OPERATIONS IN THE TREATMENT OF PALMAR ABSCESS.¹

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As a rule, the operation upon a palmar abscess consists in making numerous short incisions through the skin over the metacarpal bones. The operation is simple of execution, and by allowing the greater part of the pus to escape greatly diminishes the danger of further extension of the suppurative process. It does not, however, give the surgeon a chance to see and examine the true condition of the structures in the palm. Even with the free use of the curette, it is lacking in thoroughness, owing to the fact that in the greater number of cases many pockets of pus remain undiscovered and unopened.

The post-operative treatment of cases operated upon by this method is unsatisfactory, for the reasons that the openings are so small that gauze drainage is likely to prevent free drainage rather than favor it, and the

obtained by the old method. The operation consists in making a long incision following the natural furrows of the palm and in dissecting back the skin, thus converting the palmar bursa into an open pouch. The incision is commenced at the end of the transverse furrow, on the ulnar side, carried almost the entire length of the furrow, then carried across to the furrow which winds around the base of the thumb, and along this to the wrist. If necessary the incision can then be carried up the middle of the forearm. After the incision has been completed the skin is carefully dissected up from the palmar fascia and the flaps turned outwards.

With the palmar fascia exposed the whole area of the palm can be explored and the various pockets of pus can be seen and curetted. Free access is given to examine and, if necessary, open the tendon sheaths. There is little danger of cutting the larger vessels and nerves, for they can be seen and avoided.

removal and replacing the wicks during the daily dressing cause the patient considerable suffering.

The incisions themselves, owing to their number, location and direction in which they are made, are the cause of a great deal of the stiffness which is so commonly seen in the palms of patients who have had palmar abscesses operated upon by this method, as they leave scars which run at right angles to the natural folds and are generally firmly adherent to the deep structures. Such being the case it is next to impossible for the palm to fully regain its natural flexibility.

In view of these facts, any operation which would seem to offer the advantage of being more thorough, which makes the daily dressing less painful and tends to lessen the amount of subsequent stiffness, is worthy of consideration and trial.

For the past year I have used the following method of operating upon these cases, and the results have proved most satisfactory as compared with the results

After the operation is completed the bursa is packed with gauze which has been wrung out in hot bichloride solution (1-5,000). The skin flaps are allowed to remain outside of the packing. The whole hand is then done up in an antiseptic poultice.

As a daily dressing the poultice is removed and the whole hand, with the packing still in place, is put into a hot antiseptic bath for an hour or so. Either during the bath, or immediately after, the packing is easily removed and replaced without much pain.

After a week or two the structures in the palm become covered with bright red granulations. As soon as they appear the packing is no longer used, but the skin flaps are folded back and a dry dressing applied. Union takes place between the skin and the subjacent tissues. From day to day the edges of the flaps are drawn more closely together till they come to lie on nearly their original positions.

The diagram, "A," will give an idea of the course of the incision. The dotted line should have been made on the line of the furrows.

¹ Read before the Boston Society for Medical Improvement, January 16, 1899.

The second diagram, "B," shows how the flaps are to be turned back, and also shows how, by the splitting up of the palmar fascia, free access is given to the deepest part of the palmar bursa.

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PRELIMINARY NOTE ON THE PROGNOSIS OF NEPHRITIS.¹

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THE material upon which this study is based was obtained as follows:

From the records of the Massachusetts General Hospital for the last twenty years, the course and symptoms of all fatal cases of nephritis were noted, and the duration of each case, from the time of the first symptom to death, was estimated as accurately as possible. In addition to this, circulars were sent to the address of every patient who had left the hospital between 1880 and the present day, suffering from nephritis of any type. By means of these circulars, we attempted to find out the condition of the patients since leaving the hospital, and the date of death in the fatal cases. Only a portion of those to whom circulars were sent returned an answer, but the answers received were very instructive. All of the cases diagnosed in the hospital records as nephritis who returned any answer to our inquiries were followed up as carefully as possible, and in many cases the urine was examined. The number of these cases, together with the fatal ones, is 332.

In addition to these, we have a considerable body of data, sent us with great kindness by a large number of physicians to whom we wrote, asking whether they had ever known a case of chronic nephritis to recover, and also how long they had ever known a case of nephritis to last. This data furnished us details of 191 more cases, making a total of 423 in all.

We were stimulated to make the above investigations by the indefiniteness and disagreement of the statements in the text-books on the subject of the Prognosis of Nephritis, especially in its chronic form. Many writers show a strong tendency to hedge when it comes to the question: "Does a case of chronic nephritis, properly certified as such, ever recover?" Thus, for example, Rotch, in his "Diseases of Children," says of the prognosis of chronic nephritis: "Some cases, having the clinical features of the disease, have apparently recovered." Delafield, in the "American System of Medicine," says, under Chronic Diffuse Nephritis, "Recovery seems to be possible." Osler says that in chronic parenchymatous nephritis, recovery rarely takes place in a case that has persisted for more than a year, but occasionally in children, even when the disease has persisted for two years, symptoms disappear and recovery takes place. Senator,² speaking of chronic diffuse nephritis, says that termination in recovery is a rare exception, but undoubtedly occurs. He agrees with Rosenstein that these are usually cases which, after acute onset as a result of infectious disease or exposure, become chronic, and after one and one-half or two years, end

in recovery, the urine becoming entirely normal. An entire *restitutio ad integrum* of all the kidney tissue does not occur, but this is not indispensable for complete functional recovery. He also says that death is invariably the result in interstitial nephritis where the typical contracted kidney is developed, and the heart hypertrophy is marked. Recovery (functional) is possible, and under proper treatment is not rare in the first stage, that is, as long as no sign of heart or vessel lesion has developed.

Strümpell, in his last German edition, speaking of chronic diffuse nephritis, says that complete recovery undoubtedly occurs, but is rare. By the passage of the large kidney into secondary contraction "apparent healing" may occur, in which the subjective condition of the patient is almost entirely satisfactory. He considers chronic interstitial nephritis incurable, though life may be prolonged without any considerable unpleasant symptoms for many years. Bartels, in "Zeimsens' Encyclopedia," says that chronic nephritis is incurable after a certain time, but that cases have recovered even after months of dropsy. On the other hand, Brault in the "Traité de Médecine," says that in chronic nephritis the future is always sombre; sooner or later uremia or a complication leads to a fatal ending. Tyson, also, and Loomis, in the "Twentieth Century Practice of Medicine," say that cases never recover. In Albutt's System, and in Fagge, no definite statements are made on this point.

Under these circumstances, with such variety in the opinions of the foremost writers, our interest centered about the question: "Does a case of chronic nephritis, certified as such, ever recover?"

At this point it seems best to define what we mean by chronic nephritis and by recovery.

(1) We recognize two important types of chronic nephritis: (a) Chronic diffuse nephritis, and (b) interstitial nephritis.

(a) By chronic diffuse nephritis we mean a disease characterized by prolonged anasarca and effusions into the serous cavities, early and pronounced manifestations of uremia, such as headache, vomiting, and dyspnea, vascular changes, such as cardiac hypertrophy and a high tension pulse, and a pale urine usually diminished in amount, containing a large amount of albumin, with an abundance of fatty elements in the sediment.

(b) By chronic interstitial nephritis we mean a disease of insidious onset and long course, with comparatively early appearance of the vascular changes above mentioned, and little or no edema until the heart fails, with late and usually less marked uremic symptoms, a large amount of urine of low specific gravity, with albumin present in very small quantities if at all, and a sediment containing usually only a few hyaline and granular casts.

(2) We consider a patient to have recovered when he has no subjective symptoms characteristic of nephritis, and passes normal urine.

Defining our terms in this way, we have now come to the analysis of our cases, and taking first the data from the Massachusetts General Hospital records, we find that of the total 304 cases in which a diagnosis of chronic nephritis stands recorded on the books of the hospital, and which we have been able to follow up till death, or till the present time, there are only 17 whose urine and general condition show that the patient has really recovered. In most of these cases,

¹ Read at the annual meeting of the Massachusetts Medical Society, June 13, 1899.

² Senator: *Erkrankungen der Nieren.*