CASE OF
CARIES OF THE SPINE, WITH PARTIAL
PARAPLEGIA, TREATED BY THE APPLI-
CATION OF SAYRE'S JACKET;

RECOVERY OF POWER OF LOCOMOTION IN TWENTY-FOUR
HOURS.

By MARTIN OXLEY, M.D.,
CONSULTING PHYSICIAN TO THE LIVERPOOL INFIRMARY
FOR CHILDREN.

MARY D—, aged ten years, came under notice on June 1st, 1883. There was disease of the fourth, fifth, and sixth dorsal, also last dorsal and first lumbar vertebrae, there being two distinct angular curves, the upper the more marked. She had been four months in the Aberystwith Infirmary under treatment. When discharged she had lost the use of her legs, and could not stand or walk. When seen by me she was unable to walk, although she could stand with assistance. She cried out suddenly with pain, caused by spasmodic jerking of her right leg. I applied a Sayre's jacket and a jury-mast while she was suspended, putting on extension enough to straighten the body, but without attempting to open out the two angular curves. The feet were flat on the ground, and she grasped the cross bar with her hands, an assistant giving her support and steadying her during the application of the jacket. She was then placed in bed. The next day, on my visiting her, I was told that she had been out of bed,¹ and had walked without difficulty. On hearing this I tested her walking powers, and found that they were quite restored. She went to her friends in Liverpool until November 10th, 1883, when she returned to have a new jacket. She was then in excellent health, and I exhibited her at a meeting of the Medical Institute. In June, 1884, she had a new jacket applied, and was able to walk about without any support. Now (April, 1885) the patient is again in Liverpool,² and has had a new jacket and jury-mast applied. She is able to go about quite comfortably without the support; but having seen bad results follow when the corset has been given up too soon, I intend to keep a light jacket on for some years.

Remarks.—The relation of this case will, I hope, convince those who doubt the efficacy of Sayre's mode of treating spinal caries—viz., by the application of a well-fitting plaster corset, which allows the patient at once to walk about and behave like a healthy individual. I consider the above as good an instance for testing Sayre's method as one could have. 1. The patient is old enough to speak for herself, and is highly intelligent. 2. She had previously been under treatment in hospital, under a skilful surgeon, by rest in the recumbent position. 3. She had disease of two separate portions of her spine—viz., the fourth, fifth, and sixth dorsal and the twelfth dorsal and first lumbar vertebrae. 4. She was unable to walk when she came under treatment. Further, a few days after the application of the jacket she was sent out into what we know too well as squalid Liverpool; and when she came to see me again, six months after the first application of the jacket, her dirty condition told very plainly how little care had been bestowed upon her.

Liverpool.

A NEW REMEDY IN GOUTY OBESITY AND
DYSPEPSIA.

By J. MORTIMER GRANVILLE, M.D.

I HAVE been obtaining some very good results of late in cases of gouty obesity and dyspepsia with a remedy which, although familiar and based on the simplest physiological principles, is, so far as I am aware, new as I use it. It occurred to me some time ago, as indicated by the physiological state in gout, chronic and irregular; and having now had ample opportunities of trying it, I venture to suggest it to practitioners generally, to whom I think it will at once commend itself as essentially *likely* to be of service.

¹ This was contrary to my orders, as I always keep my Sayre's cases in bed between the blankets for three days after the application.

² I again showed her to the members of the Medical Institute at one of their meetings, this time without the jacket.

One of the earliest, if not a primary, error of function in gout, whatever may be the real *cause* of that malady, is failure of the liver to secrete sufficient, or normally constituted, bile. The product of liver function is, as we know, excremento-recremental, the greater part of the bile being re-absorbed in the intestines; and among other uses in the economy, such as helping to hold the cholesterin, *and perhaps the uric acid*, in solution, it is destined to facilitate the proper digestion and assimilation of fats. If fat be not duly assimilated, it will be deposited crudely, as in the omentum and elsewhere, with the result of obesity, coupled with deficiency of heat production and maintenance; which is a very different thing from obesity with full or even excessive powers of calorification. I think it is important to make this discrimination between two distinct and totally different classes of cases. In the former class—common in persons with an inheritance of gout, in which there is obesity with a low grade of heat-force,—I am giving the biliary salts, extracted from ox bile, in the form of a pill, to be taken as pepsine is taken, with food. The results are very striking. The stools are rendered characteristically rich in bile without purging, the food is readily digested, and the accumulations of fat seem to melt slowly away. The taurocholate of soda with the glycocholate of soda are readily obtained from ox bile by evaporating to dryness and pulverising, making an alcoholic extract, filtering, and precipitating by small successive additions of ether. The deposit is non-crystallisable so far as the taurocholate of soda is concerned, while the glycocholate of soda appears, if the deposit be left to stand, in acicular crystals, forming themselves into rosettes. With any suitable excipient the mass may be readily made into pills, each containing about four grains of the taurocholate, and coated so as not to dissolve in the stomach. One should be given with each meal or immediately after food. The effect of this new remedy, both for defective digestion and assimilation, and for obesity in cases in which fat is accumulated instead of being burnt off in the system as nutritive fuel, will, I think, be found highly satisfactory.

Hanover-square, W.

AN INSTRUMENT FOR THE TRANSFUSION
OF DEFIBRINATED BLOOD.¹

By T. W. CARMALT JONES.

THIS instrument is intended to be used for transfusing defibrinated blood. It could be equally well used for injecting milk or any other fluid into a vein. It consists of a holder (A), into which the defibrinated blood is to be poured; a tight-fitting metal cap (L), in the centre of which is a hole, a pipe leading from this hole communicates by means of an indiarubber tube with a valved handball (T). When the cap is in position on A, air can pass easily to A, but pressure on the handball will force air into A and compress it on the surface of the fluid in A. At the lower end of A is a piece of indiarubber tubing (B), which can be compressed by the clip D, and at the other end of the tubing is a hollow coned metal plug (C), which fits into the silver nozzle (M). The instrument with its accessories, as supplied in the case, provides all that is required for the performance of the operation of transfusion of defibrinated blood, with the exception of a clean ordinary tumbler, or, preferably, a small milk-jug and a basin of hot water. The steps of the operation are as follows. 1. Bleed the donor, in an adjoining room if possible, to five or six ounces into the measured vessel (H). 2. Whip the blood with the whip (P), and strain through the strainer into the tumbler or milk-jug. 3. See that the indiarubber tube (B), plug (C), and clip (D) are in place. Pour the defibrinated fluid into the holder (A), and put the cap (L) on firmly, then place the holder in the basin of water at 100° F. 4. Open a vein in the patient's arm, and insert the silver nozzle (M, K, or I)—three sizes of nozzles are provided—and block up the open end of the nozzle with the finger. 5. Have the holder brought to you; ease the clip until the fluid flows out of the plug, then tighten the clip again, take the finger away from the end of the nozzle, and insert the plug and remove the clip. Note the height of the fluid in A. The fluid in the holder is now in free and direct communication with the blood in the patient's vein. If any force is required, squeeze

¹ A paper read before the Harveian Society of London, March 5th, 1885.

the handball gently. 6. After the operation is over again note the height of the fluid in A, remove the short piece of indiarubber tubing (B) and burn it. The other parts can then be easily and thoroughly cleaned.

The instrument is very simple in action, has no delicate or complicated parts that can get out of order so as to cripple it, has no taps to puzzle the operator, and can be thoroughly cleaned and inspected. Supposing anything were to happen to the handball, an assistant could supply all the force required by blowing, though

H, Vessel marked in ounces for donor to be bled into. P, Whip to be used in H. F, Strainer of lawn muslin on wire frame. A, Holder to receive defibrinated fluid. B, Indiarubber tube about three inches long. C, Coned plug (hollow). D, Clip. L, Metal cap for A. T, Handball. M, Nozzle. K, I, Additional nozzles. E, Blood director.

not so conveniently as by the handball. The piece of indiarubber tubing at B is to be a clean new piece each time the instrument is used, and is to be burnt directly after use, so that no danger may arise from dried blood not removed after previous use. The inside of indiarubber tubing is rough and not easily cleaned, and cannot be inspected to see if it is clean. This piece of tubing allows sufficient play and breaks the rigidity, but is purposely kept short. The amount of blood taken from the donor and the exact amount injected into the patient will be known. The instrument is made for me by Mr. Hawksley of Oxford-street, to whom I am indebted for several practical suggestions.

ANTHROPOLOGICAL INSTITUTE.—At a meeting held on April 14th (Professor Flower, F.R.S., Vice-President in the chair), Dr. J. G. Garson read a paper on the "Inhabitants of Tierra del Fuego." Three tribes inhabit the Archipelago of Tierra del Fuego: they are called the Onas, who occupy the north and east shores, and resemble the Patagonians in being a tall race, chiefly living by hunting, but supplementing their food with shellfish and other marine animals; the Yahgans, who live on the shores of the Beagle Channel and Southern Islands—a short, stunted race, subsisting almost entirely on the products of the sea and birds; the Alaculofs, who dwell in the Western Islands, and are closely similar to the Yahgans. These last two tribes lead a very degraded life, wandering from place to place; they possess no houses, but construct shelters out of the branches of trees; they build canoes of bark, and wear very little clothing. In stature they are short, the men averaging about 5 ft. 3 in., and the women about 5 ft. In cranial and osseous development they resemble the other wild native tribes of America, but by isolation have assumed certain characters peculiar to themselves. The population of the Fuegian Islands appears to be about 3000.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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

MIDDLESEX HOSPITAL.

THE following two cases of hernia are of considerable interest. In the first, where hæmorrhage from a deeply-seated vessel complicated the operation for strangulated femoral hernia, we have an example of a condition which is very uncommon, and which, when it does occur, is usually due to an abnormal position of the obturator artery, the hæmorrhage arising from a wound of which is apt to be very troublesome. The second case is one in which the removal of the sac was carried out as an essential part of the treatment, and Mr. Hulke pointed out to his class the importance of closing the peritoneal cavity, and so preventing drainage backwards of discharges from the wound into the abdomen, a frequent cause of fatal peritonitis.

For the reports of the cases we are indebted to Mr. Ernest E. King, house-surgeon.

STRANGULATED FEMORAL HERNIA; OPERATION; RECOVERY.

(Under the care of Mr. J. W. HULKE.)

M. R.—, aged forty-five, a washerwoman, was admitted on Jan. 29th, 1885, complaining of swelling in the upper part of the right thigh, accompanied with pain in the abdomen and retching. The patient states she has had a swelling in the right thigh since her last confinement, eight years ago, but it has never given her any inconvenience, and she has never worn a truss. Five days ago she got a "chill" and began retching, and, the retching continuing, she noticed the swelling in her thigh was larger than usual, and somewhat tender. Thirty hours before admission the symptoms became aggravated; bowels not open for three days. She describes the vomited matter as "clear, watery, and frothy."

The patient's state on admission was as follows. In the upper part of the right thigh, external to and below the spine of the pubes, was a swelling about four inches long by two and a half wide, its long axis being from below upwards and outwards. On palpation the swelling was fluctuating, and a thrill of fluid could be distinctly felt. The lower border was much better defined than the other. It extended beyond Poupart's ligament, and was superficial to it. No impulse on coughing; dull on percussion, except on a very small area close to the spine of the pubis. It was irreducible. She had also an umbilical hernia. The disease was diagnosed to be strangulated femoral hernia, probably both gut and omentum.

Two hours after admission the patient was placed under ether, and an incision was made over the inner border of the swelling until the sac was reached. On opening the sac a large quantity of bloody serous fluid escaped (roughly estimated at two ounces). The finger was then passed in, and the gut was found to be surrounded by adherent omentum in places; consequently the wound was enlarged upwards and downwards; one or two vessels were divided, but easily controlled. The finger was then passed to Gimbernat's ligament, which was divided. As the hernia was still irreducible, the omentum was isolated as far as possible, and the pedicle transfixed with an aneurysm needle and double ligature, and the omentum carefully snipped away with scissors. There was no further hæmorrhage at this stage. The gut was then returned, and two or three little oozing points ligatured. After they had been stopped it was noticed that there was still bleeding from the bottom of the wound, and a ligature was passed with an aneurysm needle beneath it and tied, and the hæmorrhage being apparently checked, the closing of the wound was proceeded with; but again blood welled up, and the wound was freely opened and large retractors introduced, and at once a comparatively large atheromatous artery was seen spouting away freely. From its position it was evident that this was a large communicating artery between the deep epigastric and the obturator, lying just behind Gimbernat's ligament; it gave