On the morning of the 9th it was reported to me that the patient passed a very restless night, starting up in his sleep several times. The leg looked perfectly normal, and there was no difference in size, shape, and temperature with the other. Adduction of the foot performed by the patient caused a shooting pain, which was felt in the shin, and extension of the foot caused a similar pain. Pressure applied to the head of the fibula for the first time this morning brought about a sharp pain felt in the lower and outside of the leg. No "whip or springing" was obtainable.

Involuntary movements causing pain and night startings aroused the suspicion of a fracture, and a radiograph revealed a distinct longitudinal fissure about 4 inches long in the lower third of the fibula, occupying a rather central position in the bone.

The future progress of the case was uneventful, but the points of interest are:—

(*a*) The result of indirect violence.

(*b*) The absence of pain at the seat of fracture.

(*c*) The distance of the fracture from the spot where the opposite bone had been struck.

(*d*) The reflected pain.

(*e*) The usefulness of radiography.

Gask and Wilson state that "as a rule the presence of deformity, abnormal mobility, and crepitus, render the diagnosis easy, but with simple fissures without displacement these signs *except for localised pain may fail, and in fracture of the fibula alone the presence of the local tenderness will nearly always be the only sign.*"

I am of the opinion that the fracture being subperiosteal accounts for the lack of pain at the seat of fracture.

THREE INTERESTING CASES.

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THESE are some of the interesting cases which I found on perusal of my case records which are worth reporting to a journal.

Case 1.—A male boy, aged 6 years, was brought before me.

Condition on admission.—The boy's tongue was protruding out of the mouth. It was filling the whole mouth. There was marked salivation. On first appearance, it looked as if it was a case of macroglossia. On closer examination the left half of the tongue was found to be markedly enlarged and there was a cystic feel about it. The history was that it rapidly grew to the present size in three weeks and the boy was not able to swallow anything. A provisional diagnosis of neoplasm was made and I decided to tie the lingual artery of the left side to prevent further growth of the neoplasm by cutting off its blood supply. On the sixth day after the operation, I noticed a slit-like aperture on the left side of the tongue in the prominent part of the tumour and out of the slit came an oval white cyst-like structure of the size of a hen's egg and the tongue collapsed to normal size. The slit closed up the next day and the boy made an uneventful recovery and was able to take solid food as usual by the tenth day.

I preserved the cyst for pathological examination but it was spoiled by the neglect of the assistant. I was of opinion that it was a case of *Tænia solium* or *Tænia saginata* cyst* taking into consideration the caste of the boy who is accustomed to all the varieties of flesh and there is every chance of the flesh being contaminated since they live in dirty huts and don't cook their food well.

Case 2.—A male, aged 40, appeared before me with a foul-smelling cauliflower-like growth arising from the pterygoid region of the left side and protruding out of the mouth. There was constant dribbling of saliva. The swelling was highly vascular. The submaxillary glands, submental glands and glands in the anterior margin of the left sternomastoid were enlarged.

I dissected out the submental and submaxillary glands and the glands along the anterior margin of the left sternomastoid and I tied the external carotid artery just above where it gave off the superior thyroid branch and closed up the wound of the neck. Then I slit the cheek and cauterised the base of the growth and removed it and stitched up the split cheek. The man was in a state of profound shock for 24 hours. He was given rectal feeds for 3 days, and gargles several times a day. After the third day he was given nasal feeds for another four days and the usual gargle. Later he was fed by the mouth. After 6 weeks he was able to take solid food. He was under my observation for 6 months. There was no recurrence of the growth. Then I lost sight of him.

Case 3.—A man aged 35 years was brought to my care who had a scalp injury and who was unconscious and brain matter was flowing out of the wound. Since he was unconscious no general anæsthesia was given. The entire scalp was shaved and prepared antiseptically. A circular flap was dissected under novocaine. The bone near the parieto-frontal suture was splintered and imbedded in the brain substance. The dura was torn. The bone splinters were removed carefully. The brain was gently irrigated with warm boric lotion and a small tube was put in, the rent in the dura closed by a few intermittent stitches and the flap stitched up. The man was unconscious for another 3 days, he later regained consciousness and he was not able to speak in spite of several trials for another 10 days. Later he developed speech suddenly. The tube was removed after 24 hours, the sutures were taken out after 10 days. The man made an uneventful recovery.

GANGRENOUS STOMATITIS FOLLOWING THE PUERPERIUM.

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IT is generally stated in textbooks that the above condition occurs in young children living

* (Cysts of Tænia do not reach this size.—EDITOR, *I. M. G.*)