This paper, which is one of very considerable length, occupying over fifty-pages, is one we cannot analyze, but will simply direct attention to as interesting and instructive.

VIII. *Sebaceous Tumour within the Tympanum, originating on the External Surface of the Membrana Tympani, Bands of Membrane occupying the Cavity.* By JAMES HINTON.

In the number of this Journal for April, 1862 (page 468), in a review of the forty-fourth volume of the *Medico-Chirurgical Transactions*, attention is directed to a paper by Mr. Toynbee on sebaceous tumours in the external auditory meatus. These sebaceous tumours are there said to grow in the external meatus, and even to reach a considerable size, causing absorption of the bone, without the occurrence of pain. As a general rule the attention of the surgeon is called to them either on account of the deafness which follows the occlusion of the meatus, from the presence of a fetid discharge, or from symptoms of irritation of the brain, which too often terminates in death.

In the case related in this paper, one of these tumours implicating exclusively the membrana tympani, about the size of a pea, was found at the post-mortem examination of the body of a female, eighteen years of age, who had died of tubercular meningitis. During life there had never existed any symptoms to direct attention to the ear. The bands of membrane occupying the cavity of the tympanum were regarded as the remnants of a previous structure, which had incompletely wasted; as evidences of an imperfect "vacuolation" of the tympanic cavity.

This paper is illustrated by a plate containing two figures.

IX. *A Collection of Cases of Foreign Bodies in the Stomach and the Intestines.* By ALFRED POLARD.

In this paper Mr. Polard has collected all the cases he was able to find recorded of foreign bodies in the stomach and bowels. Some of them are exceedingly curious; one of them, that of the knife-eater, who died at Guy's Hospital, and which was reported by Dr. Marcet in vol. xii. of the *Medico-Chirurgical Transactions*, is perhaps as much so as any in medical literature.

Dr. Polard promises to consider the propriety of performing enterotomy and gastrotomy in such cases, in a future number of the reports when introducing a paper on penetrating wounds of the abdomen.

X. *Some Observations on the Iodic Test for Morphia.* By A. DUPRE, Ph. D., F. C. S.

When the morphia or its salts are in a solid state, Dr. Dupre recommends that a drop of starch should be added to the morphia, or the substances supposed to contain it, and the whole carefully evaporated to dryness. The dry residue left, after cooling, should be moistened with iodic acid, when it will assume a dark blue colour, which is still well marked, even though not more than $\frac{1}{10000}$ the grain of morphia be present. When the morphia is in solution, the mixture of morphia, iodic acid, and starch, should be allowed to stand for ten minutes, and then a very dilute solution of ammonia should be carefully poured upon the top of it. The $\frac{1}{10000}$ th of a grain in solution will give a satisfactory reaction.

W. F. A.

ART. XXI.—*The Surgical Diseases of Children; being the Lettsomian Lectures delivered before the Medical Society of London, March, 1863.* By THOMAS BRYANT, F. R. C. S., Assistant-Surgeon to Guy's Hospital, etc. etc. 12mo. pp. 148. London, 1863.

THESE lectures are devoted to a subject of no trifling importance, and which has not, in all its branches, received that special and separate consideration it demands. Although in the lectures of Mr. Bryant, only some of the more prominent particulars included within the scope of the surgery of infancy and childhood are briefly sketched, his teachings, as far as they go, will be found

replete with sound pathological views and correct practical directions. The lectures will be read with interest by every medical practitioner, and with especial profit by those in whose practice the surgical diseases of infancy and early childhood are the most frequently encountered.

The lectures of Mr. Bryant commence with a very brief sketch of the differences which are found to exist between the surgical affections of early and those of adult life. A difference that is dependent mainly on the greater activity of the vital forces during infancy and childhood, which are then, in great measure, directed for promoting the growth and development of the organism, and not, as in the adult, chiefly for the maintenance of structures which have already attained their full growth and entire development. It is to the abnormal direction given to one or other, or both of these natural processes of growth and development, that most of the special affections of infancy owe their origin.

"All malformations are, hence, according to the lecturer, but results of some defective power, either in the process of growth or of development, or of both; and they are always to be explained by the predominance, diminution, or abnormal manifestation of one or of the other. Hare-lip, fissured palate, monsters, cerebral tumours, spina bifida, etc., are to be explained by some defect in the natural development of the child; its growth and maintenance being, in the majority of instances, perfect of its kind; whilst instances may presently have to be recorded, in which growth alone has proved defective, development being perfect."

The greater activity of the vital process throughout the several organs of the body previous to the adult age—from birth, through infancy and childhood—renders them all particularly prone to take on morbid action; those tissues and organs in which development is progressing the most actively are also the most liable to become the seat of such morbid action.

The first of the surgical affections of the infant treated of by the lecturer is *hare-lip*. From his own experience, and reliable statistics within his reach, Mr. B. shows that hare-lip is always met with in the upper lip, and most frequently to the left of the median line; 63 per cent. of the cases occurring on the left side to 36 on the right. That it is more common in the male than in the female; in the proportion of 70 per cent. of the former to 30 per cent. of the latter. In the simple, uncomplicated cases, the proportions were found to be less marked, however; but as the cases become more complicated, the greater frequency of its occurrence in the male sex is more apparent; the proportion between the sexes being 80 per cent. and 20 per cent. It would also appear to be a rare thing to find a double hare-lip in a female child.

In operating upon uncomplicated cases of hare-lip, the following points are referred to by the lecturer as those which appear to be the most important: *First*, to separate the lip freely from the gum; *second*, to make a free section of the edges of the fissure; and, *third*, to bring the edges accurately together, not by pins, but by fine interrupted sutures, either of silk or wire, introduced at a distance from the wound's margin, and deeply placed.

The plan of operation to which preference is given by the lecturer, is one originally suggested, it is believed, by Malgaigne. By it, he asserts, the labial notch is, almost to a certainty, done away with, and the deformity most completely remedied. It consists in simply paring the edges of the fissure from above downwards, leaving the inverted flap adherent to the labial border. After the raw edges have been brought together and secured, "the lower flaps may be connected by a fine suture." If too long, they can be curtailed, so as just to leave sufficient to fill up the gap, which is too often the result of other plans of operating.

In cases of double hare-lip, the lecturer recommends that both fissures be operated on simultaneously. He has, he assures us, in no instance, witnessed any evil resulting from such a procedure, and is at a loss to understand why it is that surgeons still adhere, in cases of double hare-lip, to the old practice of a separate operation for each fissure, the second being postponed for an interval, after the first has been completed.

In some cases of hare-lip the central incisive or intermaxillary portion of bone is found projecting outwards, and interfering to such an extent with the opera-

tion as to prevent its performance altogether, or, at least, to prevent its success in the removal of deformity. In all such cases the lecturer advises that an attempt be made to press the projecting portion of bone backwards. If this can be effected by a moderate degree of force, he thinks it preferable to the removal of the projecting bone. If, however, the depression of the bone by force should prove impossible or inexpedient, there is no alternative but to remove the projecting portion by means of bone-forceps. It is true that, by removing the central portion of the maxillary bone, we destroy also the incisor teeth; but even this is preferable to allowing the original deformity to remain, especially when we remember that, if the projecting bone be left, the incisor teeth would, in all probability, appear much out of place, even to the extent of piercing the lip, a contingency which the lecturer had, in one case, seen occur.

"There is one other point in the treatment of these cases," remarks the lecturer, "which the surgeon should remember, viz., that if the first operation fail, and union by first intention cannot be procured, there is still a good hope of securing ultimate success by union from secondary adhesion. This end is to be obtained by the application of strapping, or, in preference, sutures to the granulating wound, so that the edges may again be placed in apposition. In several instances which have been tabulated, this practice was followed, and a good result took place. In two cases which came into his hands several years ago, equal success can be recorded. Both were infants, upon whom he had been led to operate at a very early period—two and three weeks only being their respective ages. Sloughing followed the original operation; and, when the parts had begun to granulate, sutures were re-applied, and a good recovery was eventually secured."

The next subject treated of by the lecturer is imperforate anus, or occluded rectum. The description given of the several forms of this congenital deficiency is confessedly borrowed from the excellent and exhaustive paper of Mr. Curling, published in the *forty-third volume of the Medico-Chirurgical Transactions*. The following are the lecturer's general deductions in respect to the treatment of imperforate anus:—

"In all cases, with some rare exceptions, whether of imperforate anus, obstructed rectum, or misplaced anus, an exploratory operation in the normal anal position is perfectly justifiable, and it may be attempted with the fair hope that, in nearly half of such cases, primary success will be secured. Such exploratory procedure, however, to be successful, must be conducted with great caution; the puncture or incision being made always in an upward and backward direction towards the sacrum.

"If these measures fail, or if, from some peculiarity in the case, they appear useless and unjustifiable, the intestine is to be opened in the groin: the lumbar or Callisen's operation being quite inapplicable. In the inguinal operation, the right groin appears to possess advantages over the left; as the intestine is found with more certainty, and the benefits to be expected from the operation are equally great.

"The treatment of these cases does not terminate with the success of the primary operation—constant dilatation of the artificial anus is a necessity to preserve life."

In the second lecture we meet with some excellent remarks on injuries of the head in childhood. After pointing out the important fact that a child can bear blows and falls upon the skull with most surprising impunity—the anatomical structure of the bony centres in the child being such that they invariably receive the first impression of the blow or fall, and their membranous margins or fontanelles taking up the impulse, retard and stop the force of the onward vibrations; the brain in childhood is not, therefore, as a rule, so materially shaken by a slight injury as, in surgical language, to become the subject of a concussion—we are warned by the lecturer that, nevertheless, if concussion be experienced, the symptoms denoting cerebral irritation are generally well-marked and severe. When, also, once originated, the disposition to excessive reaction, or to inflammatory complications, is very great. Hence, the necessity of preserving absolute rest in even the slightest injury of the skull, even when no symptom of

brain-mischief exists. Besides the tendency of the brain in early life to take on diseased action, from the softness and want of consistency of its texture, it is, also, more liable than the brain in the adult to become the subject of ecchymoses from slight causes, and to this fact we are to attribute the frequency in childhood of cerebral symptoms from secondary inflammatory action.

Passing by the remarks of the lecturer on *œdema* of the larynx, from the swallowing of a boiling fluid, and on foreign bodies in the air passages, which, in respect to both subjects, though very concise, are pertinent, and especially practical; the same being true, also, in respect to the few words with which the subject of foreign bodies in the nostril is dismissed, we come to the important question, What, if any, are the points of difference to be noticed between the surgical affections of the chest during childhood, and those which occur in the adult? The lecturer is disposed to believe that the most important difference consists in the fact that, in early life, injuries to the thorax are more liable to be followed by laceration of the lung tissue, without the occurrence of any fracture or displacement of the ribs. This result he attributes to the greater elasticity of the thoracic walls in the child, and the greater ease with which the lung structure may be lacerated.

In treating of *navus*, the lecturer very properly remarks that, unless it be so situated as to be an eyesore or an inconvenience, or it evinces an evident tendency to rapid increase, there is no necessity for surgical interference. The *navus* will, to a certainty, after a time, cease to grow, and, in many instances, begin to waste away, and even finally to disappear.

In cases of diffused *navus*, the lecturer expresses his partiality for the treatment by setons, which he prefers to that by injections. He states that it has proved of great value in his hands. If the *navus* be large, several thick setons may be passed through the centre of the growth, but, in general, one or two will suffice. These will excite sufficient inflammatory action to close the enlarged capillaries, and to cause their subsequent and permanent contraction.

Chronic enlargement, hypertrophy, of the tonsils is more frequently met with in children than in adults. The lecturer pronounces it a disease essentially of debility, and to be treated by tonics, of which quinia and iodide of iron are undoubtedly the best. When the tonsils become very large, indurated, and pale, impeding deglutition and respiration, they should be excised. The lecturer has never seen any good result from the local application of nitrate of silver, iodine, etc., and has sometimes thought that it did harm.

In respect to *polypus of the rectum*, an affection much more frequent during early childhood than is generally suspected, the lecturer remarks, that in all cases of hemorrhage from the bowels in children, its existence is to be suspected, and a careful examination made. *Polypus recti* are generally met with in patients under ten years of age. In some cases the hemorrhage from the bowels is constant, the polypus will then be, in general, found just within, or perhaps protruding from the sphincter. In other cases, the hemorrhage will be only occasional, and to no great extent, accompanying or following, mostly, the act of defecation, though it may occur at other times. In examining children in whom the existence of rectal polypus is suspected, some care is required in order that the presence of the polypus may be detected. The best plan is to sweep the finger, passed well into the rectum, completely round the walls of the bowel. By a careless examination, unless the polypus is very large, it is almost sure to be overlooked. When detected, its removal is the only correct practice. In a large proportion of cases this may readily be done by simply hooking the finger over the pedicle and breaking it off. No hemorrhage or other evil consequences need be apprehended. In other cases, as when the polypus is high up or its pedicle thick and firm, it must be dragged down by means of forceps, or a wire noose, and then ligatured. After the growth is removed, a cure may confidently be predicted, provided the surgeon has satisfied himself that a second polypus does not exist.

We pass over the remaining subjects, briefly noticed in the second lecture, and direct attention to the remarks in the first section of lecture third, which is devoted to a consideration of the surgical affections of the osseous system in children, on *inflammatory disease of the shafts of the long bones*, which unfor-

unately is very common in early life; the inflammatory process commencing, as we believe, in the greater number of instances in the periosteum. Unless when resulting from external injury, the disease will be met with most frequently in the cachectic and so-called strumous subjects. It is generally slow in progress, and terminates usually in the death of the affected bone. There is often a very decided want of definiteness in the symptoms, which is apt to mislead parents, and render them dilatory in seeking professional advice.

In some cases the only external manifestation of the disease is an apparent gradual enlargement of the bone, while, externally, the surrounding soft parts are pale, but otherwise natural. It is only, perhaps, after the lapse of many months that any decided signs of mischief appear externally. If, however, the disease be not checked, death of the bone will take place, followed by inflammation and suppuration of the soft parts, ending in the formation of sinuses and a cloaca communicating with the diseased bone. The constitutional symptoms vary in intensity in different cases. In the majority they are very mild; little else than a dull aching over the inflamed part being complained of; a marked difference may be detected in the temperature of the part, the integument over the diseased bone feeling much hotter than in the neighbourhood. Firm pressure over the bone will, in all probability, cause increased suffering. The bone will generally be found enlarged, its external surface being smooth and uniform. At a later period, when the soft parts have become implicated and the bone necrosed, the local symptoms are too well marked to demand notice.

It is rare, the lecturer remarks, in cases of idiopathic osteitis, for a single bone alone to be affected. The symmetrical bones generally become, sooner or later, involved, and sometimes nearly all the long bones, showing the constitutional character of the disease. The disease, in children, does not invade the epiphyses.

The leading indication in the cure of the osteitis of childhood, is to improve the patient's general health by good living, good air, and tonics. As a tonic the syrup of the iodide of iron is pointed out as a good article in these cases. The inflamed limb must be kept raised and at rest. Warm fomentations afford much relief in the early stages. The lecturer has never seen any benefit result from the local application of iodine sufficient to compensate for the irritation and pain it occasions. Diseased bone should only be removed when it has become completely separated from its matrix. Too early attempts to interfere are only followed by harm, and should therefore be avoided. Amputation of a limb in cases of osteitis is rarely if ever required.

The lecturer describes very briefly a disease peculiar to childhood, namely, *inflammation of the soft, highly vascular, pulpy layer interposed between the shafts of the long bones and their epiphyses*. He thinks that a large proportion of the cases of acute suppuration about the joints in children have their origin in this layer, as is proved by the frequent exfoliation of some portion of the surface of bone in contact with it. If the inflammation involve the whole connective tissue of the bone, a general exfoliation of the upper portion of the shaft may result, or there may take place some arrest in the growth and development of the bone.

The disease is generally acute; it is manifested by morbid swelling at the affected part, attended by great pain and constitutional disturbance. An abscess next forms, which may rapidly encompass the joint and upper part of the limb. When the abscess has opened and discharged its contents, convalescence may result, or more frequently, a portion of bone, varying in size, will come away, and the parts heal kindly. In the majority of cases the disease appears at the shoulder-joint; it may occur, however, in any other articulation. The epiphysis itself is not often involved, the pulpy layer being more intimately connected with the shaft of the bone, the growth of which is effected through it, the epiphysis having an independent vitality and vascular supply.

The lecturer dismisses in a few words, under the denomination of "*green stick fracture*," that peculiar form of fracture to which infants are liable, in which the bone is fissured vertically into fibres, but not separated transversely. No credit is given to Dr. John Rhea Barton, of Philadelphia, who was the first to direct attention to this form of fracture, and point out its true character.

In treating of the diseases of the joints in children, the lecturer very truly remarks that there is scarcely any amount of mischief to the articulations which in early life is not remediable by natural processes, although it may be with ankylosis; the only exception, perhaps, is when any necrosed bone is present to keep up the irritation, and thus interfere with the process of cure. The chronic inflammatory affections of the articulations are essentially diseases of debility, occurring in children who are naturally frail, or who have been brought into a cachectic condition by an attack of fever or other exhausting disease. Let the general health of the patients be established, and the local affection will certainly improve also. The surgeon must, therefore, first of all improve the general condition of the child by hygienic means, good food, good air, suitable exercise, bathing, etc., aided by such tonic remedies as appear best adapted to each case; without this all local treatment will be futile. Specific remedies, as mercury, etc., may, according to the lecturer, be of service in some few instances; but such instances are few and far apart. In respect to local treatment in all joint affections, the diseased joint must be kept at perfect rest by means of an appropriate splint, which leaves the joint open for inspection, while the pain in the part is soothed by warm fomentations. Counter-irritation in children is hardly ever required, and must be employed with great care and caution. When only the effects of disease remain, firm, equal, and steady pressure will be found of decided advantage. The pressure may be applied by a proper application of strapping. There are few things which have a greater influence in causing the absorption of inflammatory deposit, and of thus restoring the parts to their normal condition. Very few cases of joint disease, occurring in children, require operative interference; as a rule, such interference is not only unnecessary, but mischievous. When, however, the bones are extensively involved, and have become necrotic, suppuration being kept up, and reparation prevented by the presence of dead bone; by the removal of this we insure a more complete and speedy recovery. It is in such cases alone that any operation is called for by local considerations. In certain cases, however, the general health of the child may fail under the continued local irritation, and his life be imperilled unless the latter be removed by an operation.

We have now presented an analysis, not of the entire contents of the volume before us, but of, perhaps, the more important of them. We have read the entire work with both pleasure and profit. The chief fault we have to find with the author, is the very brief manner in which most of the subjects embraced in his lectures are treated. What he has done, he has done well; we only wish that he had taken the time to fill up and perfect the very able outline he has given. The several cases interspersed throughout the lectures have been well chosen, and are admirably adapted to illustrate the author's teachings.

D. F. C.

ART. XXII.—*Lectures on Medical Education, or on the Proper Method of Studying Medicine.* By SAMUEL CHEW, M. D., Professor of the Practice and Principles of Medicine, etc., in the University of Maryland. 12mo. pp. 152. Philadelphia: Lindsay & Blakiston, 1864.

THE term "medical education" is most commonly used in a restricted sense, to express the study of the elementary branches of medicine and of its collateral sciences; in other words, the pursuit of that preliminary knowledge the acquisition of which is essential to a successful entrance upon the proper study of medicine as a science and of its practice as an art. If the term medical education is not used in a sense quite so restricted as this in the lectures before us, yet it is only in its limitation to the studies to be pursued preparatory to an entrance upon the career of a medical practitioner that it is considered. And thus applied, the subject of medical education is discussed by Dr. Chew skilfully and profitably. No one who proposes to enter upon the study of medicine, or who has already entered upon it, can fail to be benefited by the practical remarks