that he had any successes at all with the remote and intra-venous injections, which here invariably failed signally. I am inclined to think, after a careful repetition of his work, that some experimental errors must have crept in somehow or other, but do not hesitate to pronounce gold chloride to be quite useless as a remedy for, or preventive against, cobra poison.

Cambridge.

A FEW PRACTICAL OBSERVATIONS ON THE TREATMENT OF ULCERS OF THE LEGS.

By J. M. FINZI, L.R.C.P. LOND., M.R.C.S., &c.

As it has fallen to my lot to have an opportunity of treating many cases of ulcers of the legs, and almost always with success, I think a few notes of my experience may be found of use to the readers of THE LANCET, more especially when it is found necessary to carry out the treatment without the usual routine method of confining the patient to bed. I will pass over the general treatment by remarking that it should be prolonged and regular, depending on the constitutional predisposing cause, and that in most cases of an indolent nature a persistent course of astringent iron tonic is of great use, with total abstinence from alcoholic stimulants. Coming now to the local treatment, the principal objects to be held in view are the promotion of a healthy circulation in the limb, the relief of pain, and the production and maintenance of complete asepsis. To obtain the first result it is necessary in every case that the leg should be satisfactorily bandaged, and in order to get good results this should not be left to the patient or friends, but should be done by the medical attendant himself daily, every alternate day, or every third day, as the case may require. Rest and elevation of the leg when possible are, of course, useful adjuncts to treatment in many cases, and in a few essential; but I wish to lay especial emphasis on the fact that in many persons ulcers of the legs can be cured without in any way interfering with their ordinary avocations, and in some cases they seem to progress more rapidly when treated thus than when kept completely at rest. In dealing with indolent chronic and callous ulcers the usual treatment recommended for promoting the absorption of chronic inflammatory products is pressure, and this is generally recommended to be applied by strapping the ulcer, or by the use of the rubber bandage. I have seen cases treated by both methods in which the results have been highly unsatisfactory. We are all aware of the rapid healing of an ulcer that follows—I believe invariably—after an attack of erysipelas; and, guided by this indication, I would advocate the systematic production of a similar condition, though not of a septic origin, in indolent and callous ulcers. I would suggest that our endeavour should be to produce, in almost all, if not in all, cases of indolent or callous ulcer an inflammatory condition of the ulcer and of the skin immediately surrounding it—in fact, an eczema—by some of the means to be afterwards enumerated. I have been led to the foregoing conclusions by observing how rapidly ulcers become amenable to treatment after eczema produced by causes other than erysipelas—such as putrefaction of the discharges, and by local irritant applications. In my hands this treatment has been attended by a considerable amount of success, rapid healing taking place under sedative applications after the induction of this condition. It is obvious that the replacing of the chronic congestion of the ulcer and parts around by an acute hyperæmia must promote the absorption of the products of chronic inflammation, and with satisfactory results, where the process can be kept under control by the surgeon. The local applications used in dressing ulcers of the legs may be considered under three heads: those in which the medication to be applied is dissolved in water, those in which it is applied in the dry state, and those in which it is mixed with or dissolved in or emulsified with some oleaginous material. As a rule, those cases in which water is used as the menstruum require very frequent dressing, and cannot be carried out satisfactorily without rest in bed. There are two subdivisions of this method—one in which the water is allowed to evaporate, in which case it

becomes practically a dry dressing until the renewal of the application. By this method I have seen some very brilliant results, in one case in particular, in which a large ulcer completely encircled the leg; a rapid cure was effected by applying dressings soaked in a weak solution of liquor carbonis detergens and keeping them frequently moistened with the same. I have also seen a case of perforating ulcer of the foot cured by the frequent injection of a weak carbolic lotion, while applying weak iodoform ointment to the apertures, in conjunction with appropriate constitutional treatment. Water or watery applications applied like this sometimes cause eczema.

The second subdivision of this method is where the applications are covered by an impermeable covering, as in the ordinary water dressing or poulticing. This method is very soothing in some cases; in others it produces eczema, especially when applied to a sore which has been previously dusted with iodoform; and in others cedematous granulations when continued too long. Under this subdivision comes the application of rubber bandages—a treatment apparently very much in vogue, and by many used as a routine procedure in treating ulcers of the legs. I would suggest that treatment by this method is unscientific, as keeping the whole limb in a continually sodden and relaxed condition, when we only want to produce that effect locally in and around the ulcer. As a matter of fact, the elastic compression produced by it can be equally well obtained by using over the water dressing elastic bandages which will allow the evaporation of the perspiration from the skin. My experience of these bandages has led me to condemn them as a rule.

Under the second and third heads, the dry and oleaginous applications, I would say that these are most useful when it is necessary for the patient to be about, and I generally make the applications to the ulcer direct, and cover with lint, or apply them to the lint before laying it on the ulcer; in either case several layers of lint are used, or else over the single layer of lint a mass of some absorbent and antiseptic material is placed, in all cases of sufficient thickness to prevent the discharge soaking through to the bandage during the interval between each dressing. Foremost among dry applications is the use of iodoform, and I find this one of the most useful applications for ulcers of the leg, especially when they are sloughing or spreading, and frequently when they are indolent. In a very large number of cases iodoform causes severe eczema of the surrounding skin, accompanied by much irritation and burning pain, with profuse watery discharge. This may come on after a single dressing, but very often does not appear till after several applications, and is the condition we require to produce in order to start the healing in callous and indolent cases. It is sometimes so violent, apparently in very intemperate subjects, as to promote the spread of the ulceration. In some cases iodoform causes an antiseptic scab at the edges of the wound where the discharge is not free enough to wash it away, and healing progresses rapidly underneath this scab. A thin coating of iodoform, and that in the crystalline form, is the best application. Iodoform immediately relieves the pain in cases of gangrenous ulcer. All ulcers in which there are exuberant granulation or a fungous condition require dry and absorbent dressings with or without the usual astringent applications, also firm bandaging.

Lastly, I come to consider the oleaginous applications, and these may be roughly divided into the stimulating and sedative—the former for cases in an indolent condition, the latter for those in a healing, inflamed, or eczematous condition. Of the former, the blister is one of the most powerful and rapid means of procuring the inflammatory condition previously mentioned, and is not so painful as one would expect in these cases. Then iodoform mixed with lanoline, vaseline, or lard is very irritating if used sufficiently strong. Carbolic oil or an emulsion of solution of coal tar with oil; the official ointments of tar, resin, eucalyptus, salicylic and carbolic acids, and red and white precipitate, are all very useful. The last two are also very beneficial in eczema. Among the sedative applications are emulsions of lime water or saturated solution of borax with olive oil or linseed oil, and of liquor plumbi subacetatis with oils, the ointments of zinc, oleate of zinc, calamine, boric acid, acetate and carbonate of lead, and especially bismuth. An ointment composed of equal parts of oleate of bismuth and paraffin molle I find one of the most soothing applications that I know of, and one that

will rapidly finish the healing of an ulcer which has become stationary under other methods of dressing. In the use of ointments it is necessary to spread them thinly on the lint, otherwise they cake and obstruct the flow of the discharge.

Sutherland-avenue, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

SOME BURSAL AFFECTIONS.

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HÆMORRHAGES and sudden serous effusion into the cavities of bursæ have not received much notice or the attention they deserve. Hæmorrhage into a bursa is traumatic in origin, and may follow (a) contusion or (b) severe and sudden movement of a joint over which the bursa is situated. The sacs most liable to this injury are, in order of frequency, (1) the two pre-patellar, subcutaneous and subfascial; (2) that over the olecranon process; (3) that over the tuber ischii; and (4) the subacromial bursa. The position of these over bony surfaces or "points" favour the production of this condition.

In support of these statements I append the following cases as typical of the two chief causes:—1. An old man, aged seventy, a month before coming under notice fell and struck his buttock. A swelling over the right tuber ischii quickly appeared, which has remained the same size, the skin over it now being red and oedematous. On incision the tumour was seen to consist of a glistening cavity lined with blood-clot, which was turned out and drainage established. It would not close, so the bursa was excised, and the patient made a good recovery. (2) A coalheaver, aged forty, when lifting a weight, felt a "click" in the right elbow, and found a soft swelling at the point of the elbow. This "hardened" on the way up to the London Hospital, and on admission I found a tense, painless swelling in the situation of the olecranon bursa, which on palpation was felt to contain clot. The history here was so circumstantial that I regarded it as a case of hæmorrhage into a bursa following exertion. In a similar manner a fall on, or the impact of a falling body on, the point of the shoulder causes the subacromial bursa to fill; subsequent crackling on active or passive movement has led to the diagnosis of "fractured anatomical neck" &c.

Signs and symptoms.—The subject of hæmorrhage is important because the signs accompanying the presence of blood in bursal sacs are those which would lead us to confidently expect pus, and I have seen many cases of enlarged bursæ treated by incision when the sole contents were blood in various states of change, or merely serum more or less blood stained. Following a blow, fall, or severe strain, a swelling appears in the anatomical position of a bursa; this enlargement comes on rapidly—usually in a few minutes,—and patients tell you that the lump has been "the same size ever since the fall &c.," a most important point in the history. On palpation fluctuation is readily obtained with a certain amount of pain and tenderness, especially when caused by contusion; in a few days redness and oedema of the skin over and round the bursa appear, and we have the classical cardinal signs of inflammation ("tumor, dolor, rubor, calor") present, but as we shall afterwards see not pus but "crur." The thermometer is here our best, though not an infallible, aid. In hæmorrhage pure and simple, although the signs of suppuration appear so unequivocal, we find the temperature rarely above normal. Relying on signs alone, I have seen many bursæ opened as abscesses, to find nothing but a blood clot or serum, with, in some cases, such as the pre-patellar bursæ, thin pus in the subcutaneous, but blood-clot only in the thick-walled subfascial, cavity, analogous to the so-called "reflex abscesses" outside a joint the seat of commencing disease. It is in these cases that ecchymosis is not present; when it is, no doubt exists as to what composes the tumour contents. Crackling or rubbing is a sign especially marked on palpating a subacromial bursa filled with blood-clot. The

so-called "melon-seed bodies," so often to be demonstrated by palpation at the bottom of such bursæ as the olecranon and pre-patellar, are, I take it, evidences of former hæmorrhage, being composed of condensed decolourised (more or less) fibrin, either free in the cavity or moored by a longer or shorter pedicle to the interior; occasionally they are fixed and sessile. My object in calling attention to these points is to prevent bursæ being needlessly opened, for tedious suppuration almost invariably follows and the bursa has to be excised.

Treatment.—The limb should be immobilised on a splint, an ice-bag or evaporating lotion applied, and rest of the joint ensured for several weeks if the patient be anæmic or tubercular in order to prevent suppuration. The swelling slowly subsides, leaving "melon-seed bodies" behind, and these seem to be the starting point of hæmorrhage following exertion. That hæmorrhage into bursæ is more common than it is supposed is proved by finding broken-down clot in the contents of abscesses caused by the bursting of a suppurating bursa into the subcutaneous tissues—e.g., round the knee-joint.

Another interesting condition, of which I have seen several examples in the subcutaneous pre-patellar sac, is the deposit of tubercle in bursal cavities leading to infiltration of the overlying skin, suppuration, and finally an ulcer of the size and shape of the bursa. These have been accompanied by other tubercular affections, and are most obstinate to treatment.

Plymouth.

TREATMENT OF A CASE OF CHRONIC PLEURISY BY CONTINUOUS DRAINAGE.

BY B. BASKETT, M.R.C.S., L.R.C.P. LOND.

THE following case may be of interest to readers of THE LANCET, as I am unable to find any record of the disease having been so treated. The patient was under the charge of Dr. A. J. Harrison in the Bristol General Hospital, and it is by his permission that I am allowed to submit it for publication.

W. B.—, a middle-aged man, a sailor by occupation, with a history of previous good health, was admitted to hospital on July 13th, 1891, suffering from very considerable pleuritic effusion on the left side. All the physical signs were well marked. There was absolute dulness on percussion all over the left side, breath sounds could not be heard, and the heart was displaced well over on to the right side. The symptoms had first been noticed about six weeks before admission, but he had not been tapped. As was to be expected, he was then in a very low state of health. Aspiration was at once performed, and forty-four ounces of serous fluid were removed; but, as he showed symptoms of faintness at this point, the operation was discontinued. There was no difference in the percussion resonance after tapping, and the only change observable in the physical signs was that ægophony, which could not be heard before, was perceptible at the level of the seventh dorsal spine, and that vocal resonance was present in the upper part of the cavity. The first tapping made no permanent difference, and the fluid began obviously to reaccumulate within a few days. Aspiration was accordingly done again, and then again, in all seven times—the amount removed at each sitting varying from two to six pints. Every effort was made to restore his strength by tonic medicines and nutritious diet; and later on in the case he was put on diuretics and counter-irritants applied to the chest wall. But he went steadily down hill, and after nine weeks of this treatment matters began to wear a very grave aspect. At this stage it was finally determined to drain the pleural cavity continuously. From the cachectic state at which he had arrived there was much reason to expect that the fluid, hitherto serous under the irritation of the constant presence of a drainage-tube and the frequent exposure to the air at the time of dressing, might become purulent, however rigidly the antiseptics were maintained; but if it did so, the inflammation thereby indicated might serve a useful purpose and close the cavity; while if it did not, the drainage, as in other serous cavities, might restore the balance between secretion and absorption, and so end the case. Careful examination of the fluid had been made and was hereafter made, but no tubercle was