Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON THE TREATMENT OF THROMBOSED VARICOSE VEINS BY EXCISION.

By F. A. SOUTHAM, M.B. OXON., F.R.C.S. ENG.,
SURGEON TO THE MANCHESTER ROYAL INFIRMARY; LECTURER ON
OPERATIVE SURGERY, OWENS COLLEGE.

In an interesting address on the Operative Treatment of Varicose Veins published in *THE LANCET* of April 8th, 1899, Mr. Pearce Gould describes two cases where excision of large thrombi and immediate closure of the wound was attended by very satisfactory results. Mr. W. H. Bennett has also advocated and carried out a similar line of treatment.¹ Having recently adopted this course with success in a patient who was the subject of very extensive thrombosis of the internal saphena vein in the thigh a brief record of the case may perhaps be of interest.

The patient, a male, aged 44 years, had been troubled since he was 18 years of age with slight varicosity of the veins of the right leg below the knee. Three years ago the internal saphena vein became involved in the right thigh and on two occasions he had suffered from attacks of thrombosis, limited to this portion of the vessel, necessitating confinement to bed for some time. On admission into the hospital on Oct. 20th, 1898, he was suffering from a third attack which had commenced 11 days previously. The vein from the knee upwards was extremely dilated and filled with firm clot, being plainly perceptible beneath the skin as a prominent cord. It was very painful and tender upon pressure, the skin over it being reddened and cedematous. The patient's temperature was 101.6° F. He was kept at rest in bed, glycerine and belladonna were applied, and the limb was wrapped in cotton-wool. Under this treatment the inflammatory symptoms subsided, but there was no indication of any tendency to absorption of the thrombus, the vessel remaining cord-like and distended with clot. Accordingly, at the end of a month, as the patient was becoming impatient at the prolonged confinement to bed, it was resolved to excise the thrombosed portion of the vein. On Nov. 10th a linear incision 12 inches in length was made over the course of the saphena vein in the thigh and ligatures were placed round the vessel above and below the varix, which commenced very abruptly about two inches below the saphenous opening and terminated just above the level of the knee-joint. The thrombosed portion of the vessel which was somewhat tortuous with marked pouching of its walls was then removed between the ligatures. The part excised, which was filled throughout with softish clot and measured 15 inches in length, in the greater part of its course was of about the thickness of an adult thumb. The wound was closed, no drainage being employed. It was dressed for the first time on the ninth day, when it was found to be soundly healed. The patient left the hospital on Dec. 12th and shortly afterwards resumed his occupation as a market porter, which he has since followed.

The satisfactory result of the operation in the present instance would certainly induce me to perform it again under similar conditions, for not only was the patient's convalescence hastened—the absorption or the organisation of an extensive thrombus always being a tedious process—but he is freed from any further attacks of thrombosis with the risk of embolism, a complication which is liable to occur when the main trunk of the saphenous vein is involved in the upper part of the thigh.

Manchester.

HALLUX VALGUS AND HAMMER TOE.

By T. S. ELLIS, M.R.C.S. ENG., L.S.A.,
CONSULTING SURGEON TO THE GLOUCESTER INFIRMARY.

DR. W. J. COLLINS, in *THE LANCET* of April 15th, having spoken of these deformities as being "closely allied,"

goes on to state that in a case which he reports "so strong was the valgus impulse that the coincident deformity of a hammer second toe afforded no obstacle." I ask permission to remark that when conditions are "closely allied" it is hardly probable that the existence of one would be an "obstacle" to the co-existence of the other and, also, to show that the common occurrence of both together can be fully explained.

All idea of a "valgus tendency" as an "exclusive prerogative of the hallux" or otherwise must be discarded. Given free play to the natural functions of the great toe, it will maintain a capacity to come when in action into a line with the inner margin of the foot. And this faculty may be re-acquired by exercise of function alone in those who have in very marked form the incipient hallux valgus which is, as a consequence of wearing median-pointed boots, well-nigh universal. When the great toe is at rest it is inclined upwards and outwards over the end of the second toe. It is shown thus in the frontispiece to my book¹ as the Position of Rest. On the other hand, the smaller toes when at rest are, or should be, straight. When in action as toes, they serve as pressing, and not, like the fingers, as grasping organs: they are drawn into the position shown in Fig. 1. This is essentially

FIG. 1.

Position of phalanges when the toe is in action.

the same as that given in illustrations of typical hammer toe. It will be seen that the final phalanx rests flat on the ground forming on its upper surface a level bed. Now if the great toe be fixed by the median-pointed sock and boot when it is in the position of rest, then so soon as the second toe is brought into action the great toe falls on to the level bed thus formed and the arrangement shown in Fig. 2 completed. Obviously, the second toe

FIG. 2.

Position of hallux if pressed over second digit.

FIG. 3.

Position of hallux if pressed under second digit.

has, when so placed, a difficulty in resuming the straight position, adaptive shortening of the ligaments ensues, and permanent hammer toe results. So, too, the great toe, never being allowed to attain its natural position in walking, becomes fixed in an exaggerated degree of its inclination when at rest. This is the common course of events. If, however, the great toe happen to be packed under the second, as shown in Fig. 3, there is usually a much greater interference with function and a greater degree of irritation in the metatarso-phalangeal joint. I discussed these points in a paper read before the Royal Medical and Chirurgical Society in February, 1897,² from which the illustrations are taken.

I may add that a month is full soon for Dr. Collins to feel sure as to the result of his operation. If the patient does not give plenty of room for the toes in his boot pressure on

¹ The Human Foot.

² Transactions of the Royal Medical and Chirurgical Society, vol. lxxx

the cicatrix may result in a keloid condition giving cause for regret that amputation of the toe was not preferred.

Gloucester.

"REPLACEMENT OF A SEVERED PORTION OF THE NOSE."

WE published on March 11th an interesting clinical note by Dr. W. M. Abbot-Anderson bearing this title. Briefly the case was as follows. A man while in the act of sharpening a knife cut off a portion of his nose. The piece

was found and sewn on again by Dr. Abbot-Anderson with precautions which he described in detail in our columns and which the accompanying illustration reproduced from a photograph of the patient shows to have been crowned with success.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ROYAL FREE HOSPITAL.

A CASE OF ACUTE TETANUS TREATED BY SERUM;
DEATH; NECROPSY.

(Under the care of Mr. JAMES BERRY.)

IN THE LANCET of April 22nd was recorded a case of tetanus in which recovery followed the employment of tetanus antitoxin and we pointed out then that the cases in which the anti-tetanic serum appeared to be of most value were those in which a long incubation period had occurred between the infliction of the wound and the appearance of the symptoms. In the case recorded below six days elapsed between the injury and the first signs of the disease. This is decidedly a short incubation stage and it would of itself suggest the probability of a very severe attack, for the shorter the period of incubation the more acute are

the symptoms. The very rapid progress of this case is remarkable. Cases lasting a much shorter time have, indeed, been described but many of them are more than doubtful. The often-quoted case related by Robinson of a negro butler who died from tetanus a quarter of an hour after cutting his hand with a broken plate need not at the present time be seriously considered. With regard to the anti-tetanic serum treatment in the case recorded below 35 cubic centimetres in all were administered with no sign of improvement and, on the other hand, with no manifestation of any symptoms of poisoning from the antitoxin. In the present uncertain state of our knowledge of this still novel method of treatment all cases in which it is employed, especially those ending fatally, should be put on record. For the notes of the case we are indebted to Mr. T. Percy Legg, F.R.C.S., senior resident medical officer.

A man, aged 27 years, was admitted into the Royal Free Hospital on Jan. 18th, 1899, and gave the following history. On the 12th he was climbing over some railings and ran one of the spikes through his boot into the ball of the great toe of the right foot. He took no notice of the accident as it gave him no trouble and he remained well till the 18th, on which day he went to work as usual but about 1.30 P.M. had pain in the back and neck. Soon afterwards he was unable to open his mouth for more than a quarter of an inch and could not swallow. At 6 P.M. he attended at the hospital and was admitted. There was well-marked tonic spasm of the masseters. The back was somewhat arched and the muscles were rigid and prominent. The head was drawn backwards; there was slight twitching at the angles of the mouth and the corrugatores supercilii were in action. The abdominal muscles were hard and rigid. The temperature was normal and the pulse was 120 per minute. The patient was quite unable to swallow liquids. On the right thumb there were two clean recent cuts and on the ball of the right big toe there was a suppurating wound half an inch long. This was opened and about a drachm of pus was let out; the wound was scraped well and swabbed with one in 20 carbolic lotion. At 10 P.M. on the day of admission 10 cubic centimetres of antitoxin (Jenner Institute) were injected into the muscles of the back and 40 grains of potassium bromide with 20 grains of chloral were given by the rectum. At 4 A.M. on the 19th he had a well-marked clonic spasm with opisthotonos; risus sardonicus was well marked. He was cyanosed and sweated freely. Another 10 cubic centimetres of antitoxin were given as well as the same amount of chloral and bromide as before. At noon the symptoms were more pronounced; the abdominal muscles were very hard and retracted and there was marked retraction of the head, the chin being thrown high upwards. There was constant twitching at the angles of the mouth, together with well-marked risus; the masseters were very hard. Another 10 cubic centimetres of antitoxin were given. The wound in the foot was excised freely. One-fifth of a grain of morphia was given hypodermically. At 2 P.M. he had been sleeping on and off since the morphia was injected, but awoke every few minutes with a clonic spasm which became rapidly more violent and tonic in character. The temperature was normal and the pulse was 144. Another five cubic centimetres of antitoxin were given at 3 P.M. About 4 P.M. the patient had a violent tonic spasm; the back was arched backwards completely, so that he rested almost entirely on his head and heels. He died in this attack, the muscles at once becoming relaxed, the jaw dropping, and the abdomen becoming flaccid. No urine was passed while he was in the hospital.

Necropsy.—On a post-mortem examination being made it was found that rigor mortis was not marked. The vessels of the brain were congested, the arachnoid was thickened and opaque, and the brain substance was firm. The spinal cord above the lumbar enlargement was very soft and in the arachnoid there were numerous white hard (? calcareous) spots, varying in size from that of a pin's head to that of a split pea; they were most marked in the cervical region and over the corda equina. Except that the lungs, liver, spleen, and kidneys were all much congested there was nothing else to note in the examination.

Remarks by Mr. BERRY.—The chief points of interest are the very rapid course of the disease and the uselessness of the treatment by antitoxin in such very acute cases. On admission the patient had already well-marked opisthotonos and although the serum treatment was begun within 10 hours of the onset of the first symptoms of the disease it did not apparently exert the slightest influence in mitigating the