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THESSES AT THE PARISIAN CONCOURS.
[See page 27.]

ARGUMENTATIONS ON THE THESIS OF M. SANSON, BY MM. VELPEAU,
BERARD, AND GUERBOIS.

Remarks of M. Velpeau, and Replies of M. Sanson.
M. Velpeau commenced by an eulogium on the thesis of M. Sanson, which, he said, exposed the merits of the question he had to treat in a very clear and satisfactory manner. There were, however, several points which he expected to find noticed in the thesis, that were passed over in silence. Thus, for example, there was no mention of renewing the dressings frequently, as a means of favoring union by the first intention, although every one knew that it was the main object to keep the wound clean, and free from all irritating matters.

M. Sanson answered, that union by the first intention should be established more or less perfectly in two or three days from the first dressing; if union do not take place within that time, the wound becomes a suppurating one; now, as the first dressing always remains on longer than the time above specified, it was not necessary to mention the change of dressing as a means of favoring the union.

M. Velpeau said this might perhaps be true, if a complete and perfect union took place within the first few days; but as a perfect union of the divided parts never did take place, as the wound must necessarily furnish more or less suppuration, he thought the renewal of the dressings was a capital point of the treatment, and should not have been neglected.

M. Sanson returned to his former explanation. It was a matter agreed upon universally, not to remove the first dressings after an amputation, before the sixth day, unless some accident rendered it necessary. There was not a surgeon in Paris who did not conform his practice to this rule; now, as all that could be expected from union by the first intention must obviously occur within six days, he did not see the necessity of mentioning “renewal of the dressings;” the wound was either united, or had become a suppurating one, before the surgeon ever thought of changing the apparatus.

M. Velpeau.—There is another means of favoring union by the first intention which you have neglected to mention, although it has often been employed with success, and is, in my opinion, a secondary means of great value—viz. compression.

M. Sanson said that his experience led him to a conclusion diametrically opposite. He considered compression, and everything that might
tend to irritate the wound and disturb the process of union, as essentially bad; this was his reason for not mentioning compression.

M. Velpeau.—In page 13 of your thesis, you say, in speaking of conditions favorable to primary union—"It is necessary that the wound be recent. The shorter time the wound has remained exposed to the air, the more apt it will be to heal without suppurating. The chances of obtaining this mode of union diminish in proportion as the wound inflames, and fleshy vascular granulations spring up." Although this may be true as a general rule, it is not strictly applicable to all cases, and the exceptions should have been mentioned. Thus we may have a union of a wound by the first intention after granulation has commenced; besides, you have altogether neglected to speak of those cases where a suppurating wound has suddenly changed its character and united by the first intention, although the edges have remained open for five or six days.

M. Sanson considered the condition mentioned by him as one necessary for immediate union; where granulations are once formed, immediate union is quite impossible. As to the cases quoted by M. Velpeau, they were not examples of union by the first intention, at least according to the definition of the term which M. Sanson had laid down, and which he read, "The operation by which the surgeon places in contact the opposite points of a wound, to obtain adhesion without suppurating, or with the least suppurating possible." When a wound unites, after having remained open for four or five days, it is manifestly the union of a suppurating wound.

M. Velpeau.—In page 110 you describe a mixed method of treating wounds after amputations, which consists in placing lint between the edges of the wound, and allowing only the deep parts to unite by the first intention. You say this is the method recommended by Boyer, and also the same which M. Dupuytren and Larrey follow on some occasions. Now, if I am not greatly mistaken, M. Larrey unites his stumps at once, and M. Dupuytren certainly does not put a rouleau of lint between the lips of the wound; besides, at page 50, you condemn this very method, when you say "that taws of lint often act contrary to the purpose for which they are applied in stopping the wound, and cause a stagnation of the pus, &c." Your method therefore is merely the method of O'Halloran, and is condemned by yourself.

M. Sanson.—There is so little difference between the method which I have described, and that followed by M. Dupuytren, M. Roux, &c., that I am justified in classing them under the same head. I place the lint along the lips of the wound; they place it perpendicularly, extending from the bottom to the surface; the intention however is the same, to prevent an accumulation and retention of pus, and this method is applied only when the circular incision has been employed, not after flap operations; besides, wounds made while amputating, are different from other wounds, and require a special treatment; the remark in page 50, to which you object as a contradiction, was applied to wounds in general, not to amputations, which I have in my thesis distinguished from the former.

Remarks of M. Lisfranc, and Replies of M. Sanson.

M. Lisfranc's first objection was founded on a passage, page 29, in which M. Sanson speaks of the suture after amputations, and rejects this
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means, as likely to bring on irritation and contraction of the muscles through which the suture is passed, although Delpech has employed it with advantage after disarticulation of the extremities, &c. without experiencing the above-mentioned inconveniences. Here, said M. Lisfranc, is an error which should be corrected. Delpech certainly employed the suture after amputations, disarticulation, &c., but not in the manner which you have described; he carefully avoided passing the thread through the muscles, tendons, &c., and merely embraced the skin and subjacent cellular tissue. The ideas of Delpech on this point have been published, and you will find them in the thesis of M. Serre of Montpelier.

M. Sanson was obliged to confess his error after the authority quoted by M. Lisfranc. He had supposed that Delpech embraced the muscles as well as the skin in the suture. Perhaps he had been led into this error by what he had observed in Germany, where he had often seen the suture employed, and remarked that it failed whenever the muscles, &c. were comprehended.

M. Lisfranc did not mean to defend the process of Delpech, of which he was far from approving; he merely wished to correct the error into which M. Sanson had fallen, and concluded by stating, that a means upon which Delpech placed more reliance after amputations of the thigh than the suture, was to place an assistant by the patient, who kept up a gentle pressure on the surface of the stump for a considerable time after the operation. This he found to be the most efficacious means of preventing the convulsive retraction of the muscles which so often renders it impossible to keep the edges of the wound together. (The next point gave rise to a very warm discussion between the candidates.) In speaking of wounds of the head (page 67), M. Sanson says that they "are often complicated with pain, hemorrhage, and extension of the inflammation under the cranial aponeurosis, &c. These accidents are to be combated by the appropriate means, particularly by bleeding, proportioned to the age and strength of the patient." Often, says the author, leeches behind the ears, compresses dipped in cold water, sinapisms to the legs, with laxatives, have succeeded in preventing the development of inflammation in cases where it seemed most imminent. If, in spite of the well-directed use of these remedies, inflammation of the sub-aponeurotic cellular tissue should set in, we have nothing to do but at once abandon all hopes of uniting the wound, and make large incisions (deleridements) down to the bone. M. Lisfranc now attacked this practice very warmly, and denounced it as altogether faulty. In cases of inflammation under the cranial aponeurosis, it is not necessary to have recourse to incisions as soon as inflammation declares itself. The surgeon should first endeavor to combat the inflammation by local bleeding, and particularly by revulsions on the intestinal canal. This was the practice followed at La Pitié; the facts were well known, and it was demonstrated that the necessity of incisions was often dispensed with by a sedulous attention to the principles he laid down. M. Lisfranc quoted many cases in which he had succeeded in arresting the species of inflammation alluded to, by acting on the intestinal canal, &c., and concluded that M. Sanson was in
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error in confining his antiphlogistic treatment to a prevention of inflammation, and not continuing it after the development, reserving his incisions for cases where these means failed.

M. Sanson.—(This was an objection which M. Sanson found some difficulty of answering in a satisfactory manner, not so much from want of good reasoning, but because it was necessary to take the spirit of the passage rather than the actual words. He, therefore, commenced by reading the passage which we have quoted, amidst considerable laughter excited by the way in which M. Lisfranc pronounced at every third word, "bon, bien," &c.) M. Sanson remarked, that the employment of local bleeding, purgatives, derivatives, &c. was mentioned and recommended by him. If these failed, he saw nothing to be done, except to have recourse to incisions. From a strict interpretation of the words, it might, perhaps, follow, that he only used antiphlogistics to prevent the development of inflammation; but it was evidently understood that the preventive measures were to be continued after inflammation appeared; any surgeon would comprehend him in this manner.

M. Lisfranc said he did not know what M. Sanson might have had in his head, he only knew what was written in the thesis, and it followed from M. Sanson’s words, that as soon as ever inflammation of the cranial sub-aponeurotic substance set in, he had recourse to incisions, without using those general means which the practice of M. Lisfranc, at La Pitié, showed to be successful. In page 64 (M. Lisfranc continued) you blame the advice of Petit, who recommends the surgeon to make a counter-opening near the base of the flap, in wounds of the cranial integuments, in order to avoid the inconveniences which would arise from the accumulation of pus between the flap and the bone: you prefer the immediate application of the flap supported by compresses, sutures, &c. I cannot agree with your condemnation of Petit’s practice: the formation of pus between the aponeurosis and skull is a dangerous accident, which the surgeon should avoid by all the means in his power. Now when the flap is closely applied, and the dressings are left on for several days, there is great danger that purulent matter will accumulate under the integuments, become infiltrated into the neighboring tissue, detach the scalp largely, and aggravate all the accidents of the primary wounds. In some cases the distension by the pus thus confined has been so great as to lacerate the cicatrix of the integuments.

M. Sanson explained at some length the reasons for adopting his opinion. Like you, said he, I commenced by making a counter-opening, but I soon found that Petit’s method was neither necessary nor advantageous, and that it was much better to retain the part in perfect contact. It is evident, that the best means of preventing the pus from spreading under the fascia, is to prevent its formation altogether, and this is best attained by the method which I employ; besides, if pus begin to be formed, the surgeon cannot long remain ignorant of the fact. The patient suffers more than ordinarily, and complains of pain, tension, &c. The dressings are removed, and the existence of any fluid under the thin layer of integument which covers the skull is very easily ascertained. It is now time enough to make an opening for the discharge of the matter,
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and I think that we may advantageously dispense with the preventive incisions of Petit.

M. Lisfranc.—But if the patient suffer sufficiently to draw your attention to the wound, it necessarily follows that pus is already formed, and the mischief done which Petit's counter-opening would have prevented. Besides, you recommend a methodic pressure on the flap, but you do not confine this means to any peculiar kind of wound, as you should have done. To what kind of flap would you apply pressure, or would you use it all, indifferently? In cases where the base of the flap is very narrow, the circulation difficult, &c. (and this often occurs in wounds of the scalp), methodic pressure may interrupt the feeble circulation through the strip of flesh connecting the flap with the rest of the integuments, and tend to produce gangrene. Now all surgeons, wherever there is any fear of gangrene being produced, avoid the use of pressure, and have recourse to the suture.

M. Sanson said, that his remark applied only to cases where the base of the flap was large and extensive. When the wound is narrow, there is no occasion to employ pressure, as the parts have not the same tendency to retract and keep the edges of the wound open.

(The time here expired.)

Remarks of M. Berard, and Replies of M. Sanson.

M. Berard.—Our space will not permit us to give this argumentation at any length, although he made many of his objections tell. He commenced by repeating and enforcing an objection already offered by M. Velpeau, viz. that M. Sanson had altogether neglected mentioning the healing of wounds by the second intention. There were three principal forms in which wounds heal,—by the first intention, by suppuration and granulation, and by the second intention; this latter form was perhaps as frequently seen as either of the two others, and he had expected to see its advantages discussed.

M. Sanson remarked in reply to this, that it was not a question which he had to treat; besides, it came under the head of suppurating wounds. The next point was debated warmly.

M. Berard insisted that serous membranes were not vascular, and quoted Bichat, many modern anatomists, and several judges of the concours, who were of the same opinion.

M. Sanson answered that he had injected the free surface of a serous membrane, and that he desired no better evidence than his own eyes; he had also seen pathological preparations which proved the same fact; besides, he did not want authorities to support his opinion.

M. Berard, finally, reproached the author with an inconsistency, in saying at one time that the ligature tended to plug up the wound and retain the pus, whilst at another he said they served to conduct the fluids to the angles of the wound; besides, he had neglected to mention the method practised by the English surgeons, who, instead of assembling the ligatures in bundles, and drawing them out at the corresponding angles, bring each ligature down singly in a perpendicular direction; by this means the thread traversed the least possible space, and the irritation was, consequently, less.
M. Sanson did not seem well to understand this objection, for he denied the possibility of bringing all the ligatures perpendicularly out, and we left M. Berard constructing an equilateral triangle with the sides of the stump, the apex at the bone, the base inferiorly, and endeavoring, but in vain, to demonstrate to the surgeon of the Hôtel Dieu, that he could let fall any number of perpendiculars from the sides of the triangle upon the base. M. Sanson affirmed, in reply, that the perpendiculars would be all oblique, from which we concluded that he was a much better surgeon than mathematician.

MEDICAL PHILOSOPHISINGS.

REMARKS ON THE SENSES, SOMNAMBULISM, AND PHRENOLOGY.

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