It is very necessary to attend carefully to details.

The part is rendered aseptic. A hypodermic syringe is charged with 5 per cent. solution of cocaine, and a very sharp, thin needle is pushed into the tissues near the ingrowing portion of the nail as shown at A. A few drops of the solution are then injected. At the end of five minutes (by the watch) the needle is pushed beneath the nail as shown at B, and a few drops more injected. The first application has rendered this apparently most painful procedure almost painless. After another five minutes have elapsed one blade of a sharp pointed pair of scissors is pushed beneath the nail as shown at C, and made to travel right to the end of the nail, but keeping beneath the fold of skin at the base. The blades are then closed and the strip is divided. It is then seized with forceps, and twisted out; care must be taken that the prolongation of the nail beyond the fold of skin at D comes away, otherwise the matrix will not be exposed properly at this point. The part having been swabbed dry a probe covered with cotton wool is then dipped into pure carbolic acid, the surplus removed, and the exposed matrix forcibly rubbed with it, taking care to pass it well below D. A strip of wet gauze is then packed into the groove and a wet dressing applied. The acid is rubbed in similarly on four successive mornings, and the application is not painful. On the fifth day the dead matrix can be removed, and it is never renewed. In consequence of this the nail is never reproduced, and the outermost part presents a flat, instead of a curved edge. I have never known a case which has been properly done relapse, and patients are not kept in hospital longer than seven or eight days. I have tried to do this operation under beta eucain, but it has failed. The reason is that it is not possible to infiltrate the dense tissues with a sufficient amount of the dilute solution which it is necessary to use when working with this substance.

REPORT OF A CASE OF THYROGLOSSAL CYST.

By Major F. J. W. Porter, D.S.O.
Royal Army Medical Corps.

No. 4968, Boy R., 16th Queen's Lancers, aged 18, noticed a swelling in the middle line of his neck over the notch of the thyroid cartilage, in October, 1904, "about the size of a sixpence." He was serving in South Africa at the time. The swelling was incised, and he states that only blood escaped and that the wound did not heal. The opening was enlarged on board ship, en route to England, but no improvement resulted. He was admitted to the Military Hospital, Colchester, on November 18th,
1904, and the sinus was scraped and cauterised two or three times, but without benefit. He came under my care on March 2nd, 1905, and I thought that the case was probably one of thyroglossal cyst. Under an anaesthetic a probe was found to pass upwards from the cricoid cartilage to a point just behind the body of the hyoid bone.

An oval incision was then made, including all the cicatricial tissue which was present, and the whole sinus was dissected out. The wound healed by first intention and there has been no return of the cyst.

The thyroid body is developed from the hypoblastic layer of the embryo by three separate portions, one median and two lateral. The former is developed as a median diverticulum of the pharyngeal hypoblast, opposite the ventral ends of the second visceral arches, the latter as diverticula of the fourth visceral cleft; eventually they all blend in front.

The median diverticulum, which gives rise to thyroglossal cysts, is early cut off from the pharyngeal hypoblast and becomes an island of epithelium, surrounded by mesoblast in most animals. In man, however, it remains for some time as a hollow bifid vesicle, which is connected with the upper surface of the tongue by a small duct or tract of epithelium. Later on this becomes obliterated and disappears; the only evidence remaining in the adult being the foramen cecum, which is situated in the angle of the V which marks the junction of the anterior and posterior portions of the tongue. It follows from this, that thyroglossal cysts or tumours will be found somewhere in this track, which is intimately connected with the hyoid bone and thyro-hyoid bursa, and is originally connected with the isthmus and lateral lobe of each side.

A NOTE ON THE ADVISABILITY OF ALLOWING WATER IN LARGER QUANTITIES THAN IS AT PRESENT CUSTOMARY TO CASES AFTER OPERATION.

By Major F. J. W. Porter, D.S.O.
Royal Army Medical Corps.

In the Lancet for July 8th, 1905, Sir Wm. Bennett advocates the free supply of water to cases of intestinal obstruction, and after abdominal operations. In support of this, he relates three remarkable cases, all of whom he is quite certain would have died had the usual custom of limiting the amount of fluid supplied been adopted. Since reading this article, I have given instructions that my operation cases are to be allowed as much cold water as they wish for, immediately they come round from the anaesthetic. I have kept notes of the last twenty-five cases. They include three cases of removal of appendix, in one of which there was perforation and peritonitis, and several radical cures of hernia in which the omentum had to be ligatured. I find that in ten cases no vomiting took place whatever, and one of these was the appendix case above referred to.