TREATMENT OF NÆVI BY ELECTROLYSIS.

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I AM induced to give the experience of about ten years' use of electrolysis in the treatment of nævi, because in my hands it has answered so well, and seems to possess advantages which none of the more commonly adopted methods of dealing with these growths can be said to have. Even amongst those who apply electrolysis there is some difference of opinion as to the value of the negative or positive pole for this purpose, and an equal amount of difference exists as to the wisdom of substituting a rheophore for a needle to complete the circuit. Having preferred to use electrolysis to any other plan of treatment for many years in all nævi, I have, at least to my own satisfaction, formed some general opinion upon these points of difference for future guidance.

Before passing on to the consideration in detail of electrolysis, I should wish to mention in what I consider the older plans are deficient. 1. *Ligature*: This treatment has always appeared to me to be barbarous in the extreme, because the after-suffering, even though the skin be carefully omitted from the ligature, is very great. The scar left is a very uncertain quantity, and not in other ways satisfactory. It cannot either be claimed for ligature, however done, that it is invariably successful. The nævi about the face, eyelids, nose, lips, tongue, and possibly near the fontanelles, all of which places are common situations for this form of growth, ligature is most inapplicable, because of the uncertainty as to its results. The loss of tissue involved being a factor of considerable moment in some of those parts named (lips, nose, lips) and in others (the tongue), for obvious reasons it is unsuitable. For these reasons I have entirely abandoned the ligature. 2. *Excision*: For the removal of angiomas on the trunk this operation is very suitable; the faint scar which is left when healing is rapid (and this is usually the case if proper dressing and care be used) being of no consideration. This plan, although it is effected by "cutting," as the friends express it, is not so much objected to by them, because they are glad to be rid of the matter speedily. Blood loss is always of moment in young infants, but even large nævi may be removed in this way with a fractional loss if care be taken to be well outside the capsule. 3. My knowledge of *injection* is most limited, but the risks are stated to be not inconsiderable by those who are in the habit of using it. 4. The simpler methods of treatment, such as ethylate of sodium, liquor arsenicalis, &c., are all more or less failures in my hands, the former (ethylate) being also, I find, a very painful application, which its originator states is not the case. The bulbous cautery is most useful in nævi on the tongue if cocaine be first injected or painted over the surface.

Electrolysis.—By its use we get: (1) an operation which gives no after-pain; (2) it is free from danger; (3) there is no bleeding; (4) the scar is white, and does not tend to contraction in loose structures like the eyelids. In adopting this plan, it is necessary at once to recognise the fact that it is not usually expeditious in its action; this is its chief drawback, because parents are apt to clamour for some obvious effect to be produced, and are loth to wait with patience for the gradual fading of the nævus, by which we get our best results. Occasionally, nævi may be cured at one sitting without sloughing, and they may speedily diminish; but this is in my experience uncommon, and it is not wise to attempt to obtain so rapid an action, because the chances are against the effect being good. Stop the growth and be content to wait is the better method, re-attacking if development takes place or its subsidence is long delayed. I always use the positive pole with one or more needles, according to the size of the growth and its situation. The needle (or needles, as the case may be) is moved about systematically to attack the growth in various parts. This is done without withdrawing the needle after it has remained long enough in one spot to produce some effect. It is wiser at first to work well away from the surface of the tumour, especially in raised nævi which are very florid, to avoid risk of destroying the thin covering. The circuit is completed by attaching

a rheophore to the negative pole: by this we avoid an unnecessary puncture, and I find that the process is equally effectual. I have not yet succeeded in finding a good means for insulating needles, and the scar left by the negative needles is brown and very disfiguring. I prefer to use the positive instead of the negative pole, because it is slower in its action and therefore less likely to lead to sloughing, and the bleeding on withdrawal of the needle is much less troublesome. The objection to the scar left by the negative needle has already been referred to. The number of cells used, I find in my notes, varies somewhat, but my usual custom is to commence with five Leclanché cells (Silvertown Battery Company), and increase according to the effect produced. Ten cells are generally sufficient, but in deep subcutaneous nævi I have applied twenty cells. The amount of tension caused must be carefully gauged, cutaneous nævi being capable of standing very little. Change in colour to a dusky hue is a good guide to judge when it is requisite to stop the current. I arrived at the conclusions detailed here by testing the number of cells and their effect on nævi on the trunk where scarring was of less importance. On withdrawal of the needle, all that is required is to rotate it before pulling to free it, and then paint the orifice with collodion.

Nottingham.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

DISLOCATION OF THE ELBOW BACKWARDS:
A PERSONAL EXPERIENCE.

By LEONARD W. SEDGWICK, M.D.

THE other day, whilst crossing the hall of the Grand Hotel at Brighton, and wearing a pair of walking boots with steel nails in the heels, I slipped, fell on the palm of my left hand (which I had stretched behind me to save my head), and completely displaced both bones of the forearm backwards. The joint was slightly movable and somewhat flexed, with the hand a little prone. My friend, Dr. Marcus Allen, was sent for, but he was not at home; so I thought I would try to reduce the dislocation myself. The humerus was well advanced in the forearm; the olecranon, with the great sigmoid cavity, and I think the coronoid process, were easily felt; and the head of the radius, with its cupped top, was manifest. The muscles were soft and limp, all but the biceps and its tendon, which were hard and tight. I stiffened my upper arm by the action of its muscles, and extended the lower arm as well as I could; then hooking the fingers of my right hand over the end of the olecranon, and my thumb over the head of the radius, I steadily pushed downwards, and in three or four minutes the bones quietly rushed into place. I then bent the arm to a right angle, and held it safely there; soon Dr. Allen came, examined it, and assured me that it was all right, and that there was no fracture. I had it day and night in a leathern trough-sling, and did not compress it with bandages, but kept it cool by applying whisky on a rag two or three times a day for as long as it was comforting, and at the end of twelve days I had a fair amount of motion. There was a good deal of swelling for the first four or five days, and much ecchymosis, especially on the inner side of the lower end of the upper arm and just above the anterior annular ligament of the wrist. I imagine that there was not a very great deal of pain in the proceeding, or perhaps I should not have persevered; but the pain may have been overborne by the mental pleasure of being able to put the joint in myself.

I tell this story to direct attention to the mode of reduction of the dislocation, which, if applied to another, would be to grasp the humerus firmly with one's left hand, to get the patient to extend his arm as best he could, and to hook on to the olecranon with the fingers of one's right hand and pull, or rather push, it in the direction of the axis of the limb. In the extended position the coronoid process of the ulna would be, to some extent, lifted out of the olecranon

fossa of the humerus, and any action of the biceps helping in replacement would be exerted at less disadvantage than during flexure. Thus reduction would be easy unless there were such an amount of swelling that the olecranon could not be felt.

Gloucester-terrace, W.

A CASE OF STRICTURE OF THE BILIARY DUCT.

By F. LUCAS BENHAM, M.D. LOND., M.R.C.P.

THE following is an example of a somewhat uncommon condition of obstructive jaundice, difficult of diagnosis during life, and of which, though several other cases have been recorded, the cause is still obscure.

H. W—, aged eighty-six, was formerly a butler, but had for many years been too infirm to work, and had been living on a pension. He had had originally a good constitution, but had suffered for a long while from chronic gout, attacks of which had left his knees stiff and weak; consequently he seldom went out of the house. His skin was pale and rather sallow and waxy, but he had never had jaundice or any attacks at all resembling biliary colic. On April 3rd, 1886, he was suddenly seized with severe pain in the right hypochondrium, with acidity of stomach and constant vomiting. In a day or so jaundice appeared, with bile pigment in the urine, and colourless fæces, just like yeast. The jaundice became deeper. The pain subsided partially to mere aching in two or three days, but the burning and acidity in the stomach and throat persisted. There was very troublesome itching of the skin, the pulse was slow, and the bowels constipated. There was very little recurrence of pain, but the right hypochondrium remained tender. The liver could be felt just below the ribs and xiphoid cartilage, hard, but without any great irregularity of outline. After a few days the patient got up daily, but in about a month (early in May) he became weaker and took to bed again, and then began noticeably to lose flesh. The skin had become of a deeper hue—brownish yellow; urine and fæces as before. Acid dyspepsia occurred on eating anything solid. About the middle of May he gradually became drowsy by day, rambling a little by night, and more prostrate; the tongue, hitherto quite clean, became coated with thick, rough, dry fur. On May 18th partial suppression and incontinence of urine took place, without distension of the bladder; relief was given by stupes. The urine was scanty, and somewhat offensive. On the 19th there was an increase of tenderness all over the abdomen, especially the right hypochondrium. The patient was sinking, and nearly fainted once or twice. Passive congestion of the lungs supervened, and he died on May 20th. The treatment had been by mercury and chalk, with saline aperients, and afterwards iodide of potassium was tried, but without any appreciable effect on the jaundice.

A necropsy was made thirty-two hours after death. The abdomen only was opened. The liver could not be felt through the abdominal walls. Parietes fat. Very little fluid in the peritoneum; no peritonitis. Bowels moderately distended with flatus. Liver small, sunk beneath the ribs; rather hard, but flaccid; very dark, mottled with yellow on surface and section; no perihepatitis. Gall bladder nearly empty; it contained very thick dark-green mucus, and two or three small masses of inspissated pigment. On examining the bile duct, it presented an indurated swelling, about the size of an almond kernel, on the hepatic duct, at its entry into the cystic duct. This was found to be a local thickening of the wall of the hepatic duct, narrowing the tube so as to be almost impermeable, and partially involving the cystic duct also. The mucous membrane, though constricted and shrunk, was smooth and healthy. No gall stone or any sort of concretion was found. The ductus communis was inflamed, but patent. Kidneys large, soft, and red from recent congestion; capsules easily stripped; substance soft, but cortex very thin and atrophied.

Remarks.—This case is similar to one described by Dr. Phillips before the Clinical Society in October, 1887, and to others referred to in that paper previously reported by Holmes, Moxon, and Johnson: the character of the stricture was the same; calculi were absent throughout; there was no ulceration of the mucous membranes, and the cause of the affection was equally obscure. During life I supposed the case to be one of impacted gall stone, or else of cancer of the liver, but without positive evidence of either. One

peculiarity of this case was the sudden onset of the symptoms, which I can only explain by the duct—which from the hardness and thickness of the stricture must have been affected for a considerable time and become much reduced in calibre—having become plugged with mucus. The typhoid condition and nervous symptoms which appeared at the close of the illness may perhaps be attributed to the atrophy of the liver which took place then.

Elizabeth-street, S.W.

GANGRENOUS INFLAMMATION OF LABIA: CASE OF NOMA.

By E. ST. GEORGE QUEELY,

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THE following case has just come under my notice and may be of interest.

Jessie M—, aged nine, had been suffering for about five days previously to my seeing her from swelling and inflammation of the right labium, which her mother had poulticed continually. When I saw her on the evening of Oct. 12th the right labium was greatly swollen, of a dark-red colour, and very painful to the touch, and about the middle there was a small shallow ulcer. The tongue was foul, skin hot, pulse quick, and bowels confined. No history could be obtained, only she felt some irritation there a few days before she complained. She had always been a healthy child, the only illness being an attack of measles about four months before. At first her father thought she had been injured by riding across a fence, and suggested a splinter, but of this there was no sign. On the third day of my visit both labia were very enlarged and of a deep-red colour. There was an ulcer about the size of a threepenny-piece, and a second, but smaller one, above it. The child screamed on the slightest movement. The urine was passed with difficulty in a standing position, causing great agony. There was a slight discharge from the vulva, from which the epithelium was stripped, leading to ulceration the next day. On the fourth evening there was great itching, which lasted for some hours in spite of all treatment. On the fifth day the symptoms were much worse; the glands in the right groin were enlarged and inflamed, and the abdomen was swollen. The ulcerations had become larger, and fresh ones had appeared on the fourchette and perineum. The buttocks were covered with a rash. The vulvar opening was continually closed by discharge, and the labia were gangrenous. The bowels were open, dark-green matter being passed, which was very offensive. On the fifth and sixth nights the patient was slightly delirious. The symptoms remained unchanged on the seventh day; but from the eighth the disease seemed to decline, and on the sixteenth she was able to leave her bed, and two days afterwards was convalescent.

With regard to treatment, the child was confined to bed and absolute cleanliness enforced. She was placed sitting in a warm bath (into which a little potash permanganate was thrown) three times a day, the parts to be gently syringed with Condy's fluid, and lint soaked in a lotion of opium and carbolic applied. The dressings had to be changed while the child was under the influence of chloroform. The ulcerations were checked by the free use of the solid nitrate of silver. I found zinc ointment made with vaseline and a little carbolic acid of more use and better borne by the patient than any other application; in fact, it was the only thing that seemed to give relief from the excessive irritation, and from the time I commenced the ointment the disease seemed to fade. I used it very thickly, especially between the lips of the vulva. Internally, I gave quinine and iron, with abundance of strong liquid nourishing food and port wine. The bowels were relieved by saline aperients.

On my first visit I diagnosed the disease as phlegmonous inflammation of the labia, but as there was no formation of pus or abscess, and as the ulcerations increased and were gangrenous, with ash-coloured secretion and dusky-coloured skin, I saw that I had to deal with a more serious affection, which is not fortunately of frequent occurrence in Queensland—namely, noma. I believe now that this gangrenous inflammation of the labia was a sequela of the measles, as I since found that the child was neglected during the attack, and that she fell into a low state of health in consequence.

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