thread a needle. There is no statement as to mental condition. She recovered from the second operation, but it is too early to judge definitely of results.

In *The Medical News* of January 3, 1891, Dr. Trimble, of Baltimore, reports the case of a child, 3 years of age, whom he trephined on November 8, 1890. On the right side of the middle line two buttons of bone, 1 inch in diameter and $\frac{1}{2}$ inch apart, were removed, so that the opening measured $2\frac{1}{2}$ by 1 inch. Some improvement was noted on December 6, 1890.

I have not included these cases under the head of linear craniotomy, since it seems to me that they should be considered simply cases of trephining for microcephalus and idiocy, as has previously been done by Fuller and others. The essential difference between trephining and linear craniotomy is this: that in linear craniotomy the intention is to make the entire side of the head a *bony flap*, as it were, whereas the trephining in the cases alluded to simply removed two buttons of bone and the intervening bridge, and so produced a difference in pressure and possibly allowed, simply at the point of trephining, a little bulging of the brain itself. As to the results, so far as the brief time in all the cases will allow us to judge, they seem to be quite as good after trephining as after linear craniotomy proper, and if so, it may be a matter of indifference which is done. But at the present time it seems to me more logical to do the craniotomy than the simple trephining.

The operation of Wyeth seems to me unwise, and likely to be followed by a fatal result in more cases than if the less heroic method usually employed is followed. Even this has resulted in two deaths already, and if a double operation is done and the two sides of the cranium are forcibly separated, the danger would seem to be far greater. The dura might easily be torn, especially as it is so adherent in children. Moreover, the brain cannot suddenly follow the widening bone, but must be persuaded, as it were, to occupy a larger room by favoring its gradual growth. This, I think, is better obtained by the process I have followed than by Wyeth's method. The same remarks apply to McClintock's case.

A SYSTEM TO DEFRAUD INSURANCE COMPANIES.—There is said to be a gang in Paris, the members of which thrive at the expense of the insurance companies. Their plans are simple. A man lets himself be run over. The driver is his accomplice. The authorities are appealed to. An insurance inspector reports on the case, making the slight injury sustained appear a very serious one. The profits are divided up. As occurrences like this became frequent, suspicion began to be aroused. The result ended in the imprisonment of sixty-five members of the gang.

DISLOCATIONS, UPWARDS AND BACKWARDS, OF THE SCAPULAR END OF THE CLAVICLE.

Read in the Section of Surgery and Anatomy, at the Forty-second Annual Meeting of the American Medical Association, held at Washington, D. C., May 5, 1891.

BY WM. H. DOUGHTY, M.D.,
OF AUGUSTA, GA.

In the July No. of the *Richmond and Louisville Medical Journal* (now *Gaillard's Medical Journal*), for 1876, I published an article entitled:

"True Method of Treating Dislocations, upwards and backwards, of the Scapular end of the Clavicle, with report of a case illustrating the principle employed."

According to standard authorities such injuries are rare and their treatment extremely unsatisfactory. Since 1876 I have seen but two cases, both of which occurred within a few months of each other in 1888: one in my own practice, report of which accompanies this paper; the other in that of my friend and neighbor, Prof. Thos. R. Wright, of this city, through whose courtesy I am permitted to refer to it, and report an excellent result from the method of treatment given herein.

My first case was published in illustration of a new principle in the management of such injuries, and it was thought that the simplicity of the treatment and its satisfactory result would at least claim the attention of the surgeons, if not their approval of the principal then first enunciated. I am, however, not aware of its employment, or even recognition by others, a fact that induces me to present it before this body on this occasion, with two additional cases, perfect in their results, to support its claims to confidence and adoption. Hamilton, in sixth American edition of his great work on "Fractures and Dislocations," Wyeth, Ashhurst (*Encyclopædia of Surgery*), still detail the old imperfect methods.

The wood-cut given with the first case was intended to show the position of the arm, mode of dressing for maintaining this, and the permanent reduction and retention of the displaced end of the bone. It was a poor "cut," a libel on an excellent photograph from which it was made, taken soon after the dressings were applied. The photograph accompanying the present report shows the *result*, having been taken six weeks after the injury; the loose worn bandage bespeaks its own superfluity, having been used longer than was actually necessary to prevent the premature use of the arm by a thoughtless youth. As to the permanency of this result, I may report that an examination of the parts in March, 1891, nearly three years after treatment, revealed an altogether satisfactory condition. I wish also to state that a similar examination of my first case after the lapse of twelve years

showed a reproduction of the displacement, although at the time of discharge of the case it was fully restored as then reported. This fact suggests the necessity of restraining the early, free use of the limb with laboring men as an additional protection against the return of the luxation. The acromio-clavicular articulation is perhaps one of the weakest in the body, surgically speaking, and may need therefore greater attention in this particular, especially with adults, subjects of injury.

Of the three cases now reported under this method of treatment two give unquestioned

backwards against the side of the chest, thus stretching to the utmost the fibres of the deltoid arising from the outer third of the clavicle, and antagonizing the trapezius whose vigorous action maintains the displacement; and further, rotating and fixing the scapula by drawing upon its attachments (muscular and otherwise), to the humerus. The arm is then secured firmly and immovably by wide strips of adhesive plaster encircling the body and arm.

Injured June 1st, 1888. Photographed July 13th, 1888 (6 weeks), when bandage was removed. Illustrates result.

satisfactory and permanent results, while under former methods the latter were so rare that Hamilton says: "my notes furnish only *two* cases of perfect retention after a complete dislocation at this point" (p. 566), having recorded forty-one cases in all.

For the benefit of those who may not have read the former article on this subject (copy of which is enclosed herewith), the principle referred to, briefly stated, is as follows: *In lieu of direct pressure on the displaced end of the clavicle, made by pads, straps, bandages and other similar devices for retaining the same in position, it is suggested to draw the arm forcibly downwards and*

Illustrates position of arm, mode of dressing for maintaining permanent induction, etc.

It is not necessary to encircle the arm first (see photograph of first case) and then the body and arm together, as there is liability when this is done to great tumefaction of the forearm and hand, as my second case developed.

A little reflection will satisfy the thoughtful that there is gained by this mode of management, as nearly as possible, the immobility of the scapula, the requisite antagonism of the trapezius by the deltoid, with the consequent replacement and retention of the displaced bone.

All of the structures about the shoulder-joint, thus drawn upon, aided by the substantial leverage of the humerus when pressed upon the side of the body, sustain the deltoid and contribute to the result. Moreover, the rotation of the scapula rather relaxes the fibres of the trapezius inserted into the spine of the scapula, while those of the deltoid arising therefrom are pulled upon. The position of the end of the clavicle, no longer free to move, is the mathematical resultant of the operation of these opposing forces, now equally balanced.

Thus, quoting from my former article, "by this simple mechanism was beautifully illustrated that cardinal principle in the surgery of dislocations, namely, that their safe and proper reduction and treatment can best be secured by a careful study of the muscular action that maintains the displacement (a factor in its production also), and the relations of the muscles that normally antagonize it." (P. 4).

By this plan of permanent adjustment the shoulder is left open to inspection at all times, and the bungling, irksome apparatus of every kind, heretofore employed, is dispensed with.

Report of Case.—On June 1, 1888, Herbert C., about 14 years old, was thrown from a road-cart, violently striking the right shoulder; was immediately disabled thereby, and complained of great pain in the shoulder and inability to move the arm.

An examination showed, besides a contusion of the soft parts about the shoulder, a dislocation upwards and backwards of the scapular end of the clavicle. The extent of the luxation was sufficient to produce a bulging of the fibres of the trapezius, very distinct, when viewed from all directions. Dislocation was easily reduced and bone maintained in position by method detailed elsewhere. Result was entirely satisfactory as will be shown by accompanying photograph taken on July 13, six weeks afterward.

SUGGESTIONS ABOUT ABDOMINAL AND PELVIC SURGERY.

Read in the Section of Obstetrics and Diseases of Women at the Forty-second Annual Meeting of the American Medical Association, held at Washington, D. C., May, 1891.

BY WM. H. WATHEN, M.D.,

OF LOUISVILLE,

PROFESSOR OF ABDOMINAL SURGERY AND GYNECOLOGY, KENTUCKY SCHOOL OF MEDICINE, ETC.

The recent contributions upon abdominal and pelvic surgery are probably more numerous and practical than upon any other department of general or special surgery; still, there is a variety of opinion as to the best methods of treating pathological conditions within the peritoneum, or as to the immediate or permanent results of the many procedures that have been practiced.

This is especially true of pelvic surgery, where we find, in the practice of the most experienced and successful operators, accidents during the operation and complications following it, for the prevention of which, there is no united opinion as to the correct technique to adopt; nor is it always possible to explain why troublesome complications occur in one case, and do not occur in another apparently similar case. Careful observation and experience may finally teach us much wisdom in these matters, and I will ask your kind indulgence while I briefly allude to a few things that may be of value, if carefully discussed by the members.

There is too much laparotomy done and too many men are doing it; men who know too little about the diagnosis and pathology of abdominal or pelvic diseases, or about the best technique in operating, and have few facilities for doing such work. Continuously good laparotomy work cannot be done except by men who largely devote themselves to this department of special surgery, and with such men some cases are operated on where the indications do not justify it. The appendages are sometimes removed for vague nervous troubles, where there is no disease of the ovaries or tubes, or peritoneal adhesions. Such cases are made worse, and are mutilated in a way that cannot be corrected.

The pendulum has swung too far, but many of our best operators are earnestly urging upon the medical profession that the operation is not indicated except in cases where there is well defined disease that has resisted, or will resist, other more conservative means.

As the experience of an honest surgeon widens, he operates relatively less frequently, and he can recall cases that he does not believe should have been operated on. An honest, intelligent and careful man may, when young in observation and practice, make mistakes in the selection of suitable cases for laparotomy, but this is less frequent than it was a few years ago. It is criminal to do dangerous or capital operations while ignorant of the best methods of doing such work, or for the purpose of adding a little cheap glory to our reputation; or to report cases that apparently recover from the immediate effects of the operation as permanently relieved before the final results can be appreciated. Such men usually have many bad results or deaths that they do not report so promptly, and the profession, or the people, seldom hear much about them.

I have reported but a small minority of my successful cases, but have promptly reported my bad results or deaths, because by a careful study of such cases, we finally do better work, by learning how to avoid or prevent complications or accidents that may cause the death of our patient. Reported recoveries in simple cases of laparotomy do not always indicate superior or unusual skill in