthmus was broad and very adherent. There was a good deal of unavoidable handling of the tumour mass. After excision I noticed that the cut surface of the isthmus was oozing freely and continued to do so, but the blood was thin and watery. The amount of blood lost was small. This was fortunate, for an hour afterwards, I was urgently summoned to the wards on account of hæmorrhage. On removing the dressings, there was an appalling gush. I opened up the wound and, passing my thumb round immediately above the clavicle, commanded all the vessels and secured a branch of the internal jugular, which had been cut near the main trunk and had retracted. The ligature had apparently slipped off from the strain of vomiting. The patient had lost 15 to 20 ounces of blood in the interval.

He was fairly well till the following day, but began then to get restless, and a troublesome cough set in, and his condition soon became critical. He kept on trying to clear his throat and complained of severe headache. The pulse rate was found to be very high—148, while the temperature was 100·2°. The patient's face was