

without the tumour being at all pendulous or detached around. It strikes me that one of the preparations in the pathological collection of the University illustrates this variety of hernia. Here the division of *one layer of serous membrane* will expose the contents. In the other of which we have been speaking, *three layers of serous membrane* are interposed.

In the performance of the operation on *Napp*, you would observe that the stricture lay very deep; in fact, in the situation of what has been called the "internal ring." This stricture was divided by the introduction of a bistoury on the finger. A slight notch was made on the edge of the stricture, and along with it was cut the small portion of peritoneum covering it. No attempt was made to push the knife outside this membrane so as to divide the tendon or fascia, far less to divide the stricture without opening the sac. If the sac is to be opened, which is almost always proper, in order to ascertain the state of the contents, to determine as to whether they are in a fit state to be returned or not, then it is surely a useless refinement and complication of the process to set about saving half an inch, more or less, of the neck of the sac. Besides, you must keep in mind that the neck of the peritoneal sac is frequently contracted permanently, so as to act as a cause of strangulation. The *strangulation*, interruption to the return of blood, and passage of the intestinal matters, does not depend upon any change in the state of the containing parts, so much as upon the condition of those contained. The neck of the sac is firm enough of itself to resist dilatation, and in order to relieve the protruded parts this must be divided equally as the fibrous investments.

You would observe, that after the stricture was cut, the same attention was paid to position of the trunk and limbs as in the attempts at the taxis; and in reducing the portion of intestine, the sac was firmly fixed in its position. If these points are not attended to, the difficulties of reduction are much increased, and you may be altogether foiled in your attempts; you may think the obstacle is occasioned by the stricture, and this may be notched again and again without effect. Much time is often spent in this way, and very unprofitably to the patient; the bowel and sac coming down so soon as the pressure is removed.

As regards the dressing, you will find it quite essential for the first thirty-six hours to apply firm compression, in order to prevent the re-escape of the intestine or omentum. When the common T bandage has been resorted to for this purpose, I

have more than once seen unpleasant consequences follow.

After the operation, the prognosis is always rendered more favourable by the free evacuation of matters downwards, the cessation of vomiting and pain in the abdomen. The action of the bowels from above may be solicited by large warm enemata. These act beneficially; but some time must be permitted to elapse before medicine, even of the mildest and least irritating kind, is put into the stomach.

You are fully aware I presume, that although this patient has been cut for rupture, he is not freed from the risk of further protrusion. In the old operations, when the neck of the sac was tied, the chord being included, when the testicle was really cut away, and even when exfoliations from the os pubis followed the cauterizations, the rupture came down as before. It will be proper for the patient to be fitted with a truss, which, in consequence of the awkward position of the testicle, will be no easy matter. But this will all be arranged before the patient leaves us, which I expect will be on a very early day.

I shall revert to this subject on some early occasion, and notice then such points as have been omitted at this time.

## LIGATURE

OF THE

### SUBCLAVIAN ARTERY,

FOR THE CURE OF AN

### ANEURYSMAL TUMOUR OF THE INNOMINATA;

WITH A CASE AND OBSERVATIONS.

By CLAUDIUS TARRAL, Esq., *Ex-Surgeon-Major to the Polish Army, &c. &c.*

BRASDOR's proposal of tying an artery on the distal side of an aneurysmal tumour, again put to the test of experiment and strenuously advocated by Mr. Wardrop, has excited great attention. Many surgeons have judged this ingenious operation without thoroughly understanding its true principle of action; and others have denied its success, or have explained it by theoretical views which will not bear inspection. Brasdor, Desault, Deschamps, and Boyer, the first who wrote on this subject, imagined that this operation would completely obstruct the circulation, and therefore allow coagulation to take

place within the tumour, or might even cause the rupture of the sac. Sir Everard Home, it is supposed, first observed that after John Hunter's operation the circulation sometimes continued through the tumour; he therefore concluded, that a simple diminution of the force of the circulation was sufficient to produce coagulation in the sac, and hence to effect its obliteration. Mr. Wardrop applied the same reasoning to Brasdor's method, and established a complete analogy between these two operations, maintaining that nature employs a similar process in the spontaneous cure of aneurysmal tumours. In fact, as Mr. Wardrop has justly remarked, these spontaneous obliterations entirely confirm the principle of the Brasdorian operation.

Besides the cases mentioned by authors (see Sir E. Home, Sir C. Bell, Wardrop, &c.), there is a beautiful specimen of the spontaneous obliteration of an aneurysmal tumour of the arteria innominata, coinciding with the entire closure of the right carotid artery, among the anatomical preparations of the *London Hospital*. The subject of this case was under the care of Mr. Luke, who employed venesection to a great extent; unfortunately the history of the patient is too briefly recorded in the catalogue of the museum; his death was attributed to disease of the brain, supposed to have been produced by deficient arterial circulation.

Although Mr. Wardrop has laid great stress on the true principle of the Brasdorian operation, many most talented surgeons still profess the old opinion, that of its inventor, that it causes a complete stoppage of the blood. The consequence is, that they insist upon no branch existing between the ligature and the tumour; under this condition alone will they undertake the operation, and according to this fact they explain its success or its failure. Before I attempt to combat these opinions, I will lay before the reader a most interesting case, which will contribute much towards forming a correct notion of the value of this method.

*Case.*—I was requested by my excellent friend M. Laugier, surgeon to the *Necker Hospital* of Paris, to examine and give an opinion on the disease and treatment of the following patient.

M. Clery, aged fifty-seven, complained of troublesome catarrh, dyspnœa, difficulty in swallowing, and incapability of placing his body in any but the erect posture. His neck presented a tumour of the size of a large hen's egg, which pulsated synchronously with the radial artery. The tumour extended about two inches above the right clavicle, whose sternal extremity it had

dislocated, and pressed against the trachea, which was visibly pushed to the left side. Outwards, it reached to near the middle of the right clavicle; downwards, to about two inches from the top of the sternum, which was here prominent.

Several large superficial thoracic veins covered the tumour, and anastomosed with the veins of the neck. These symptoms might have led to a belief that the subclavian and right carotid arteries were alone affected; but on carefully examining the tumour, there was great reason to suppose that the innominata, and perhaps even the arch of the aorta itself, participated in the disease. The deviation of the trachea to the left side; the dull sound furnished by percussion on the first and second ribs, where no tumour was sensible to the eye; the difficulty of breathing; the peculiar resonance of the voice, which was of an œgophonic character, easily distinguished by auscultating the back of the chest, a symptom of great importance in these cases; the impossibility of feeling the termination of the tumour below the clavicle, joined to a consideration of the frequency of coexistent aneurysms of the innominata and aorta &c., were the principal sources from whence we formed that diagnosis. The tumour, which the patient attributed to a blow he had received, was now considered to be the principal cause of all his symptoms. M. Clery, although much weakened by his disease, was still in a tolerably good condition for an operation, to which he gladly consented.

M. Laugier having for several days administered opiates, determined (12th June, 1834) on taking up the right subclavian artery soon after it passes beneath the clavicle. Much against my wish, M. Laugier followed M. Lisfranc's mode of operating, that is, by cutting between, or, if possible, by separating, the sternal from the clavicular portion of the pectoralis major muscle. But proceeding thus, the surgeon attained the artery with great difficulty, and only after having transversely divided the clavicular portion of the pectoralis muscle. The vessel was then isolated, and tied by a single silk ligature. The great dyspnœa which the patient experienced by extending the neck during the operation, necessarily rendered it tedious and painful, and it would now have been almost impossible to put a ligature around the carotid artery, which I proposed to M. Laugier, thinking it would afford a greater chance of success. The operator being always opposed to this view, we paid but little attention to the state of that vessel's pulsations.

The lips of the wound were brought

together by sticking-plaster, and the patient was put to bed. No visible change occurred in the tumour immediately after the ligature was tightened.

The following day (13th) the tumour was evidently smaller, its pulsations were weaker, and the patient was able to sleep, which he had not done for several nights previous to the operation. The radial artery did not beat, the limb was natural and comfortable.

June 14. He felt much relieved, breathed easier, swallowed better, and demanded food, which was granted to him; the pulse in the left arm was good.

19. The patient went on well until this day, when a slight hemorrhage from the wound took place; the blood was of an arterial colour. This accident returned several times, but entirely ceased on the 22nd.

27. The patient assured me that he now perceived that his trachea was resuming its natural position; he complained of pain in the shoulders and back; was constantly sitting with his chest erect, and his head bent forwards and downwards; the pulse in the right arm was sensible to the touch. The ligature still remained in the wound, which continued to suppurate; the veins covering the tumour were much diminished.

July 2. He complains of pain in his back; his cough torments him; the tumour in its most elevated point seems to beat more strongly than before the operation. Acetate of lead and digitalis, in small doses, were now prescribed.

9. A violent paroxysm of dyspnoea came on, which was combated by bleeding; the cough continued, the respiration was very laborious; insomnia.

All these symptoms increased, and the patient expired on the 12th, one month after the operation, the ligature still remaining in the wound.

*Post-mortem Inspection Twenty-four Hours after Death.*

The limits of this communication will not allow me to give a minute description of the various interesting morbid states which were discovered; what pertains especially to the operation will alone be noticed. On laying open the thorax we found a large aneurysmal tumour of the arteria innominata, the pendicular length of which was five inches and a half (French measure); its breadth from side to side was six inches five lines; the tumour evidently pressed against the trachea; the bronchi were considerably flattened. The aorta was also dilated; its arch, in its middle, measured six inches three lines in circumference; immedi-

ately after it gives off the left subclavian artery, its circumference was three inches; the inner membrane of the aorta presented numerous and common cartilaginous points. The arteria innominata was the real seat of the aneurysmal tumour; its membranes could not be traced far; the sac was nearly filled by firm, dense, coagulated layers of fibrine; the lower part of the tumour contained more-recently formed coagula, and one coagulum, most probably formed since death, extended into the descending thoracic aorta.

The right common carotid artery, from its origin to within a third of its extent, was completely obliterated, and presented here and there singular valvular-like pseudo-membranes. The right subclavian artery, of natural diameter, was quite pervious to within half an inch of the point where the ligature was applied—that is, two inches ten lines from the internal mammary artery, or one inch eleven lines above the circumflex humeral artery. The ligature had divided the axillary artery, but was retained in the wound by a coagulum which had formed in its noose during the hemorrhage, which probably came from the lower end of the divided vessel, which was much less firmly closed than the upper one, and into which the clot evidently extended. Besides, close to the lower mouth of the artery existed a tolerably large collateral branch, which may have been the cause of the hemorrhagy, and the less perfect obliteration of this part of the arterial trunk. The subclavian artery was alone tied; the branches given off between the tumour and ligature, viz., the vertebral internal mammary, thyroid axis, &c., were of natural size and appearance, and quite pervious. The left carotid and subclavian arteries were healthy. The vena cava superior was much compressed; the subclavian veins, pushed from their proper situation, were likewise flattened and partially obliterated, the collateral branches were considerably enlarged, &c. &c. The third and fourth dorsal vertebræ were carious or ulcerated at their surface, and covered by a fetid matter, which communicated with the interior of the lower and back part of the aneurysmal sac. Exactly in this situation the trachea was extensively diseased; its inner membrane was thick and dark-coloured, and presented on its surface a dirty-gray mucus, its follicles very prominent, &c. The œsophagus was here found ulcerated, and communicated with the fetid matter of the diseased vertebræ; the lungs were engorged; the other viscera presented no lesions worthy of our present notice.

Here then is another case exemplifying

the great difficulty of making a correct diagnosis of aneurysmal tumours when situated in the neck and superior part of the thorax, a subject which has particularly attracted our attention elsewhere.\* In the present instance, however, we were fortunate in forming a right opinion with regard to the principal vessels, and in adopting a rational surgical operation. Nevertheless many morbid lesions escaped notice; the complication of diseases and the similarity of their symptoms, was the source of error. Was it not plausible to ascribe the pain in the back, the pain in the throat, the difficulty of deglutition, &c., to pressure of the tumour? Was it not reasonable to suppose the origin of the right carotid and subclavian arteries likewise affected, especially the carotid, whose pulsations were exceedingly feeble just above the tumour? I regret not having examined this vessel more minutely during life; the patient could not bear pressure on the neck, it even produced syncope when applied by M. Laugier. From the slight examination of this vessel, we merely thought it implicated in the disease, not obliterated. But the most valuable fact in this observation is undoubtedly the decrease of the aneurysmal sac, both the subclavian artery and its large branches being pervious and of natural size. This circumstance certainly tends most fully to establish the principle of the operation. May it not be considered most fortunate that the surgeon abstained from employing force (which many practise) in pulling the ligature away? for this course evidently might have caused a serious hemorrhagy, by withdrawing the plug of coagulum which closed the mouth of the artery, and filled the noose of the ligature.

Since the publication of Mr. Wardrop's book on Aneurysms and their Cure by the Brasdorian Operation, various opinions have been adopted, which I will briefly notice. The limits of this paper render it impossible to do justice to the numerous cases and memoirs written on the subject, although there is much more to blame than to commend. I must refer to the principal authorities.†

\* See *Journal Hebdomadaire de Médecine*, Paris, Sept. 26, 1829.

† The following works are the most worthy of being consulted:—

J. U. L. Casamayor's "Réflexions et Observations Anat. Chirur. sur l'Aneurysme Spontané," &c. Paris, 1825. Brasdor's operation by Deschamps is here well described.

Hodgson and Breschet's "Maladies des Arteres"—English and French edition.

Besides the operations mentioned in Mr. Wardrop's work, it may be useful to

These authors appear opposed to the method.

Chelin's "Handbuch der Chirurgie," b. 1, p. 869. This author supports the method, but without, perhaps, understanding its real principle. Heidelberg.

Rust's "Theoretisch und Praktisches Handbuch der Chirurgie." Berlin, 1830. B. ii. art. "Aneurysma." Nothing new, but some gross errors.

Omodei's "Giornale Universali di Medicina." Milano, 1829. A review of Mr. Wardrop's book, without any judgment or just criticism.

Samuel Cooper's "Dictionary" and Lectures, delivered at the Lond. University. — *Med. Surg. Gazette*, Oct. 1833.

Mr. Lawrence's Lectures on Aneurysms.—"Med. Gaz.," vol. 6. In the same volume read Key's and Mott's Observations and Reflections.

Charles Bell's "Principles of Surgery," New edit. 1826. vol. 4. This author relates some interesting facts relative to obliteration of tumours following a diminution of the circulation; he is a strenuous partisan of the Brasdorian method; indeed he lays some claim to the discovery of the true principle "of our operations for aneurysms, the effect of which is only to diminish the impetus of the blood through the sac." p. 439. I am not aware that Sir C. Bell laid much stress upon this subject, until the publication of Mr. Wardrop's book.

Begin's "Dict. de Médecine Pratique," b. 2. Paris, 1829. Article "Aneurysme." A very bad composition.

Dupuytren's "Clinique Chirurg. de l'Hotel Dieu," b. 4. This work, composed by incompetent flatterers, proves the vanity and ignorance of the eminent surgeon, who does not yet understand the principle of the operation.

C. Tarral's "Réflexions et Observations sur les Aneurysmes," and "Journal Hebdom. de Méd." Paris, 1829.

Berard (Prof.), "Memoire sur l'Etat des Arteres," and "Archives Générales de Méd." Paris, xxiii, 1830.

T. M. S. Villardebo's "Thèse sur la Méthode de Brasdor. Soutenue à la Faculté de Paris." 1831.

J. Lisfranc's "Thèse pour le Concours d'Une Chaire de Clinique Chirurgicale." Paris, 1834. This author is far from seeing the true principle of the operation; his thesis, besides being a mere compilation, contains on this subject some gross mistakes.

Marjolin and Berard's "Dict. de Méd."

cite the following, which are either unknown, or have attracted but little attention.

Sir E. Home was the second surgeon who followed this plan. In 1825 he tied the femoral artery for the cure of an aneurysmal tumour of the iliac vessel. The aneurysm, he says, increased after this operation, he therefore had recourse to another ingenious method, of which we will speak hereafter. Sir E. Home is too laconic in his description of the diseased vessel: it is not said precisely where the ligature was placed, or what was the state of the collateral branches, &c., and hence the difficulty of forming a judgment of the operation.\*

Mr. White has also tied the femoral artery below the profunda cruralis, which was given off high up; here the vessel on which the ligature was placed was quite obliterated. The patient died from erysipelas, and not from rupture of the sac, as Mr. J. G. Guthrie asserts: this observation is also very imperfectly reported.† It can hardly be considered a trial of the Brasdorian operation, on account of the vessel tied being already obliterated.

Mr. James, of Exeter, followed Sir E. Home's example of tying the femoral artery for iliac aneurysm. This operation did not ameliorate the patient's state; Mr. James, therefore, determined on trying the bold resource of taking up the abdominal aorta. The unfortunate result is fully known.‡

M. Dupuytren § has likewise given this operation his approval. For an aneurysmal tumour of the subclavian and innominate arteries, he placed a ligature around the axillary trunk. The cause of the patient's death would require too much examination to find a place in the present paper. I have elsewhere explained that the after-treatment was the principal, if not the sole, cause of the unfortunate result.

Mr. Aston Key || has also tied the subclavian artery for the cure of aneurysm of the innominate. The patient, it will be

recollected, died a very few hours after the operation, and without any evident cause.

Mr. John Scott, surgeon to the *London Hospital*, for a tumour which was supposed to have its seat in the arteria innominata, put a ligature around the right common carotid artery, which was shortly obliterated. The upper part of the tumour, some time after the operation, appeared to have somewhat diminished. At last, however, Mr. Scott proposed obliterating the subclavian artery, to which the patient would not consent and left the hospital. I am indebted to my friend Mr. Hamilton, demonstrator of anatomy, for having had the opportunity of seeing this poor fellow, who presented a prominent and frightful tumour of the neck, which for several days menaced rupture, which finally occurred, giving rise to a quickly fatal hemorrhage. We called to see this patient a few hours after his death, but his friends, all of the Jewish persuasion, would not (as usual) consent to our examining the body; it is, therefore, quite impossible to form any correct opinion of the operation.

The operations of Mr. Mott\* and Mr. Montgomery, † so satisfactory as regards the principle of this method, are well known, and at present need no further comment.

These are all the operations with which I am acquainted, and here is the judgment which has been passed upon them. A young author, in whose erudition and scientific faith I place but little confidence, expresses in a pamphlet which is dedicated to the Lord Chancellor, and written for the "public and the profession," the following extraordinary opinion:—"Doubt appears to exist whether the operation of Brasdor has ever been successfully performed." (page 13.‡) He maintains with M. Begin, that Deschamp's operation was followed by rupture of the sac, which never occurred, for the sac was laid open by the knife, &c. But boldly to publish the following phrase, gives at once the measure of his great impartiality:—"In three or four cases he (Mr. Wardrop) has performed the operation, and, in one instance, he *believes* with success." Mr. Wardrop never made use of such an expression. Our author should read the works of those whom he pre-

New edit. T. 3. Article "Aneurysme." Paris, 1833. This article, like most others, is much better treated in this new dictionary than in any similar work published on the continent.

\* "Philosophical Transactions." 1826, London.

† Mr. J. G. Guthrie's Op. cit., p. 8. Villardebo Op. cit. Paris, 1831.

‡ "Medico-Chirurg. Trans." vol. 16, 1829.

§ See "Memoire sur les Aneurysmes," Journal Hebdomad., Paris, 1829.

|| "Lond. Medic. Gazette," vol. 6, page 703.

\* "Lond. Med. Gazette," vol. 6, p. 61 or the "American Journal of the Medical Sciences," for February and August 1830.

† "Lancet," June 29, 1833; Dr. Johnson's "Journal," page 448. 1833.

‡ Phillips' (Benj.) "Series of Experiments on Arteries." Lond. 1832.

sumes to judge. Mr. J. G. Guthrie\* on the other hand, does not deny the success of the Brasdorian operation, but explains it by the ligature producing inflammation and suppuration in the tumour. From this fact he argues also, that the operation is dangerous when performed on large vessels near the heart.

This exclusive theory, so at variance with the facts which science possesses, is the great characteristic feature of Mr. Guthrie's late Hunterian Oration at the Royal College of Surgeons in London. It would have been still more remarkable had Mr. Guthrie endeavoured to prove that the operation of the illustrious surgeon, whose memory he was perpetuating, was founded on a newly discovered principle! Has Mr. Guthrie never seen suppuration of aneurysmal sacs follow John Hunter's operation? Why not then attribute their cure to that cause? Having had the advantage of examining several morbid specimens which clearly show that coagulation and obliteration of a sac may take place without the assistance of suppuration, by means of a ligature applied either on the distal or the cardiac side of the aneurysm, I decidedly differ from a professor who maintains his *suppurative theory* by such slender reasonings! That suppuration of the sac may actually occur in certain cases, no one will attempt to deny, but these may be justly considered as exceptions to the general rule. Another opinion, of a much more plausible kind, requires brief notice, especially as it has for its advocates the names of Boyer, Dupuytren, Lisfranc, Velpeau, and Begin. These authorities assert that the Brasdorian operation presents little or no chance of success where collateral branches are given off between the tumour and the ligature; and hence most continental writers have divided these cases into two classes; in the one no branch exists between the ligature and the tumour; in the other, collateral vessels are given off; consequently, also, they admit the operation in the former division and reject it in the latter.† M. Lisfranc has committed a great mistake in placing M. Dupuytren's case in the second class, for I have elsewhere shown that the collateral arteries (the dissection performed by myself) were all entirely obliterated;

therefore this circumstance evidently renders the case analogous to those of the first division. M. Laugier's case proves, clearly, that collateral branches, both large and numerous, between the ligature and the tumour, are not an obstacle to the cure. There are other facts, already known, which corroborate the same observation, but it is still unsettled what degree of circulation in the sac will prevent coagulation.

The danger of rupturing the sac by producing a sudden stoppage of the circulation, is an objection which merits but short notice, although much supported by writers. Sir A. Cooper's is the only case where this accident can possibly be attributed to the ligature, and even there it was exceedingly equivocal, some time having elapsed between the operation and the death of the patient; there was no post-mortem examination; besides, the ligature was placed on the femoral artery, below some collateral branches, &c.

The greatest difficulty pertaining to the Brasdorian method is, how to ascertain its comparative chances of success. Most authors have committed an extraordinary error in calculating the number of operations, and merely mentioning their result. Thus it is that the most illegitimate opinions are formed. For instance, is it not absurd that my learned friend M. Velpeau\* should bring forth Mr. A. Key's operation as a new argument against the method? Here the patient died a few hours after the ligature of the right carotid artery was performed; the examination of the body displayed the singular coincidence of a partial occlusion of the left carotid artery. The brain too, scantily supplied with blood, was here, probably, the sole cause of death. Mr. Lambert's operation is also termed "fatal." Truly the patient died of hemorrhage, but the tumour was in a rapid stage of cure.

M. Laugier's operation, which certainly confirms all that can be said in favour of ligatures on the distal side of aneurysmal tumours, will soon, no doubt, enlarge the list of fatal cases! Mature reflection, however, will easily point out the fallacy of thus confounding all cases together,—of drawing conclusions so arbitrarily,—and will prove the necessity of taking into consideration each individual case, of weighing each peculiarity, &c. In judging of an operation, inquiry should first be made if the requisite conditions for its success were present; the various complications of disease which may either impede or prevent its effects, should also

\* Mr. J. G. Guthrie on the Diseases and Injuries of Arteries with Oper., &c., Lond. 1830.

† See his "These pour le Concours de Clinique Chirurgicale à Paris," 1834. See Op. cit. "Journal Hebdomadaire," Paris, 1820.

\* See "Médecine Opératoire," Ligature des Arteres.

claim minute attention. With regard to the present subject, whoever will carefully study the observations which are recorded, will find few where the operation had great chance of success; and this, not on account of the collateral circulation, but because the disease was either too far advanced, the tumour communicated too largely with the aorta, or the position of the sac was such as not to allow the ligature of the artery to have sufficient effect on the circulation. These conditions are of the utmost importance, and as a general rule it may be established, that the more freely the tumour communicates with the aorta,—the more the axis of the artery tied deviates from the centre of the tumour,—the less expectation of coagulation taking place should be entertained. For instance; in M. Dupuytren's and Mr. A. Key's cases, the tumour communicated so largely with the aorta, and the axis of the arteries tied corresponded so little with the axis of the sac, that the operation was almost hopeless. Assuredly the frequent and sometimes insurmountable difficulty of forming a correct diagnosis of aneurysmal tumours of the neck and abdomen, of appreciating the diseased state of the aorta, the form of the tumour, the direction of the arteries arising therefrom, the complications of disease of the surrounding and deep-seated parts, &c. &c., tend much to perplex the surgeon, and render his conduct most difficult.

After carefully considering all these facts, the following conclusion appears to be the most correct,—

1. That the Brasdorian method (similar in principle to the Hunterian) having been completely successful in obliterating tumours by coagulating their blood; its principle is fairly and indisputably established.

2. That collateral arteries, provided they are neither too numerous nor too large, are not an impediment to its success; nevertheless, as we are yet uncertain how far the force of the circulation must be diminished, prudence dictates that we should, where it can conveniently be done, place the ligature on their cardiac side.\*

3. That rupture of the sac need not be dreaded. But,

4. And lastly, as the Brasdorian operation requires the existence of many anatomical peculiarities, which, unfortunately, are here rarely met with, it is, for this reason, seldom doomed to succeed; and

\* Might not compression applied to the tumour after the operation of ligature, considerably facilitate its object,—coagulation?

hence the importance of prosecuting experiments on the tumours themselves, a plan already adopted by Sir E. Home in 1826,† and long ago hinted at by that modest, erudite, and conscientious surgeon, J. B. Monteggia, of Milan.‡

Paris, March, 1835.

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CORRESPONDENCE WITH THE  
POOR-LAW COMMISSIONERS,

*Relative to an Order against the Official Medical Attendance of Licentiates of the Apothecaries' Company on Pauper Patients.*

*To the Poor-Law Commissioners, Somerset House, London.*

GENTLEMEN,—At a meeting holden yesterday in the poor-house of Faringdon, of the guardians of the parish of Faringdon, and of the twenty-nine parishes which, under the authority of the Poor-Law Amendment Act, have recently been united with it, your assistant-commissioner, Mr. Gulson, decided that no medical practitioner, not being a member of the College of Surgeons, should be permitted to contract, or be considered eligible to contract, for attendance on the poor in any of the united parishes of which this place is the centre.

Your assistant-commissioner further stated, that the same rule would be invariably acted upon throughout all the parishes in England and Wales.

As a licentiate of the Apothecaries Company, and as a medical practitioner in this place of nearly nine years' standing, and who has been the parish surgeon and apothecary, not only of Faringdon, but also of several of the adjoining parishes, I enter my protest against this most extraordinary, impracticable, and unjust decision.

1. Extraordinary—because, in making it, the assistant-commissioner has exercised powers which have hitherto only belonged to, and been exercised by, the three estates of the realm, inasmuch as, upon his own responsibility, he has actually given a decision which, if persisted in, will have all the effect of an *ex-post-facto* law, and will virtually repeal that part of the Apothecaries Act which pronounces

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† “Philosophical Transactions” for 1825, on the Coagulation by Heat of the Fluid Blood in a Tumour, &c.

‡ J. B. Monteggia, “Istituzioni Chirurgiche,” vol. 1, p. 259, nuova edizione. Milano, 1829.