"jol"; the patient being much more conscious than the previous day. She was informed that the stomach tube would be used whereupon the patient stated that she could swallow alright. Barley water was tried and the patient drank one ounce of it without any dysphagia, nausea, or dyspnœa accompanying the act. After this the patient showed a marked improvement in deglutition; though most of the time she remained in a sleepy state. Later in the day she was said to have had a convulsive attack accompanied with delirium which lasted about an hour. Small quantities of essence of chicken and barley were given by the mouth and nutrient enemata continued. The adrenalin injection was repeated, the mixture for vomiting continued and no other treatment was indulged in. The patient was much better than on all the previous days and passed the night peaceably.

4th Day.—Patient markedly better. Could now recognise faces and answer to questions though most of the time she preferred to remain undisturbed. During the day a convulsive attack similar to that on the previous day was reported to have occurred, but I did not witness either. The use of ammonia was encouraged and stimulants kept up. No other treatment was given. Salines per rectum and injections all omitted. At 5 P.M. the patient had a severe attack of vomiting and two nematodes—(*viz.*, Ascaris Lumbricoides) were expelled in the vomited matter—one 7 inches long and the other measured 14 inches. This possibly was to account for the persistent nausea. No time was lost in attending to this new symptom, so santonin gr. iii, calomel gr. iii and glycerin one drachm was administered in the form of a paste before the patient retired.

5th Day.—Patient was given a saline purge early in the morning. Later on a motion was passed but no trace of any more ascarides was visible. The patient was said to have had 3 or 4 convulsive attacks during the day. About 7 P.M. she became quite conscious, spoke to all her relatives in turn and complained of hunger. Fluid diet was continued.

6th Day.—Patient was quite convalescent; was kept quiet in bed and fluids continued; medicines were discontinued as she objected to taking any.

7th Day.—The patient had another convulsive attack though none the worse for it. I was never present at any of these reported convulsions.

8th Day.—Santonin was again given, this time in combination with castor-oil emulsion with splendid effect; about 20 or 30 ascaries lumbricoides being expelled in the stool.

The patient is now quite well, though she does not perform her domestic duties as she gets occasional attacks of syncope and is more or less asthenic.

I am of opinion that the case is one of Addison's disease and that hysteria and the round worms have taken an active part in the performance. A great deal of the trouble was probably due to auto-intoxication and the belief in the theory of the Oriental physician (Kabiraj) is probably much in favour of ascaris lumbricoides setting up the auto-intoxication in the condition known as *Cremibikar* (Bengalee), which may be said to be the correct diagnosis of the disease. Unfortunately much stress is not laid on the symptoms set up by this nematode in our English text-books on medicine. However the picture presented is very much in accordance with Osler's description of Addison's disease and that is what I suspected the case to be, though the only symptom that may be said to be wanting was "Pigmentation of the Skin." The case being of exceptionally rare occurrence I think it worthy of record and it may be an impetus for further work on ascaris lumbricoides which I believe to be a much more common disease in India than Addison's disease.

A NEW PEDICLE SUTURE.

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THE methods of applying an interlocking suture as described ordinarily in text-books are sometimes difficult to carry out in practice. One is apt too at about the third loop to twist the wrong end, thus spoiling the whole suture. This may not happen in the case of those who use the suture with great frequency, but with most general surgeons it is only occasionally that the need arises: then, when suddenly confronted with the necessity of applying it, if one has not forgotten it entirely, the mistake mentioned above is quite likely to be made.

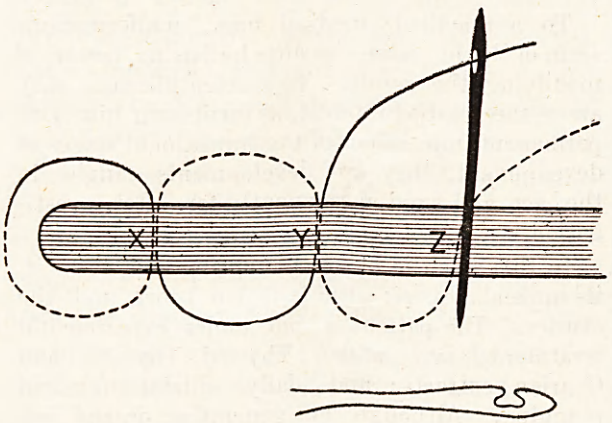
As a result of having made this error myself, I devised the suture to be described as a substitute and have now used it often—mostly for tying off the large lumpy masses of omentum so often met with in old hernia sacs. It is very simple and reliable and can be applied in less than half the time taken to do the ordinary interlocking suture, and, as far as I know, it has not been 'devised' before.

Various instruments may be used for the application; I use a special blunt pointed needle which I had made for the purpose. This needle has its eye near the point and is practically a herniotomy needle with one side of the eye filed out making it into a double hook. This is the most convenient instrument but, as will be seen, a pedicle forceps or even a sinus forceps will serve quite well; only if these be used care must be

taken to pick up plenty of slack or the thread will be frayed in pulling it through the pedicle.

The ligature may be applied in two ways according to the thickness or vascularity of the pedicle to be treated. In the first place, with a pedicle that is thin and only moderately vascular it is applied as follows:—

A length of suture material—I use silk—roughly double the length of the width of the pedicle, is taken and arranged round the neck of the pedicle at the level at which it is to be tied; it is doubled round the root of the pedicle so that it lie in two equal lengths one on each side—like a hairpin; then beginning at the loop end, the thread nearer the operator is hooked up by the needle and pushed through the selected spot in the pedicle, the thread is slipped out of the hook and the entire length of this side thread is pulled through and left on the far side. The other thread is now hooked up by the needle and pulled back through the same hole, its whole length also being pulled through. Another spot further along the pedicle is then chosen and the process is repeated, and so on, the threads crossing each other a number of times according to the nature of the pedicle until the further end is reached. The two ends are now drawn on and the neck of the pedicle is pulled in like a concertina. When drawn tight enough the ends are tied.



The rough diagram above should make the deficiencies of description clear. The needle is shown having pushed one thread through and being about to withdraw the other through the same hole at Z, previous crossings having been made at X and Y. Of course, in practice the loops are not left slack as shown. The two halves of the thread are differently marked for the sake of clearness. This could of course be done in use, but there is no need for it, as a mistake between the two threads need hardly be made even in the dark.

Next, if the pedicle is so thick that it is not considered safe to ligature it in this way, a slight modification makes it quite safe and takes very little more time. The ligature is arranged round the pedicle in the same way as described above, the nearer thread is pushed through a selected spot, unhooked and pulled entirely through, also in the same way. The needle *is left in situ* while the two lengths of thread are tied with a surgeon's knot as tightly as possible on the further side of the pedicle, thus tying off the packet of tissue at one end. The needle then hooks up either thread—it does not matter which—withdraws it through that same hole and takes it through again further along the pedicle where the process is repeated; each time care must be taken that the needle remains in the hole made until the threads are tied so that the thread may be brought back through the same hole.

It will be seen that this amounts to tying off the pedicle in sections, but it has the advantage of being done very rapidly, each knot tends to tighten the previously made knots and there are no scraps of tissue left to ooze between each bundle of tissue. There is also less likelihood of the knots slipping off if the pedicle is inadvertently cut unduly short.

Various combinations of the two methods can be used according to the nature of the pedicle, either all crossings or all knots or a series of crossings and knots alternately.

CASE OF ABSENCE OF UTERUS.

By MISS B. K. CHOWDRY, L.M.S.,
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17*th April* 1914.—A patient, named Dhapo, Hindu female, Jat by caste, admitted herself to the Lady Porter's Hospital for treatment of Amenorrhœa since the age of her puberty, and for sterility. She was married at the age of 12, eleven years ago.

Family history.—No parents living; she had one brother (dead). Two sisters; both married; one has children, and the other had none, although married for 20 years.

Personal history.—General configuration of the body.

General appearance.—The patient has a peculiar expression, as if something is wanting in her appearance. She has not a feminine face: she has more of masculine features, but no down on chin or lip. Hair short; voice deep; breasts of middle size with small areolæ. Her measurements are as follows:—

Height	62″	Weight	7 stone 6 lbs.
Measurements of		Shoulders	35″
,,		Busts	29″
,,		Waist	26″
,,		Hip	32″

There is a defect in the bony structure of her spinal column, *viz.*.—Spinal Scoliosis at the sacral