and a microscopic examination showed the presence of multiple fat emboli.

The extreme infrequency of this injury, and the fact that no precedents have established a rule of treatment, render it worthy of record and comment. All compound dislocations are rare, when compared with simple dislocations. Norris's table makes them two per cent of all dislocations; Hamilton, four per cent.; Alison, about six per cent. It is probable then that about ninety-five simple dislocations occur to five compound ones.

Simple dislocation of the hip is not frequent, in comparison with the shoulder, elbow, and ankle. Compound dislocation of the hip (meaning without fracture and without crushing of the soft parts), is excessively rare. Malgaigne says it probably *never* occurred. Stimson, however, has collected six cases; and we can add two more, making eight. Of these, three were reduced; two were excised; one was not reduced; in one it is not stated; one died, almost immediately.

CASE I. In the practice of Dr. William Ingalls, of Boston, Mass., reported by Dr. William J. Walker to Sir Astley Cooper, and published in his works (p. 116), the head of the femur was forced through the groin, reduction was effected by manipulation; the patient died of extensive suppuration in three weeks.

CASE II. Report of the fourteenth Prussian army corps (1878). Head of femur forced through the groin; rupture of the femoral vein; death in twenty-four hours.

CASE III. Macouchy (Dublin). Head, neck and great trochanter of femur forced through the integuments over the sciatic notch; excision; death in two days.

CASE IV. Moxon. Dislocation on the dorsum; head lying bare in a rent through the glutei muscles; speedy death.

CASE V. Taylor. Head of femur in the obturator foramen, and a laceration through the perineum, by which head of bone could be felt; reduction; abscess after nine weeks; recovered; and in eight months rode horseback.

CASE VI. Woodward (Worcester). Head, neck and great trochanter of femur lay out across the scrotum, emerging from a lacerated wound; death in five hours; after death, reduction could not be made.

CASE VII. Dr. John W. Perkins (1890). Head of femur thrust out on pubes, at middle of Poupart's ligament; reduced and drained; recovered; walked in three months.

CASE VIII. Cheever. Head of femur forced out on pubes (sub-spinous), clean and unbroken; small opening through skin; excised; death in two days; severe internal injuries.

Of these eight cases four were pubic, two obturator, one dorsal, one ischiatic. Four were due to moving vehicles, or trains; two were due to falls; two were due to weights falling on the person. Five were of seventeen years and younger (fourteen, twelve and eight years); three were adults; two recovered (aged eight and seventeen years); six died (three youths and three adults). There are two recoveries out of eight cases, a mortality of seventy-five per cent.²

² Up to the time of the meeting at which this case of mine was reported, I had not heard of the successful case of Drs. Langmaid and Cabot, otherwise I should have included that among those here given. A full account, however, of the case is given at length in the report of the meeting.

As to treatment, it is quite without settled rule, as the opinions of the following surgeons show:

Hippocrates advised the non-reduction of all compound dislocations. He says they die if reduced, and often live if not reduced. Both he and Celsus mention excision. Agnew would excise. Gross would reduce. Holmes reduced and hopes for ankylosis. Erichsen excises or amputates. Bryant is not clear. Hamilton excises, and says the future false joint is more useful than adhesions. Ashhurst excises or amputates. Stimson would excise. Five excise; two reduce; one is not decided.

Such a rare accident, presenting itself as an emergency, requires immediate decision, without distinct precedent or rule. For myself, I was governed by the conservative impulses of general surgery, to *excise*, deeming the tension of the parts, the laceration of fascia and capsule thus best relieved, and also thus securing a drainage impossible after reduction.

Whether antiseptic dressings could avert inflammation, tetanus or suppuration, after the reduction of the head of the femur into its very deeply situated socket and torn capsule, seems to me problematical.

RECURRENT APPENDICITIS WITH ADHESIVE BANDS ABOUT THE HEAD OF THE COLON: OPERATION FOLLOWED BY CURE.

BY HENRY O. MARCY, M.D., BOSTON.

THE interesting paper by Dr. Charles B. Porter, published in a late number of the JOURNAL (April 2, 1891), upon operative measures for the cure of recurring appendicitis during a remission of the acute symptoms, induces me to report the following case, as an interesting contribution upon this subject. Moreover, it is the first case, so far as I have been able to learn, where operative measures were deliberately undertaken, during a remission of the symptoms, for the cure of this disease; and this conclusion was arrived at quite as much by Dr. Nelson's own deliberate opinion as from any advice I was able to give him. The following notes are condensed from a report with which Dr. Nelson has recently favored me.

Dr. Samuel N. Nelson, aged twenty-nine years, when a post-graduate student in Vienna, in March, 1885, during an operation upon the cadaver, was accidentally subjected to a severe strain. He felt something "give away" in the right iliac region. This was followed by severe pain. A few hours later he had a marked chill with an elevation of temperature. He was considered dangerously ill and was under medical care for a month, with a localized pain and swelling in the right side, diagnosed as perityphlitis. He was unable to actively resume his studies until June.

The following autumn he returned to America in good health. In March, 1886, occurred the first of a series of relapses, of which he had eight during the succeeding eight months. These relapses came on at intervals from three to six weeks each, and commenced under varying conditions of activity, some beginning in the night when asleep. The attacks, however, were very similar, being short, sharp, and very severe. The pain was the first symptom; a chill soon occurred, followed by a temperature rarely exceeding 102°. These attacks generally lasted only three or four days, when the acute symptoms subsided, and he was left in a very

weak and exhausted condition. Having suffered from three such attacks, he concluded that surgery alone could give him relief, and to this end he consulted several prominent surgeons in New York City, being at the time associated in the work at the Carnegie Laboratory; but operative measures were not advised.

A long sea-voyage was suggested as of probable advantage. Acting in accordance with this advice, he made the trip to the Azores; but, during the three months he was on board ship, he suffered severely from two attacks not unlike those previously experienced, and he returned to Boston decidedly less well than at the time of his sailing.

Dr. Nelson was under my personal observation during the last attack, which commenced with a severe chill, followed by a marked rise of temperature. There was a distinct tumefaction in the right iliac quarter, which was very tender upon pressure. The pain was so intense that it required one-fourth-grain doses of morphia, administered hypodermically about every three or four hours, in order to keep the patient in any degree comfortable. The acute symptoms promptly subsided, and in three or four days he was able to sit up for a little while at a time. The swelling and tenderness were nearly gone at the end of a week. It was then determined that operative measures were imperative; and two weeks later, November 9, 1886, I operated upon him at my private hospital, assisted by the late Dr. Holt, Dr. Chapin of New York, Dr. A. P. Clarke and others.

An oblique incision was made through the abdominal wall, three inches in length, directly over the seat of the former swelling. The tissues of the abdominal wall were unchanged, and the peritoneum was healthy. The appendix was much shorter and larger than usual, but free from adhesions and empty. Slight bands of adhesions radiated in various directions from the head of the cæcum. I examined very carefully the small intestine for a considerable distance above the cæcum, also the large intestine, but both appeared to be normal. I then divided freely the bands about the cæcum, but it was the opinion of all present that the condition of the appendix did not warrant its removal, although it was undoubtedly in a degree abnormal. The wound was closed in lines of buried animal sutures, without drainage, and hermetically sealed with collodion.

The patient had developed an inguinal hernia upon the left side, which was but imperfectly retained by a truss. This I operated upon for radical cure after my usual method. Both wounds healed without suppuration, or pronounced suffering; and convalescence ensued without any noteworthy symptoms. He was discharged from the hospital the twelfth day after the operations, being conveyed to Boston in a carriage without suffering or harm.

Dr. Nelson closes the notes of his case, which he sent me within a few days, as follows: "I have not had my attention called to my abdomen by reason of pain or other symptom since recovery from the operation, and at this date I am as well as ever. In the summer of 1888, after a long period of very hard work, a right inguinal hernia rapidly developed, which despite my care soon became scrotal and could not be retained by a truss. In November, 1888, Dr. Marcy operated upon me for cure after his usual method. I have had no discomfort at the site of the herniæ since either operation, and have never worn a truss."

It was the opinion of each of the surgeons present at

the operation, as well as my own, that it was exceedingly doubtful if the bands of adhesion were sufficient to have served as cause for the many severe attacks of local pain and swelling which the patient had suffered; but the resulting history of prompt and complete cure which has now remained permanent for nearly four and one-half years, indicates that in some way the adhesive bands resulting from the primary attack so interfered with the physiological functions of this circumscribed portion of the bowel as to induce the severe and oft-repeated inflammatory attacks.

I have since operated eight times for the cure of appendicitis in the acute stage, fortunately followed by recovery, save in a single instance, but during the entire period I have met with but the one case where the attacks had been recurrent.

THE TREATMENT OF ACUTE URETHRITIS.¹

BY GARDNER W. ALLEN, M.D.,
Surgeon in the Genito-Urinary Department, Boston Dispensary.

I HAVE no new contribution to genito-urinary therapeutics to offer, but merely wish to make a few general observations on the treatment of acute urethritis in the male, based on my own experience.

The internal treatment is of some importance. The value of copaiba, I think, is apt to be underestimated, and, because it is disagreeable to take, some physicians discard it from their formulary. Many persons take it well, and it undoubtedly has a marked influence on the disease in a large proportion of cases. Where internal treatment is indicated, copaiba should be considered, but, of course, must be stopped when found to produce gastric or intestinal disturbance, or a cutaneous eruption. Sandalwood oil is perhaps even more efficient and is less nauseating. It is expensive, however, and most preparations of it are unreliable. Its action on the kidneys should be looked out for. My experience with salol is small and somewhat disappointing, as far as it goes.

For diuretics, acetate of potassium and liquor potassæ are perhaps as good as any. The latter combined with compound tincture of cardamom makes an agreeable preparation, but where there is severe pain on micturition, it works better if given with hyoscyamus.

Local treatment, however, is the most effectual, and although many advise the postponement of injections until the third week or later, it seems to me that the sooner we begin with them the better. If we are to use simple astringent injections it may be well to wait until all acute symptoms have subsided, but I think the time has come when we should consider the question whether it is not better to eliminate simple astringents from the routine treatment of gonorrhœa. They are doubtless useful in certain cases and should not be wholly neglected, but it seems to me that we now have more reliable agents, namely, antiseptics, which should always be used when practicable, beginning the treatment as early as possible. In cases of extremely intense inflammation or of phimosis with long œdematous prepuce we must, of course, defer the use of injections until a more favorable opportunity presents itself.

For injecting the urethra it would seem hardly

¹ Read at Meeting of the Surgical Section of the Suffolk District Medical Society, March 4, 1891.