leading to angular deformity, but in other parts of all the vertebræ shown, hollow spaces, more or less cup-shaped, exist. This is doubtless an exceptional specimen, but even when there is far less implication of the bones the removal of the diseased parts may still be unattainable.

In dealing with tuberculous disease we have to conduct a contest between the nutrition of the patient and the disease, and it is of the first importance to render the soil unfit for the tubercle bacilli. Improvement in the patient's vitality will overcome the bacilli and perfect fixation will permit local repair to take place. This is surely a well-established doctrine and it has been proved to be true in practice. There can, of course, be no doubt, speaking generally, that in cases of degenerated and broken-down tuberculous bone the sooner and more completely it is removed the better. In caries of the spine this can be effected by the early opening of abscesses and their treatment as above referred to, and sometimes by more extensive operations for removal of bone, but to cut down upon every diseased spine and attempt to remove all affected osseous tissue is a plan of treatment which can hardly commend itself to cautious surgeons. Further, to remove the laminæ and pedicles for the purpose of approaching the diseased parts is to remove those portions of the vertebræ which are, as a rule, alone free from disease and upon which we should rely for maintaining the stability of the spinal column during the process of repair.

Queen Anne-street, W.

THE TREATMENT OF CHRONIC ULCER OF THE LEG.

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THE treatment of chronic ulcers of the leg, especially in out-patient practice, is often so unsatisfactory that it seems worth recording the results I have obtained in a large number of these cases by adopting an old but comparatively seldom used method of treatment which I have found very successful in dealing with this painful condition. The method is that of careful and systematic strapping of the leg, the ulcer being completely covered in and no other local remedy being employed.

Some years ago, when house surgeon to the Metropolitan Hospital, I was requested by one of the visiting surgeons to strap a chronic ulcer on a patient's leg situated over the tibia. The man had been attending the out-patient department for six months and had been given the usual routine remedies with little or no benefit, but his ulcer soon improved when strapping was commenced and was well in a few weeks. The rapid healing of this ulcer induced me to give treatment by strapping a more extensive trial and I have now treated in this way between thirty and forty ulcers of the leg with very satisfactory results. I can only recall four patients, all elderly women, in whom this method of treatment failed. In these instances it had to be discontinued as it caused irritation of the leg, but it is probable that had these patients rested sufficiently and had the strapping been changed more frequently the treatment would have been as successful in their cases as it has been in all others in which I have regularly carried it out. The strapping used was the ordinary adhesive plaster spread on stout, pliable holland and supplied in 12-yard rolls, 16 in. wide. It must be cut into various lengths according to the size of the leg, each length being about 1½ in. wide and applied so that the strips overlap by ½ in. It is best to include the foot, commencing at the base of the toes and carrying the strapping up the leg to 3 in. or 4 in. above the ulcer, which is thus completely covered in. A strong calico bandage should then be applied over all, reaching from the toes to the knee, and this should be changed by the patient daily or as often as it becomes soiled.

Occasionally small vesicles and excoriations form beneath the strapping or the skin round the ulcer may become irritated by retained discharge. This is less likely to occur if the patient can rest, and is not of much importance, as the excoriations readily heal on the application of an ointment composed of equal parts of zinc ointment and soft paraffin,

applied on small pieces of lint, the whole being then covered in with strapping. Care should be taken that the lint is not placed too close to the ulcer, as otherwise it may interfere with the firm pressure which should be maintained by the strapping on the healing edges. It is usually sufficient to change the dressing twice a week, but if the ulcer is large and there is much discharge it may be necessary at first to renew it more frequently and if there is much inflammation of the skin around the ulcer it is well to subdue this before commencing to strap in the first instance.

At the Hospital for Diseases of the Skin, Blackfriars, where many out-patients attend with ulcer of the leg, the surgeon to whom I was acting as assistant kindly allowed me to treat many of his cases with strapping. On referring to my notes of ten of these patients I find that their ages varied between thirty-three and sixty-three years, five of them being over fifty years. Several of the ulcers had an area of about the size of a crown piece, others were smaller. Nearly all had had months of hospital treatment up to the time strapping was commenced, but with little or no improvement, and in some instances the ulcers had latterly been extending. Many of the patients had varicose veins and œdematous legs and they almost invariably expressed themselves as much relieved soon after treatment was begun. The average number of strappings required in each case before healing was completed was twelve. After the ulcer has healed the patient should be directed to wear an elastic stocking or a Martin's rubber bandage. The latter is to be preferred for hospital patients and should be worn over a soft calico bandage which helps to prevent the irritation which sometimes arises when the rubber is immediately in contact with the skin.

The improvement which this treatment leads to is, of course, largely due to the support which the strapping gives to the limb. The pressure causes diminution of the œdema and a more satisfactory condition of the circulation of the leg, and, in consequence, the granulations become vascular and active, the ulcer becomes healthier, and new skin gradually spreads over it from the margin. This method of treatment is no doubt somewhat troublesome and requires more time than can usually be given to individual out-patients, but there is nothing to prevent its being carried out in private practice or by students under careful supervision in hospitals to which schools are attached. There is no special novelty claimed for the method, which has long been a recognised one, but an experience extending over many years in various out-patient departments in London has shown me how comparatively seldom it is tried and I venture to assert that for chronic non-specific ulcers of the leg of moderate size, where the patient is unable to rest, none of the usual methods of treatment yield anything like such satisfactory results as that which I have endeavoured to describe.

London.

A CASE OF OBSTRUCTED PREMATURE LABOUR.

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THE following case may probably be of some interest to the readers of THE LANCET.

On August 5th, at 7.30 A.M., I was called to see a woman, a multipara, aged thirty-eight years, who was about seven months pregnant. A certificated midwife who was present told me that the patient had had a fall three days previously and that the "pains" had set in at about 3 P.M. on the previous day and had gradually increased in severity. She added that they were typical labour pains but that they made no impression on the os, which was then of the same size as it had been on the previous night. I found the patient quite exhausted. The head was presenting, the membranes were intact, and the os was abnormally thickened and tough, barely admitting a finger. I ordered 15 gr. of chloral and left. I saw the patient again at about 12 noon—i.e., twenty-one hours after the pains had set in—and I found that the os was almost the same size as it was when I saw her previously. I learned that the patient had slept for a couple of hours and had awakened refreshed only to be soon prostrated with the

pains, which came on with redoubled vigour. I then resorted to artificial dilatation with Champetier de Ribes's bag, and with some difficulty got it into position and retained it for about two hours, at the end of which time I was surprised to find that the os even then only admitted two fingers, and this with difficulty, there being thus hardly any appreciable increase in size. I ruptured the membranes, and, nothing else being at hand, made a couple of slight snips in the cervical tissues with a pair of scissors. I then performed bipolar podalic version and succeeded in bringing down a foot. The tough cervical band grasped the thigh so tightly that the leg in a few minutes became almost black from the obstructed circulation. After about half an hour the cervix showed signs of relaxing and the rest of the body up to the neck followed with difficulty. A further complication now occurred by the after-coming head being extended and much too large to get through the imperfectly dilated os. As it could not be extricated by the ordinary methods, forceps were tried but without avail. I was then preparing for craniotomy, when a strong pain, aided by stronger traction, succeeded at last in expelling the head. A further complication in this interesting case was a prolapse of the anterior vaginal wall containing the partially distended bladder (cystocele). The placenta was expelled soon after but was incomplete, there being numerous small islets of placental tissue wanting. I found it necessary to insert my hand four times to remove portions of the placenta with my fingers and also to introduce a curette—which was done by a colleague—to scrape away the remnants which had escaped the fingers. A hot iodine douche was then given and was ordered to be repeated once a day and a hypodermic injection of ergotin and strychnine administered. Hot-water bottles were placed to the feet and other precautions were taken to counteract the collapse of the patient. She soon rallied and at the time of writing, a week after the delivery, is quite well, not having had any hæmorrhage or offensive discharges whatever.

The interest of the case, to my mind, lies in the following facts: (1) an abnormally tough and thickened cervix; (2) the unsuccessful artificial dilatation; (3) the evidently diseased placenta; (4) the presence of cystocele; and (5) the value of strict antiseptic precautions, for notwithstanding the number of times that the above complications necessarily entailed manual insertion not the slightest indication of sepsis appeared. I used the pellets of perchloride of mercury specially designed for private use.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON AUSCULTATORY FRICTION AS AN ADJUNCT TO AUSCULTATORY PERCUSSION IN ABDOMINAL EXPLORATION.

BY WILLIAM EWART, M.D. CANTAB., F.R.C.P. LOND., AND A. C. PEARSON, B.A. CANTAB.

THE method which is briefly described in this note is not new, although it was recently re-discovered in the wards of St. George's Hospital.¹ Professor Bianchi had introduced it in 1894 in connexion with the Biazzi-Bianchi phonendoscope, but it does not appear to have come before the practical notice of the profession in this country. The expectations which had been raised as to its clinical value have not been fully realised; on the other hand, it is capable of so much precision within a limited range of use that it is worthy to be brought more prominently than has hitherto been the case before the notice of clinical workers. The principle and the procedure are analogous to those of auscultatory percussion. Any amplifying stethoscope, such as the phonendoscope, will have an advantage over the

common stethoscope, but the latter is quite sufficient for all ordinary purposes. If the finger be drawn lightly over the skin away from the spot where the chest-piece is applied the otherwise inaudible sound will be loudly heard through the stethoscope, but only for a short distance, beyond which it will cease. The edge of the nail or the top end of a pencil or the like will answer the same purpose as the finger. If the chest-piece be applied over a hollow organ, such as the stomach, the intestine, or even the lung, the friction will continue to be perceived for a considerable distance without any diminution until it abruptly ceases to be heard. By repeating the operation in radiating fashion an outline can be drawn of the vanishing points all around, and on testing this it will be found to correspond exactly with the superficial outline of the organ. It was in mapping out a distended colon that the method was re-discovered at St. George's Hospital. No more striking illustration could be obtained of the fine localising power of the method, for in this case the boundary had to be drawn between the distended gut and the distended stomach. No other method can do this with the same definiteness, and the method also stands alone in the ease of its performance and the absence of any disturbance to the patient, whose state may forbid rougher means of examination. The method is applicable to the study of other regions and organs, but upon this we need not enter at present, as further reference will be made to it elsewhere.² The practical experience hitherto gained shows that the method is nowhere so successful as in mapping out the distended viscera in the abdomen, provided the abdominal walls themselves be not unduly tense. Excessive tension of the parietes puts a stop to its differentiating power. With this reservation the results are such as to deserve the attention of clinicians.

SARCOMA OF THE SOFT PALATE, &c.

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THE following report may be of interest, as it is the subsequent history of a case, reported in THE LANCET,³ of sub-parotid and retropharyngeal sarcoma successfully operated on.

It was noticed in January, 1897, that the growth had recurred and occupied the soft palate, invading the right pillars of the fauces, rendering swallowing painful and difficult, and causing considerable dyspnoea. It also involved the right side of the hard palate, especially the alveolar edge. The main central growth was of the size of a small hen's egg, but the edges were ill defined, though several little outlying lobules could be felt. After consultation with Mr. Jacobson it was decided to operate, and on Feb. 12th I, with the assistance of Dr. Stamper, Mr. Williams, and Mr. Mills, removed the growth. Chloroform was given and a preliminary laryngotomy was performed, the pharynx being plugged. Shortly after the patient became livid and apparent respiration ceased, the pulse remaining fair. On lowering the head and rubbing the epigastrium and performing artificial respiration for about five minutes colour returned and natural breathing began again. An incision was then made along the right side of the nose, round the ala, and through the middle of the lip; this flap was rapidly dissected from the bone and bleeding was stopped by pressure and torsion. The hard palate was sawn through in the middle line after removing the right incisors, and the upper jaw was cut through transversely just below the level of the nasal bones. The separated bone was then drawn forward and an attempt was made to separate the growth. To deal with it properly, however, the right cheek had to be slit back to the masseter and much trouble was experienced in getting it all away. The soft palate was removed on both sides and the buccal mucous membrane was dissected off from the masseter, leaving its fibres bare and glistening; all the soft parts were removed as thoroughly as possible. Hæmorrhage was stopped by Pacquelin's cautery and iodoform was dusted over the surface; the skin incisions were brought together by silver wire. The

¹ Dr. Ewart states that to Mr. Pearson belongs the credit of having found out for himself this additional means of determining the boundaries of viscera and of having called attention in the case in which he had first applied it to the fine results which may be obtained by auscultatory friction.—ED. L.

² Clinical Journal, July to September, 1898: "On Practical Points in Auscultation and Percussion and in the Physical Examination of the Chest." Lectures to Advanced Students. By Wm. Ewart, M.D., F.R.C.P. Lecture iv.

³ THE LANCET, June 27th, 1891, p. 1429.