most abused, and there is hardly a skin affection to which I have not, on and off, found that name being given. All forms of pruritus, sycosis, lichen, prurigo and many parasitical dermatoses are occasionally baptized with the always ready name, eczema.

The term lupus, too, is often used in a very loose manner. First there is rarely a distinction made between lupus vulgaris, that one form of local tuberculosis of the skin and lupus erythematosus, which has nothing to do with the other and ought better to be called according to Hebra sen, *seborrhœa congestiva*. Then, the natural history of lupus vulgaris is often ignored. Thus I saw a short time ago that diagnosis made in a man near the fortieth year, who had a pea-sized follicular infiltration on his nose, while it is the rule for lupus never to appear after puberty. In another case a young man, over 30 years old, had an indurated and superficially ulcerated sore on his lower lip of the size of a hazel-nut. He came to me pretty well scared, for during six weeks of previous treatment two prominent physicians had pronounced it as epithelioma, while another took it for lupus. My first question of this patient, after examining the trouble was, "When have you had a chancre," to which the prompt reply was given, "Ten years ago." The presence of a large scar on the chin, the absence of any cartilaginous induration on the borders of the ulcer and the considerable pain further pointed to the diagnosis of an ulcerating gumma, which was sufficiently proven to be correct by the result of treatment, which in the course of ten days caused the ulcer to heal up.

I could easily mention, from my own experience, any number of further cases, illustrating various diagnostical errors, but this would go far beyond the scope of this merely suggestive essay. We all know that mistakes will sometimes be unavoidable, not only in dermatology, but in all other departments of medicine; as long, however, as the patient gets well, all is well. To show, on the other hand, how treatment based upon a false diagnosis may be followed by almost disastrous consequences, let me give you, in conclusion, a few notes about a case, which impressed itself especially strongly upon my mind. A young widow from Boston came to Chicago, upon the solicitation of her sister, to place herself under the care of a physician who stands at the front of the homœopathic fraternity. She suffered from extensive ulcerations in her face, particularly the nose, cheeks and lips. The doctor and his assistant, after reading up the case, decided upon the diagnosis, lupus, and finding in their reference works recommended as one of the methods of treatment, thorough scraping and excision, proceeded to follow this line of action. During a year the patient submitted to twelve different surgical operations under chloroform narcosis, but

new ulcerations appeared, and the continued suffering almost made her a physical wreck. When finally her remarkable confidence and power of endurance had given out, she consulted Dr. I. N. Danforth, of this city, who kindly referred her to me. I found on her face about half a dozen smaller and larger ulcers, which showed the very characteristic horse-shoe form. The greater part of the upper lip was missing, having been excised, which made the closing of the mouth almost impossible, and the whole ala nasi of the right side had also been sacrificed at one of those "surgical" procedures. Numerous disfiguring scars, moreover, gave the face a very pitiable aspect. The fact could easily be ascertained that the lady had, some years ago, been infected by her husband, which was followed by various eruptions on the body, and also by iritis. How, with such an anamnesis and with the unmistakable, objective signs, syphilis could be overlooked, and in entire defiance of all that is known about lupus, this diagnosis made, is beyond my comprehension. The lady made a splendid recovery as far as the ulcers then present were concerned, which healed in two weeks and never again appeared in a year; but whether a plastic operation, which she now contemplates, will be able to restore the shape of the nose and the mouth, when no flexible skin is available in the adjoining parts, I doubt very much. I have no further comment to make upon this case, except that I succeeded in preventing the lady from beginning a suit for malpractice.

Let me finally assure you that the foregoing paper is presented with no ill spirit, but with the sincere wish to awake a little more interest in the somewhat neglected study of dermatology.

MEDICO-LEGAL RELATIONS OF LAPAROTOMIES.

Read before the Chicago Medico-Legal Society, Dec. 6, 1890.

BY J. H. ETHERIDGE, M.D.,

PROFESSOR OF GYNÆCOLOGY RUSH MEDICAL COLLEGE,
CHICAGO, ETC.

Abdominal Surgery is comparatively new, there is nothing settled concerning the method of performing abdominal surgery, that is, *absolutely* and *definitely* as compared with what may be said to be settled about the treatment of fractures and dislocations. Whenever a case of medico-legal interest finds its way into the courts concerning the treatment of fracture or dislocation, there is very little difference of opinion in the minds of surgeons concerning the treatment of these cases—and they constitute nine-tenths of malpractice suits—for the reason that the treatment of fractures and dislocations is nearly as old as the human family. Abdominal surgery cannot boast of this ancient lineage, but is so recent and new,

and so many innovations are coming in every day that it seems to me one might, after looking over all the would-be settled points concerning the technique of the operation, conclude that there is nothing very definitely settled. And when the President of the Medico-Legal Society, in the seductive way he has, asks a man to handle this subject in ten minutes, before an audience of this kind, I think he has thrust a herculean task upon that man. I cannot thoroughly go over the wide ground covered by this subject in ten minutes, but I will touch briefly upon the most important points.

First, it seems to me we are attackable in many ways concerning the subject of positive knowledge in diagnosis. There is nothing that is more easy to be deceived in than the diagnosis in abdominal troubles. One can operate a hundred times in succession upon the various cases that come along in abdominal surgery, and make a correct diagnosis in perhaps sixty per cent, and in the others he may not, but when a man has operated ten, fifteen—twenty times, and has not made a correct diagnosis, he begins to feel like the surgeon who said, he who makes a diagnosis after he opens the abdomen is the man who is most cautious and correct. So I think if a doctor should be brought up before the courts to answer for a faulty diagnosis—for the doctor, legally, is responsible for his diagnosis—and is made responsible on that account, that he is possessed of a very large loophole of escape, in that so many doctors are unable to make a diagnosis before operating.

So many things are involved in abdominal surgery that have to be gone over clinically, that I cannot pause longer than to make the barest mention of these points:

First is the condition of the hands and sponges; the hands of the operator, the hands of the nurse, of the internes, and everybody implicated in the operation. It is a settled fact that complete cleanliness is the only thing permitted, any doubt as to this makes the doctor reprehensible. The most perfect means of cleansing the hands and sponges should be required of the physician.

A point was made in a recent case brought up in the East, concerning the length of time of an operation. It was claimed that the doctor was too long, and the astounding evidence was given by one laparotomist, that resection of the intestine ought not to occupy more than twenty minutes. That evidence was very material with the jury, since the physician had been some three and a half hours getting through with the operation. I think it is safe to say that no man can do that operation successfully and safely under two hours, and a man who goes upon the witness stand and gives such evidence as that quoted above is exceedingly dangerous, almost as dangerous as the man who testified that a case of

puerperal fever was owing to the uncleanness of the attending physician.

Next, as to the time of operating, whether before or after supervention of reaction. In all ordinary cases of gunshot injuries and the like about the limbs, surgeons, generally speaking, desire to await reaction before operating, but in cases of abdominal wounds, where intestines are perforated and fixed organs injured, we know that collapse almost always follows at once, and to await for reaction here would seem to me to be waiting for peritonitis to invade the premises and make short shrift of the patient. I think any one giving testimony and saying we ought to wait for reaction in such cases, is a dangerous person.

We all know that it is only a few years since gunshot wounds of the abdomen were first operated upon, but dogs have been shot, under anæsthesia, and the intestinal preparations closed up and the dogs have recovered and lived good long lives afterwards. In this investigation the intestines were distended by hydrogen gas for the purpose of locating the holes in the intestines that could not be located by ordinary digital examination. To-day there are some men in the country who believe that we are as bound to operate upon a man who is shot in the abdomen as we are to operate in almost any plain case in ordinary surgery. Statistics are hard things to combat: The old-fashioned treatment was to put the patient at rest, giving opium, and letting him run along in that way until the intestinal wounds healed and he escaped the possibility of fatal peritonitis; if he got well—well; if he didn't—ill; that was about all. Statistics in the State of New York, for the last ten years, compiled by skillful surgeons, show eighty-four cases of intestinal perforation by gunshot wound operated upon with a mortality of eighty-three per cent. In the preceding ten years the number of cases treated, not by operation, resulted in a mortality of only thirty-five per cent. Therefore I think the man who goes on the witness stand and says this patient with an intestinal gunshot wound should have been operated upon by the surgeon in attendance, that he should not have waited to take the old course, is very dangerous.

Now a few words concerning the incision: As a rule the incision should be as short as possible, still there are cases where the incision should be made from the pubes to the ensiform cartilage. So when a man says there is any cast iron rule in regard to the operation he doesn't know what he is talking about, and is giving misleading testimony.

Another point is concerning the pedicle, whether it be ovarian cyst or uterine fibroid. In years gone by, but not so very remote, the pedicle used to be treated with a clamp outside of the abdomen. Twenty years ago that was classical

treatment; to-day it is not. It seems to be pretty well settled in the matter of ovarian tumors that the treatment of the pedicle should be by ligature, and accordingly we will find that all cases treated by ligature will be good surgery, and the man who attempts to treat by the clamp outside would not be judged a good surgeon by the medical profession, and on the witness stand would be handled pretty badly; there is but one opinion in regard to the treatment of the ordinary ovarian pedicle in laparotomy. But there is a variation of opinion concerning the ligatures; some use Japanese silk, some Chinese silk; some plain and some braided silk. Some operators are so strenuous that they will operate only with one kind of silk, while others will only operate with catgut. I saw a gentleman in the East a short time ago, who believes that all the ovarian pedicles should be treated by catgut ligatures and nothing else, for the reason that suppuration may follow the use of silk whereas catgut is absorbed. That man going on the witness stand with this kink in his mind would testify very strongly against any one who used silk ligatures.

In regard to the treatment of the pedicle of uterine tumors, in cases of myomectomy there are two ways, one is to treat the stump in the intra-peritoneal way, and the other is the extra-peritoneal way. One making a covering of the peritoneum over the stump, stitching it tightly and dropping it back; the other is to bring it forward, anchoring it to the abdomen and letting it slough off. These two methods are very satisfactory, but they both have their defects. We are in a stage of transition concerning all these things.

Concerning ligatures: Not only in the abdomen, but for the treatment of the wound silk is used a very great deal, and so is catgut externally; the majority of the profession I think use nothing but silk, and they use the silk with one sweep through the mural tissues on both sides of the incision in that way including in the loop the skin and all tissues to the abdominal cavity. Another way to close the abdomen is to make three banks of stitches, first sewing the peritoneum down, then running the same ligature back again taking the connective tissue and the muscles through up to the upper angle of the wound, and then, with silk, bringing the skin together in three banks of stitches. I saw a gentleman who had done this operation a hundred times and never had had a hernia, and he believes that is the classical way of doing it; if that man should go on the witness stand and give evidence he might hurt those of us very much, whose method, varying from his, chances to be followed by a ventral hernia.

The toilet of the peritoneum is another point we will consider. In abdominal surgery absolute cleanliness is required, any uncleanness is reprehensible; I think there is but one opinion

on that point. Next, in regard to drainage, shall we drain or not? I believe there are cases appropriate for draining, and cases that do not call for it, but we will find that a drainage advocate will claim that all cases should be drained. But the man who is best posted on this question will on general principles usually have as little foreign substances in the abdomen as possible, and for this reason: The pressure of the organs against the drainage tube permits the formation of a fistula, and in that way we have intestinal fistulas opening into the abdomen followed by peritonitis. So you see there is something to be said against the drainage tube. I think in some cases a good method of drainage is through the vagina.

In regard to the after-treatment a great deal can be said. I can scarcely stop to go into the details, but on the first day after a laparotomy the fear of hæmorrhage is entertained, and on the second day the well-marked symptoms of peritonitis may come on, and if the physician is ignorant of this he may not employ the usual means of treatment. On the third day we are likely to get sepsis, and the man who does not know about this fails to recognize the condition, and in that way the patient may die, and this may lead to a mal-practice suit.

All that can be said about these cases is that very little comparatively is well settled in regard to them.

DR. C. T. PARKES: It is hardly necessary for me to occupy your time on a subject which has been handled so perfectly by Dr. Etheridge. He has opened so many questions for discussion that it would be impossible to go over them all if we talked a month. I agree with him entirely in the rather positive assertion he makes that doctors are dangerous men, and they are more dangerous to themselves than to most other people. Especially is a doctor a dangerous man when he gets to be a very positive man, when he has had so much experience as to get into a rut; has had so many successful cases that he knows he is going to have a good result—and perhaps does generally get good results whatever the case. And that brings to us the thought that the method of doing things is of immense advantage. It does not make any difference whose method it is, the thing for the individual to do is to make it his method, and if he knows all about it—all about its peculiarities—that method is going to succeed. Medical men who get into the habit of being dependent upon themselves as to their methods will, I am sure, get better results by that means than by any other, but when they do that, they should always feel that it is owing to the fact that they have practiced in this way that they have become successful, and should believe that their friends and associates with other plans are doing as well as themselves.

I am interested a little bit in the subject of gun-shot wounds of the abdomen. I do not believe in statistics; you can prove anything by statistics, even a fact. I am quite sure that Dr. Etheridge in his quotation of statistics has taken them from the monograph of friends of mine in New York, Drs. Stimpson and Manley. Apparently they have collected all the bad cases, and, just so as to not make it too bad, they have put in a few good cases. People would not believe them if they said all the cases were fatal. That is all right. Doctors are apt to make their side of the question the most reasonable side if they can; that is all right too. There is no question but that the doctor is responsible always when he takes human life in his hands, but there should be a little liberality shown him when he takes a case of this kind, in which the life of the individual is absolutely gone, as in the vast majority of cases of gun-shot wounds of the abdomen; certainly if it is a fatal wound, he should not be blamed if occasionally he happens to lose a case of gun-shot wound of the abdomen.

The profession is apt to be elated about every thing a little new, and go wild over it, and the same is true with reference to operations for gun-shot wounds of the abdomen. When laparotomy for this injury was first advocated by myself, everybody began to operate upon individuals who had received gun-shot wounds without remembering that he who advised this method of opening the abdomen to treat these injuries had asserted positively that in his belief the majority of gun-shot wounds of the abdomen were fatal. The fatal injuries were not the ones we were after, but cases like the ones we often met with in hospital experience, in which the patient dies, and upon a post-mortem examination it was found that there was only a small wound, or two or three holes in the intestines which caused death, and they were separated from security only by the thickness of the abdominal walls. No man can tell what is done in the peritoneal cavity when a bullet has penetrated it until it has been opened; and while we must ask our legal friends to be a little liberal with us in these cases, I certainly agree with the author of the paper, that the item of abdominal surgery is entitled to more support from the general profession than perhaps that in connection with any other part of the body. It is the *terra incognita* of surgical practice. All general surgeons know how impossible it is for us frequently to tell the character of a simple tumor beneath the skin, and how are we going what is the character of a mass in a person's abdomen that fills it to such distension that we can find no signs of the existence of the ordinary organs in it? And how is a man to tell of those conditions which produce death many times, and yet are so simple in their specific development that they cannot be discovered without

opening the abdominal cavity? A doctor always takes a risk, and that is part of the nobility of the profession.

DR. W. E. CLARKE: At this late hour the only thing that I wish to refer to in the matter of abdominal surgery is the size of the incision. In my opinion, more injury can be done through a small one, in consequence of the shock produced by the traction and the abscesses that might result from the bruising of the parts, than would follow if the opening were sufficiently large to enable the surgeon to operate readily and with less violence.

DR. ETHERIDGE, in closing the discussion said: I have nothing additional to say beyond mentioning a characteristic case that recently came up in the courts. One man shot another and was taken and held until the result to his victim could be ascertained. The wounded man was taken to the hospital and had the holes in his abdomen sewed up and promptly died. The case came to trial and the defence was that the man came to his death at the hands of the surgeons. Thus we see that matters *may* assume a most grave aspect in abdominal surgery, and which at once put medical men upon their metal to defend themselves. I mention this circumstance to show the indirect possible bearing of legal responsibility in laparotomy.

A REMARKABLE CASE.

BY W. J. GALBRAITH, M.D.,

PROFESSOR CLINICAL SURGERY, OMAHA MEDICAL COLLEGE; VICE-PRESIDENT NATIONAL ASSOCIATION RAILWAY SURGEONS; VISITING SURGEON ST. JOSEPH'S HOSPITAL, AND CONSULTING SURGEON IMMANUEL HOSPITAL, OMAHA, NEB.

Incredible as it may seem, I trust the readers of THE JOURNAL will not consider me a fit subject for an insane asylum in reporting what I sincerely believe to be a fact. I most cordially invite any member of the profession to examine this unique pathological freak with me and trust you will avail yourself of the invitation. I fully appreciate the amount of criticism I will receive in reporting this case, and I realize that you will take the same version of the case that I did before I examined her. Notwithstanding I had good authority regarding her malady, I could not for an instant entertain the statements in any other light than those applied to a case of pure and adulterated deception; but since my examination and two months constant care I have changed my views, and feel that I am fully prepared to substantiate my statement by submitting the patient to any examination or test you may choose to make, and, moreover, I trust that many of you will feel sufficiently interested in this case to make a personal examination.

Mrs. M., aged 26, married five years, mother of one child two years old, medium height, light