Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON THE TREATMENT OF THROMBOSED VARICOSE VEINS BY EXCISION.

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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.

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HALLUX VALGUS AND HAMMER TOE.

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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

¹ *THE LANCET*, Oct. 15th, 1898, and April 8th, 1899.