Post-mortem.—On removal of the skull-cap meninges and brain were found intact. On removal of the brain a fracture was seen extending from two inches below and in front of the right parietal eminence downwards and forwards through squamous portion of temporal, through greater wing of sphenoid and body of that bone, between anterior and middle clinoid processes, right across base of skull in practically the same line, to the mid-point of the left squamo-parietal suture. A second fracture, V-shaped at its upper end, encircling the right parietal eminence, ran almost vertically downwards to the suture between squamous and parietal bones, followed this suture backwards for about half an inch, then ran vertically downwards through squamous into external auditory meatus, and then forwards and inwards to foramen lacerum medium, traversing the glenoid fossa. The right malar bone was fractured at its frontal and temporal processes. On examining the calvarium it was noticed that the groove in the parietal bone for anterior branch of middle meningeal artery was about the size of a quill on the left side, but on the right side the groove could barely be made out, and the artery itself was demonstrated with difficulty. On replacing the crown of bone from the first trephine opening the groove noticed at the time of operation on its inner surface was found to correspond with the groove for the anterior branch of the middle meningeal artery. The chief points of interest about this case seem to be:

1. The operation bore out the belief that the fracture was extensive, and that the middle meningeal artery was ruptured.
2. That, owing to sudden collapse of the patient on the table, further operative measures, such as tying of external carotid, were not justifiable.
3. That, though the artery was not found and tied at the operation, the bleeding practically ceased after plugging the trephine openings with gauze.
4. The inability to find the torn artery on the right side at autopsy owing to hemorrhage and the small size of the vessel.

The accompanying photograph of the skull serves to demonstrate the extent of the fracture.

A CASE OF RUPTURE OF THE RADIAL ARTERY CAUSED BY A BLOW.

By Major E. M. Morpew.
Royal Army Medical Corps.

Lance-Corporal C., 21st Lancers, was admitted to the Military Hospital, Colchester, on April 19th, 1906. The previous afternoon, while engaged in mounted combat, he received a blow from a sabre on the right forearm. Owing to excitement he took no notice of it, but a minute or so later he received another blow, which caused a contused wound on
the outer and posterior side of the right wrist, and necessitated his discontinuing the fight. This wound was sutured; and, at the time, a small swelling was noticed about four inches above the wrist in the line of the radial artery. Next morning the swelling was about the size of a hazel nut; there was distinct fluctuation, but no pulsation, and the forearm was swollen and the skin ecchymosed. On the morning of the 20th the tumour had increased to the size of a small walnut, and the swelling of the forearm was more marked. Fluctuation was visible in the tumour, and could be distinctly felt one and a half to two inches away all round. It being now evident that a rupture of the radial artery had occurred, an incision was made in the line of the artery over the tumour, and after the clots had been turned out and the extravasated blood allowed to escape, the artery was ligatured just above the site of the tumour, traced down for one inch and another ligature applied, and the intervening portion removed; this piece was crushed and had two rents in the coats. The man was discharged to duty on April 30th, 1906.

The points of interest in this case were: (1) that there was no connection whatever between the two injuries; (2) that the wound for which he was admitted was so trivial that admission would not have been necessary had not the other injury to the arm been noticed at the time.

A LITTLE-KNOWN TREATMENT FOR SUNSTROKE.

By CAPTAIN M. F. FOULDS.

Royal Army Medical Corps.

While stationed in Jhansi, India, in 1903, I saw my first case of sunstroke. Jhansi in 1903 was exceptionally hot, the thermometer registering anything from 105° to 115° F. in the shade.

The cases that were admitted were all of the same type, the patient being brought to hospital in an unconscious state; the breathing was deep and stertorous; the skin dry, hot and burning; pulse rapid, and the body temperature between 107° and 110° F.

The patients were stripped and put on a bed in the shade; one man poured water (as cool as could be obtained) from a height; two other men rubbed the body with pieces of ice, and the back of the neck was blistered. An iced-water enema of about two pints was given; a large clinical thermometer was kept under the armpit, and the iced-water enema repeated every ten minutes till the temperature fell to 102° F.

It is the internal active treatment, i.e., iced-water enema, I particularly wish to bring to notice, as I consider the repeated enemas in each case saved the man's life. In that year, 1903, we had nine cases of sunstroke admitted, and all recovered. We also had six or more cases of men brought into hospital with temperatures between 103° and 105° F., complaining of pains in the head and dizziness, and very drowsy, but not