yielding contraction; in fact, the urethra appeared to be obliterated. It was now resolved to make a passage to the bladder, of sufficient size to admit a full-sized catheter, if possible. With the assistance of my friends, Messrs. Pearce and Gibb, I performed the operation on the 13th of March, eleven days after the first operation. He was placed in the position for lithotomy, and, after having been rendered insensible by chloroform, a catheter was introduced as far as the bulb of the urethra, and an incision made down to the point of the instrument; with the aid of a director and the catheter, gradually advanced, the incision was carried to the prostate gland, where the instrument came in contact with another calculus, which occupied almost the whole of the prostate. An incision was then carried through the lower part of the prostate, and a stone about the size of a large filbert-nut extracted, and the catheter now glided into the bladder. From this time the man has gone on well; the catheter was at first allowed to remain in about a week, but it is now only introduced occasionally for a few hours in the day. The external wound is almost healed, and very little urine flows from it.

April 8th.—The urine flows in a full stream from the urethra, and the man's general health is better than it has been for several months.

This operation may be considered as a modification of that advocated by Professor Syme, for the cure of stricture. With the learned Professor, it is a *sine qua non* that a grooved staff be passed into the bladder. In this case, all efforts of myself and friends to pass an instrument proved fruitless. Probably Professor Syme might have succeeded, as he scarcely admits having failed to pass an instrument in every case that has come under his care.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum, et dissectionum historias, tum aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

Cases of Nævus, with a new mode of applying the Ligature to particular forms of these growths.

(Under the care of Mr. ERICHSEN.)

It will be allowed by all those who have paid attention to the improvements introduced within the last ten years in the treatment of nævus, that a considerable amount of ingenuity has been evinced by several of our hospital surgeons. We see a great many operations for the removal of these vascular tumours, and have witnessed different modes of applying the ligature to them. These methods we have duly recorded in former "Mirrors," (*THE LANCET*, Feb. 9, 1850, p. 186; Feb. 23, 1850, p. 246; Oct. 12, 1850, p. 421;) and by perusing these descriptions, our readers have certainly become convinced that considerable strides have been made in the treatment of nævi. The variety affecting merely the capillaries of the integuments is not generally interfered with; that principally situated in the areolar tissue, and presenting an unelevated appearance, is often treated by potassa fusa, (see below.) But the ligature, the arrest of vascular supply, or attempts at a change of structure, is brought to bear upon that variety which is composed of dilated bloodvessels, raised above the surface, either pulsating or not. As to the deligation of the tumour itself, we beg to record the following cases, which illustrate the latest views of Mr. Erichsen upon the subject.

CASE 1. *Nævus of the anterior fontanelle.*—A child, six months old, strong and healthy, was admitted, under the care of Mr. Erichsen, Nov. 1850, with a nævus on the anterior fontanelle. The tumour is almost as large as a pigeon's egg; it occupies the whole of the fontanelle, extending over the osseous boundaries of this space on the left side. The heaving of the brain can be distinctly felt underneath it; there is no pulsation in the tumour, but several large veins are seen running from it on each side. The mother states that she noticed the discoloration of the skin shortly after birth; it increased

rapidly since that period, and almost visibly during the last fortnight.

Mr. Erichsen resolved to use the ligature, seeing the size and prominence of the growth; but the difficulty in the application of this means consisted in passing the threads across the base of the tumour without wounding the membranes of the brain, which lay in immediate contact with it. This difficulty Mr. Erichsen overcame by using a blunt-eyed probe to convey the threads, instead of the common nævus needle. A puncture was therefore made about an eighth of an inch above the tumour, and an eyed probe, conveying the whipcord, was pushed across the base of the mass. Mr. Erichsen then cut down upon its point when it projected below the tumour, and then drew it across; the transverse threads having been carried through in a similar manner; the knots were tied in the usual way, and the mass firmly and effectually strangulated; the child, having been under the influence of chloroform, suffered no pain. The threads and sloughing mass separated in three days, leaving a healthy granulating surface, which speedily cicatrized.

CASE 2.—A heavy child ten weeks old, was sent to Mr. Erichsen on May 28th, with a nævus situated, like the last-mentioned, in the anterior fontanelle. It was about as large as a walnut and was growing rapidly. Mr. Erichsen operated in this, as in the former case, by carrying the threads across the tumour with a blunt-eyed probe through punctures in the healthy neighbouring integument. The case did perfectly well.

CASE 3.—On the same day in which Mr. Erichsen operated in Case 1, we saw him remove, by the double whipcord ligature, an ulcerated and bleeding nævus, as large as half an orange, from the back of an infant eleven weeks old. The child having been rendered insensible by chloroform, bore the operation (an extremely severe one for so tender an age) remarkably well, making a perfect recovery without any bad symptom.

The treatment of long, flat nævi, when above a certain size, is always a troublesome matter. If small, they may be readily removed, either with nitric acid, or passing threads across their substance, or by the introduction of needles, &c. We have seen Mr. Lloyd operate with great success at St. Bartholomew's Hospital upon flat nævi. The method consists in destroying the abnormal growths by potassa fusa freely applied for a few minutes. We recollect one child in particular, less than a twelvemonth old, who presented a nævus of this kind on the inner surface of the labium; the same caustic was used by Mr. Lloyd, and with the best results. But if so large and elevated as to require more energetic means, the surgeon often finds himself much embarrassed in the proper application of the ligature. Mr. Luke some years ago published a description of a mode of effecting this, by carrying a single thread, having several needles strung upon it, across the tumour, then cutting off the needles and tying the knots. We had the pleasure of describing this peculiar mode of applying threads, and adducing a case in illustration of the practice, (*THE LANCET*, Jan. 26, 1850, p. 129.) In the following case Mr. Erichsen adopted a very simple and successful plan of accomplishing the same object, using only one needle and a double thread.

CASE 4.—A child, two years old, was admitted, on the 23rd October, 1850, under the care of Mr. Erichsen, having a nævus on the right side of the forehead, about two inches long, three-fourths of an inch broad, and slightly elevated above the skin. Various but unsuccessful attempts having previously been made to destroy it with caustic, Mr. Erichsen proceeded to use the ligature, which he did in the following manner with complete success:—

A long triangular needle is threaded on the middle of a whipcord about three yards in length; one-half of this is stained black with ink, the other half is left uncoloured. The needle is now entered through a fold of the sound skin, about a quarter of an inch from one end of the tumour, and transversely to the axis of the same. It is then carried through, until a double tail, nine inches in length, is left hanging from the point at which it entered; it is next carried across the base of the tumour, entering and passing out beyond its lateral limits, so as to leave a series of double loops at least nine inches in length on each side. Every one of these loops should be made about three-quarters of an inch apart, including that space of the tumour, and the last loop should be brought out through a fold of healthy integuments beyond the tumour. In this way we have a series of double loops, one white and the other black, on each side. All the white loops should now be

cut upon on one side, and the *black* loops on the other, leaving hanging ends of thread of corresponding colours.

The tumour may now be strangulated by drawing down and knotting firmly each pair of white threads on one side, and each pair of black ones on the other. In this way the tumour is divided into segments, each of which is strangulated by a noose and a knot; by *black* nooses and *white* knots on one side, by *white* nooses and *black* knots on the other.

Mr. Erichsen thinks that this mode of applying the ligature will be found of service in all those cases of elongated flat *nævi*, in which, from the shape of the tumour, it is not possible to effect the strangulation by the ligature as ordinarily used, without enclosing an undue quantity of integument, and thus producing a larger cicatrix than is necessary for the eradication of the disease. The ordinary double ligature, or the quadruple thread, as used and figured by the late Mr. Liston, always includes a circular mass, and hence is not applicable to those growths that are very much elongated or irregular in shape.

The following case, which we have condensed from the notes taken by Mr. Ashton, one of Mr. Erichsen's dressers, is a good example of a peculiar form of cellulo-venous *nævus*, and is interesting on account of the morbid action set up in the granulating surface after the removal of the tumour.

CASE 5.—A child, about five years of age, came under Mr. Erichsen's care in February last, for a large tumour on the right nates. The parents state, that shortly after birth some swelling was noticed about the right buttock, but that it did not attract much attention until the child was about three years old, when it received a smart whipping from the grandmother in this region of the body. The tumour now increased slowly in size until it attained its present bulk. The integuments covering it also became mottled with purplish-red spots. No treatment of any consequence has been had recourse to for the removal of the growth.

On admission, a tumour as large as an orange is found on the nates of the right side, occupying the fold, and extending into the ischio-rectal fossa. It is very prominent, not distinctly circumscribed, and doughy throughout the greater part of its extent; but where it approaches the anus, it is of very firm consistence. The size of the tumour can be slightly diminished by steady pressure; but on the removal of the hand, its former bulk is speedily regained. It is not influenced by the child crying or struggling, and the skin covering it is mottled here and there with faint claret-coloured stains. There is no pulsation, bruit, or increased heat in the swelling.

Mr. Erichsen having diagnosed the tumour to be a cellulo-venous *nævus*, partially consolidated by inflammation, proceeded to remove it on the 6th of March.

Ice having been applied before the operation, with the view of lessening the vascularity of the tumour, Mr. Erichsen made a crucial incision through the integuments covering it, and reflected these to the base of the tumour, exposing a large mass, apparently composed of much-dilated and tortuous veins and cellular tissue, with a few cysts containing brownish fluid. *Nævus* needles were pushed across the base of this, and it was strangulated with strong whipcord.

In a few days the tumour included in the ligatures sloughed away, leaving a deep hollow from which it had been removed. The surface of this cavity and the contiguous flaps now took on a peculiar unhealthy action; instead of granulations, large greyish-white masses, looking like melted fat more than anything else, were thrown up; the flaps became swollen and cedematous, and it was feared that a malignant degeneration was taking place.

The child's general health was carefully looked to, and *potassa fusa* freely applied. On the separation of the sloughs produced by the use of this caustic, the same morbid condition was, however, set up again; and as the parts in the vicinity became extremely irritable, it was thought advisable not to re-apply it.

Various local applications of an emollient or specific character were now used, but none could be borne; indeed, water-dressing appeared to be the only application that did not irritate.

The surface of the ulcer gradually assumed a healthier appearance; the flaps became less swollen; they lost the peculiar semi-transparent appearance which they had before presented, and the parts around evinced less irritability. But yet, every now and then, a tendency to a return of the former morbid appearance presented itself. This, however, gradually passed away. By the middle of May, about two months after admission, the child left the hospital, with the wound soundly and completely cicatrized, and with no appearance of disease about it.

We have lately seen a very large erectile tumour of the upper lip treated by exciting in the spongy vascular tissues, not the suppurative, but the adhesive inflammation; we hope soon to be able to bring the case before our readers. Danger of hæmorrhage is so great in these instances, and is so much dreaded by surgeons, that too much attention cannot be directed to a *safe* mode of treating large erectile tumours, independently of the deligation of the principal arterial trunk.

ST. BARTHOLOMEW'S HOSPITAL.

Dislocation of the Humerus on the Dorsum of the Scapula; Reduction.

(Under the care of Mr. STANLEY.)

THE nomenclature of the various dislocations of the shoulder has given rise (at least among continental surgeons) to frequent discussions, which, as is too often the case, have not ended in a perfect understanding upon the subject; and the English reader, after taking cognizance of the divisions partially adopted in France and Germany, gladly returns to the denominations, *downwards*, *forwards*, and *backwards*, taught in our schools. The luxation which we have now to consider, and which happened in a patient of Mr. Stanley's, is called by some French surgeons the sub-variety of the sub-acromial, and by others, sub-spinal; the Germans, as stated by Mr. South in "Chelius' Surgery," call it *outwards*; but most surgeons will agree with us that *backwards*, or on the *dorsum scapulae*, is as correct a name as can be desired. That this displacement occurs but very seldom is a well known fact; it had not been seen for a long period at St. Bartholomew's Hospital; and Sir Astley Cooper says, in his work on Dislocations and Fractures: "Two cases only of this accident occurred in Guy's Hospital in thirty-eight years, the first during my apprenticeship. The nature of the accident was at once obvious from the projection of the head of the bone on the *dorsum scapulae*. The bandages were applied in the same manner as if the head of the humerus had been in the axilla, and the extension was made in the same direction as in that accident." The reduction was easily effected; the second case presented itself several years afterwards, and was reduced by the dressers. Sir A. Cooper mentions seven more cases, which mostly occurred in private practice.

That the reduction took place so readily, by using the *same* means as for dislocation into the axilla, might create surprise, for it seems at first sight natural that extension should be made a little *outwards*, when the head of the bone is lodged on the *dorsum* of the scapula. But the dislocations of the shoulder-joint are generally fraught with so little danger, the reduction is commonly so easily obtained by proper extension, counter-extension, and coaptation, that it would be perhaps unwise to establish very nice distinctions as to the precise direction in which extension is to be made.

Mr. Stanley's patient was a farm labourer, aged sixty-two years, a strong, healthy-looking man, who was admitted on the 4th of April, 1851, suffering from a dislocation of the shoulder-joint. The patient states that he was driving in a cart, in the company of a fellow-labourer, when the horse fell, and both the men were thrown or jerked out of the cart. One of them escaped unhurt, but the patient was violently thrown on his right shoulder, the whole weight of the fall being borne by that articulation. The contusion and laceration was not considerable, as he luckily fell on a plot of grass; but it would appear that the lesion was of a serious character, as some of the actions of the joint were suddenly lost.

The patient applied at once to a surgeon, who told him that the limb was dislocated, and attempted reduction, by putting his heel into the patient's axilla, whilst the latter was lying on his back. The efforts were, however, fruitless, and the man was advised to repair to this hospital. On examination, it was found that the axis of the right humerus, in its relation to the body, was very much altered. Beneath the spine of the scapula, and towards its outer side, was a firm hard swelling: this was the head of the bone, the fact being proved, negatively by its absence in the proper position, and positively by the swelling moving when the arm was being rotated. The glenoid cavity can be felt empty; there is very little motion of the arm, and the deltoid is tense. On rotating the arm, a kind of crepitus is distinguished, which does not feel like the ordinary crepitus of fracture, but is probably occasioned by the rubbing of the head of the bone against the axillary border of the scapula.

Mr. Stanley having determined to proceed at once to the reduction of the limb, the man was placed in a chair, and his body fixed; extension was first made in a direction out-