have endeavoured, though very imperfectly, to illustrate by a few examples the influence that one man, in the person of John Hunter (who has now been dead over a hundred years), exercised on the development and progress of

FIG. 3.

practical surgery. At no period in the history of surgery has this influence been greater or more conspicuous than at present.

The public and the profession owe a deep debt of gratitude to a society like this which devotes so much attention and attaches so great importance to all that relates to the life and work of John Hunter.

A NOTE UPON AMPUTATION AT THE HIP-JOINT.

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IN proportion to the gross number of amputations disarticulation at the hip-joint is, I suppose, performed more often at a children's hospital than at a general hospital. There are several reasons why this should be so. In the first place, cases of advanced hip-joint disease, for which the operation is often most admirably suited, naturally drift towards a children's hospital and the little patients as a rule rapidly pick up as soon as the hopeless limb is removed. Then sarcoma of the periosteum of the femur, for which disarticulation at the hip offers the only prospect of recovery, is particularly a disease of early life. Septic osteo-myelitis, also, which is peculiarly a disease of children, may require the high amputation.

I have assisted at the operation of amputation at the hip-joint, and I have performed it, a good many times and in a good many ways. The fact of there being many schemes for performing the disarticulation may be taken as evidence that there has been in the past no general recognition of there being any one operation of surpassing merit.

Compression of the abdominal aorta by fingers or tourniquet, of the common iliac artery by the rectal lever, of the external iliac or common femoral by the fingers, or by a rubber tube applied in one ingenious way or another, or securing the vessels in the flap—each method of dealing with the main vessels has shown some evidence of defect, or, at any rate, has left a good deal to be desired. Then as regards the division of the soft parts—the planning of the flaps—there was the dashing method (particularly associated in this country with Liston's name) which gave a long anterior flap by transfixion; there were the methods by lateral flaps, and there were various racquet-shaped incisions. In later years came Furneaux Jordan's method of enucleating the femur through a long external incision and cutting through the soft parts in the middle of the thigh, or lower, the vessels having been controlled by the rubber band encircling the pelvis. This operation has, or rather the modifications of it which have been adopted from time to time have, much simplified disarticulation at the hip. But there is a still simpler method of operating, and it is the object of this note briefly to describe it.

First, the crural sheath is opened through an incision running vertically down from Poupart's ligament and the common femoral vessels are secured in separate ligatures. This takes very little time—not nearly as long as is usually taken to secure the superficial and deep femoral vessels and their bleeding branches in the cut flaps of an ordinary amputation. Then a circular sweep is made round the thigh a little above the middle, straight on to the femur, the bone being sawn through at the same level. Thus the limb is cut off square. An incision is next made on to the femur from the top of the great trochanter downwards and the bone is enucleated, some small branches of the sciatic, gluteal, or circumflex iliac arteries possibly requiring attention. If the amputation is being done for tuberculous or septic inflammation the periosteal and muscular attachments to the femur are separated with the utmost ease by a blunt raspator, but if for peripheral sarcoma the surgeon would have to use a knife and to keep it well away from the bone.

Briefly, I would state my proposition thus: Amputation at the hip-joint is most conveniently performed after a preliminary ligation of the common femoral vessels by cutting straight across the thigh a little above the middle, and by enucleating the remaining part of the femur through an incision running down on to the bone from the top of the great trochanter.

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THE FIXATION OF MOVEABLE KIDNEY BY MEANS OF STRONG CARBOLIC ACID; SIX CASES.

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THE method which I have adopted for nephropexy in the cases here recorded is, I believe, an improvement on methods in which scarification or peeling of the renal capsule is employed in association with other measures. It is applicable to all the recognised forms of nephropexy and gives greater security to their results.

The plan consists in freely painting the whole surface of the kidney, except the hilum, with the strongest liquid carbolic acid, so that the surface becomes covered with granulation tissue within a few days. The painting is best done after the supporting sutures, &c., have been inserted, but before they are tied, by means of a swab containing the liquid not in excess. In four of the cases—those in which the kidneys were suspended by gauze slings and packing—I have been able to watch the surface of the kidney for from 10 days to three weeks afterwards and I have observed the granulations and lymph rapidly form, followed by intimate and firm incorporation of the kidney with the surrounding tissues. The kidney could then be seen to move with respiration in conjunction with the parts surrounding it, and on pressing upon the exposed renal surface it was found to be inseparably attached even in those cases in which no sutures were used. Moreover, in a case treated thus combined with gauze packing I was able to verify the results a year afterwards, for on cutting through the old scar for the relief of pain

TABLE OF SIX CASES OF THE APPLICATION OF STRONG CARBOLIC ACID TO THE KIDNEY.

Case.	Date.	Age.	Cause.	History.	Method.	Remarks.	Result.
1	Feb. 15th, 1898.	Years 24	Congenital (?)	Paroxysmal pains as long as the patient could remember; nausea, vomiting, and dyspepsia two years.	Carbolisation; kangaroo-tendon sutures.	Several slight attacks of hæmaturia after getting up.	Reported as "quite well, no symptoms" 18 months afterwards.
2	August 9th, 1899.	18	—	Paroxysmal pains for two years, with nausea and constipation; frequent micturition.	Carbolisation; silk sutures.	Complete investing membranous capsule.	Gained much flesh and left the Infirmary free from pain. The patient has now been lost sight of.
3	Jan. 16th, 1900.	25	Lifting a wash-stand.	Pains increasing for six months "as if someone gripped her loin;" vomiting.	Carbolisation; gauze slings above and below, gauze packing below.	Kidney bound to fatty capsule by strong adhesions.	Quite well for nine months, then the scar became tender and painful. The scar was incised 20 months afterwards and re-sutured in layers with complete relief. The kidney was then found to be inseparably fixed.
4	April 27th, 1900.	24	—	Pains in one loin. Tried a belt for 12 months. Unable to work.	Carbolisation; gauze.	Kidney small.	Now in service and "feels very much better than she had been for a very long time."
5	May 7th, 1901.	33	Lifting a heavy box seven years before.	Pains, tenderness, and a lump in the right side.	"	Kidney adherent to the fatty capsule and so moveable as to rotate with ease.	A year later reported "no pain in side or scar unless I overwork, then it passes off after rest."
6	Feb. 24th, 1902.	33	Lifting a bed a month ago.	Very severe pain since first acute attack in the right loin; intermittent tumour and polyuria.	Carbolisation; temporary suture of the kidney in horizontal axis; gauze packing below.	Upper ureter sinusously kinked and pressed upon by the lower end of the kidney.	Completely relieved from pain.

therein of six months' duration no differentiation of the scar tissue was visible until the cortex of the kidney was actually cut into, so intimate was the fixation. For these reasons I am very favourably impressed with the method of suspension with gauze (Senn) combined with cortical carbolisation which I have carried out in the six cases indicated below. There have been no disadvantages witnessed from the application of strong carbolic acid to the kidney and there has been a marked absence of post-operative pyrexia. One patient had temporary hæmaturia on leaving her bed, which I attributed solely to tight suturing. Hæmaturia is a recognised sequel to nephropexy.

The last case was interesting from the demonstration it afforded of the mechanical conditions causing the hydro-

upon by the lower end of the kidney in front of it. To correct these conditions it was found necessary first to place the kidney under the ribs and then to tilt it horizontally so that the lower end projected outwards to the wound (Fig. 2). Three temporary sutures, passing right through

FIG. 1.

Hydronephrosis: showing the kidney lifted forwards so as to reveal the contorted upper end of the ureter behind the lower end of the kidney.

nephrosis. When the kidney was freely exposed and lifted forwards (Fig. 1) the upper end of the ureter was found to be kinked and thrown into several folds and was also pressed

FIG. 2.

The lower end of the tilted kidney suspended by temporary suture, thus straightening the ureter. Gauze is seen placed in front of and behind the ureter. A third piece was placed between the two prior to parietal suturing.

the parietes, were used to fix the lower end of the kidney in that position and then three pieces of gauze were lightly packed beneath the kidney, one anterior to the ureter, one behind it, and the third between them and reaching as far as the ureter. The sutures and gauze were finally removed at the end of three weeks.

In three of the cases the kidney was apparently dislocated by definite injury. In most of them there were firm adhesions between the kidney and its outer fibro-fatty capsule.

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