CARNEY HOSPITAL.

SURGICAL CASES OF DR. E. H. BRADFORD.

[REPORTED BY J. B. SWIFT, M. D.]

House-Maid's Knee; Direct Incision, with Antiseptic Precautions; Complete Obliteration of the Sac without Suppuration.—M. R., cook, fifty years old, entered the hospital September 16, 1877. The patient stated that she had had the same trouble with the knee before, but never so severe an attack as the present one. The knee became painful without known cause five days before entrance, and later red, tender, and swollen. On examination the characteristic tumor of house-maid's knee was found. The skin covering the swelling was red and brawny, and at a spot below the patella there was evidence of pointing.

An incision was made directly into the tumor. A bloody, serous fluid was evacuated, with little or no pus and no rice bodies; the skin incised was as brawny as the skin in a carbuncle. The wall of the sac was found to be very firm. No attempt was made to dissect out the sac; an incision was made on the outer side, and a drainage tube was inserted. The cavity was washed out with a solution of carbolic acid (one to forty), and the limb was placed on a ham splint. No stitches were inserted, as the skin seemed sloughy. The wound was dressed with antiseptic gauze, under spray, and the usual antiseptic precautions were used during the operation. The gauze dressing was changed in the afternoon under spray, as a slight amount of discharge had soaked through; on the following morning the dressing was again changed, and the cavity syringed out with a solution of carbolic acid. Temperature 98° F.

Three days after the operation the drainage tube was removed. There had been no suppuration and no elevation of temperature. On the eleventh day after the operation the dressing was removed. The sac was apparently entirely obliterated, although there had been no suppuration. The swelling and redness of the skin had disappeared.

Four days later the patient was discharged, being able to walk about perfectly well.

Papillary Tumor of the Perinæum.—C. D., fifty-four years old, a married woman, entered the hospital October 6, 1877. She stated that for the past seven or eight years she had been troubled very much with "piles." Six months previous to entrance she noticed that they had increased in size, and since then they had grown rapidly. At times she suffered severe pain, and she had lost considerable blood.

On examination a large cauliflower excrescence was found on the perinæum, six inches long, four inches wide, and projecting two to three inches above the marginal skin. The mass of the tumor was to the left of the anus, which was hidden by the overlapping lobules of the growth. There was a thin discharge from the surface of the growth, but no ulceration. Any interference with the growth caused hæmorrhage. The greater part of the tumor was connected with the skin by short and comparatively thin pedicles, but one portion was attached by a broad base, around which the skin was inflamed. The tumor

was composed of several lobules, which could be separated exactly as can be done with a cauliflower. A finger inserted into the vagina felt some thickening of the posterior wall, and an examination by the rectum gave evidence of a resisting mass in the left ischio-rectal fossa to the depth of three or four inches; the mucous surface of the rectum was not involved.

Under ether the various lobules were removed with an *écraseur*. No attempt was made to dissect out the portion of the tumor in the ischio-rectal fossa, as the extent and depth of the mass did not seem to justify it. The bleeding from the pedicles was readily controlled by perchloride of iron. There was no subsequent hæmorrhage. The patient, a few days after the operation, was able to walk about and sit down with more ease than before. A week later she returned home. Since then she has had no hæmorrhage, and writes that she has remained quite comfortable.

A microscopical examination of the part removed, as well as of a piece snipped from the mass in the ischio-rectal fossa, was made by Dr. E. G. Cutler. The structure of the portion examined was found to be that of a papilloma. It was impossible to determine, without further surgical interference, whether there was evidence of epithelioma in the remaining mass of the growth.

Separation of the Epiphysis at the Lower End of the Humerus; Recovery with Motion.—E. A., nine years old, entered the hospital October 1st. The patient stated that three days before he fell out of bed, striking on his right elbow. The boy was brought to the hospital with his arm in an internal angular splint.

The arm was examined under ether. The right elbow was found to be swollen. The radius and ulna were dislocated backwards and to the inside. There was no rigidity; on the contrary, supernatural mobility. The deformity could be reduced by extension, but immediately returned. If the humerus were grasped by the shaft and by the external supra-condyloid ridge, which could be felt easily, no crepitus could be detected. But a soft crepitus was felt on pressing just above the head of the reduced radius. No fracture of the ulna or radius or evidence of fracture of the coronoid process could be found. A diagnosis of separation of the lower epiphysis of the humerus was made. The arm was placed in an internal angular splint, with an external coaptation splint. On the 6th the bandages were removed. There being a slight lateral deformity at the inner side, a piece of pasteboard, well padded, was placed on the inner side of the arm. On the 18th firm union, with good position, was found; the arm could be flexed and extended to a slight degree.

Passive motion was applied twice a week until the 31st, when the splints were removed, and the patient was instructed to use the arm as much as possible. At this time the arm could be extended almost in a straight line and flexed to beyond a right angle.

November 7th. Patient reported that he could feed and dress himself, and brush his hair with his right hand.