

Is it not better to seek for combinations, by means of which we can remove this last objection, in admitting them to the benefit of anæsthesia, deprived of the inconveniences and dangers which it presents in certain cases. As for us, here is the plan which we have adopted.

In the case of ablation of the tonsils, which we choose, for example, because the operation is frequent in young subjects, well disposed by their age for the application of anæsthetics, not only by reason of the fright which is inspired at the idea of all operations, but still more, and principally, by reason of the facility with which we can determine in them the desired result by chloroform. If during the anæsthetic state we could contrive to place two amygdalotomes, one upon each tonsil, to pierce at first each of them with the little fork of the instrument, which produces scarcely a few drops of blood, then in this state of things, waiting for the moment when some spontaneous manifestations indicate the awakening close at hand, we could then make their simultaneous section, with a rapidity of execution peculiar to this operation, and remove the two tonsils before the return of painful perceptions, and yet at a moment when already the patient is in a position to expel the blood which falls into the throat. We must remember that the tendency to expel from the mouth liquid bodies is, so to speak, increased by chloroform; for there are hardly any subjects who, under the influence of this agent, do not expectorate to an extent sometimes very disagreeable to those who surround them. To which we must add, that the patient lying in the horizontal, or half-oblique position, should be inclined upon the right side immediately after the section of the tonsils, in the attitude which is taken spontaneously by the sick who are so weak that they cannot sit up to vomit—a position directed for the asphyxiated by submersion, in order to facilitate in them the expulsion of liquids from the air-passages.

No accident has marked the results of several operations for removal of the tonsils, proving, according to us, that by means of precautions easy to take, one can, without any danger, allow patients, who have to submit to ablation of the tonsils, to participate in the advantages of anæsthesia. We shall, no doubt, discover within a short time, many other applications of this principle of "*demi-réveil*" immediately before the direct action of the cutting instrument in operations upon the throat, the tongue, and the nasal, buccal, and pharyngeal cavities. Lately we have acted in the same manner, and with full success, in a man, aged fifty-two years, upon whom we have performed amputation of the tongue.

[Speaking of two cases of ablation of the tonsils performed by two French surgeons, while the patients were in a state of complete anæsthesia, M. Chassaignac says,—]

At present, and after the deplorable accidents which have arisen in certain cases from the employment of chloroform, we should be far from counselling a like mode of operating; we will say more, it would appear to us superlatively imprudent. To employ chloroform upon a patient in the sitting posture, and an operation of this kind, under the triple imminence of syncope, asphyxia, and hæmorrhage into the interior, would be braving the dangers which, on the contrary, we have always endeavoured to avoid, by the minute precautions which have been the object of our assiduous researches. Thus we do not hesitate to proscribe, in these operations upon the throat, commencing anæsthesia, and still more, anæsthesia carried to a state of collapse; it is only at the moment when it is about to cease, and when one could certainly depend upon the return of the patient to spontaneous action, that we admit of its employment.

## NOTES ON THE BRUIT DE POT FÊLÉ.

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THE diagnostic value of the *cracked-pot sound* has been variously estimated by different auscultators. Some have regarded it as certain evidence of a pulmonary cavity; others have connected it with a variety of very different diseased conditions; whilst some have even doubted its pathological significance.

This diversity amongst a number of observers, equally cautious, perhaps, and competent, finds, I believe, a ready explanation in the circumstance that all are not agreed as to the sound itself, certain percussion sounds being designated by some auscultators as *bruit de pot fêlé*, which, according to

others, have no claim to such a title. Of this I have abundant evidence in the wards of the Consumption Hospital, where, upon a supposed instance of this sound, it is common enough to hear as many different opinions as there may chance to be listeners.

I might here state, as it were, parenthetically, that the *cracked-pot sound* is not the mere auscultatory refinement which some have been, and even still are, disposed to regard it. Not unfrequently it is a real and valuable auxiliary to diagnosis, coming to our aid where other physical signs are few and indistinct. It is a mistaken notion to suppose that other proof of the existence of pathological changes, sufficient to give rise to the *bruit de pot fêlé*, must be necessarily clear and unequivocal. Cases now and then occur, and I shall presently advert to them, in which this sound may be the sole reliable guide to the condition of the patient.

It would be unnecessary, even if it were possible, to describe the *bruit de pot fêlé*. It can, in truth, only be learned by the ear. To distinguish it is not, however, always so easy as is imagined; while, to elicit it clearly, attention to certain rules, as well as careful percussion is generally essential. The finger, which for this purpose is the best pleximeter, should, according to my experience, be firmly placed between the ribs, and the percussion stroke should be delivered sharply and quickly. The patient should be directed to open the mouth, and to look rather towards than away from the auscultator. Except in very rare instances, there is no *bruit* whilst the mouth is kept closed; and even when widely open, the sound is oftentimes not evident to the auscultator, if the patient's head be turned away from him. My attention was drawn to this latter peculiarity by observing that, in some cases, if a patient known to have a *bruit de pot fêlé*, happened, when under examination, to turn his face away from me, the sound became indistinct and sometimes even inaudible, whilst to a bystander on the other side it became more and more evident. The *bruit* often ceases to be heard after the first percussion stroke, and by no effort can it be reproduced until after an uncertain but sometimes considerable interval; occasionally it requires two or more strokes to produce this effect; but even when most fully developed it will generally be found that continued percussion fails to elicit it so distinctly as at first. The true *cracked-pot sound* is, to my ear, always suggestive of *emptiness*, associated with more or less *jarring and metallic* ringing.

Certain modifications of the percussion sound, which has been so happily termed *wooden*, not unfrequently bear a close resemblance to the *cracked-pot sound*; and to this circumstance may probably be attributed the uncertainty and variety of opinion with which the subject has been beset. So close, indeed, is their resemblance, that it oftentimes requires some amount of practical experience to distinguish them. The difference, however, between the two, is, I think, quite as apparent as it is important. The *wooden* sound will invariably be found to be more dull, more resisting, less jarring, and *free from the metallic ring* so characteristic of the other. Unlike the true *bruit*, it remains unaltered under repeated percussion; and although, perhaps, more fully developed when the mouth is open, its peculiar *quality* remains unchanged.

The pathological conditions giving rise to the variety of *wooden* sound which thus simulates the *cracked-pot* one are, partial consolidation of the pulmonary tissue, and pleural thickening, with contraction. The latter is, I believe, by far the most frequent cause of it. Perfectly solid matter, or complete consolidation of the pulmonary substance, is insufficient to give rise to it; there is always, when it exists, a more or less admixture of vesicular tissue, and to this circumstance the peculiarity of the note is evidently attributable.

I have never heard the true *cracked-pot sound* as a *pathological indication*, except in cases of pulmonary excavation. To my ear, the *bruit* is always (with the exception presently to be mentioned) the prophetic knell of the poor patient.

If the jarring *wooden* sound, which, as I have just stated, betrays other and very different conditions of disease, be still regarded as a *cracked-pot sound*, the subject must stand thus: we must admit varieties of the phenomenon, and must say that there is one kind indicative of pulmonary cavities, and other kinds peculiar to other diseases. It is, however, far better not to call any sound the *bruit de pot fêlé* which is not unmistakably so; and if this be adhered to, and if the ear be once familiarized with the true sound, it will, I am convinced, become an unerring guide to cavities in the lungs.

The only exceptions to such a rule exist occasionally in young subjects, even when in a healthy condition. Some years back, whilst percussing the chest of a child five years of age, apparently in excellent health, I was not a little surprised at eliciting

ing a well-marked cracked-pot sound, undistinguishable from that of a large pulmonary cavity. Since then, I have carefully watched for the same phenomenon, and have met with it little less than a dozen times. It is most noticeable in children under or about the age of six years, although it is far from being limited to that period, for I once met with it highly developed in a boy twelve years old. I have never been able to produce it unless the child's mouth has been widely opened, and have invariably noticed that where it has been most evident the percussion-sound, whilst the mouth was closed, was of a resisting, jarring, and *wooden* character, bearing, in fact, a strong resemblance to the wooden note already spoken of as mistakable for the cracked-pot sound. I have frequently noticed this jarring sound in the chests of children *unassociated with the bruit*, and believe it to be of very common occurrence; it is most evident whilst the mouth is kept open, and most frequently found in children with thin and flat chests. In emphysema, as well as in some cases of chronic bronchitis in young subjects, the bruit de pot fêlé is occasionally met with; under the latter, I have noticed it on three or four occasions, and a striking instance of it lately occurred to me in the person of a boy, thirteen years of age, affected with emphysema and chronic cough. I have also met with it in phthisical children, where, as is often the case, patches of tubercular lung have been surrounded by healthy but probably hypertrophous tissue.

The mechanism of the bruit de pot fêlé is not, perhaps, very easy of explanation. A peculiar condition of the thoracic wall is probably essential to its production, or it would be elicited in every instance of cavities of similar character known as favourable to its development, which is very far from being the case. Thinness, flatness, and flexibility of the corresponding parietes are favourable, if not necessary, to its existence. The cavity must be of some size, and must freely open into the bronchial passages. The smallest vomica in which I ever detected it, was afterwards ascertained to have been little larger than a pigeon's egg; but, as a general rule, the more extensive the cavity the more distinct the bruit. The sound seems to be produced by the sudden expulsion of the contained air, and reaches the auscultator chiefly through the patient's mouth: the former being proved by the necessity (except in very rare cases, where some peculiarity in the nasal opening would appear to answer the same purpose,) of the mouth being opened; and the latter, by the frequency with which the sound escapes detection when the patient's face is turned away from the auscultator. The occasional occurrence of the bruit in healthy children lends additional force to such an explanation of the phenomenon. We have in children the thin thoracic wall and the free opening into the bronchial tubes. The comparative largeness of the pulmonary cells in early life, the great elasticity of the lung tissue, and the freedom of both respiratory acts, would indeed almost justify our regarding the chest of the child as a large pulmonary cavity. Such conditions of course vary in degree in different children; but it is not surprising that, where they are most developed, we should sometimes find the cracked-pot sound.

I have already stated that the bruit de pot fêlé is not unfrequently a useful aid to diagnosis. Being limited to the seat of its production, it will, in many instances, enable us to mark out the size and direction of the cavity. When vomicae are very large, and so simulating many of the physical signs of pneumo-thorax that the one condition might readily be mistaken for the other—an occurrence which has several times presented itself to me at the Consumption Hospital,—the bruit de pot fêlé, should it exist, will serve at once to distinguish between them. None but the inexperienced in auscultation can affirm that a pulmonary cavity is always easy to detect. It happens now and then that the sibilant or sonorous rhonchi of an accompanying bronchitis completely mask the tubercular signs. In cases also of every chronic phthisis, especially in old persons, a cavity, although of some size, may easily escape detection, owing to the absence of secretion, combined with the old and inelastic state of the walls giving rise to but few, if any, of the usual signs of such a condition. In cases like these,—and I can call to mind three or four such,—the cracked-pot sound may come to the rescue: I remember three cases in which it was the only thing which enabled me to declare with certainty that a vomica existed; and in all of these, post-mortem examinations proved the accuracy of the conclusion. It is not therefore a mere refinement, but a sign which may not only be confirmatory of others, but may sometimes be used of itself as a means of diagnosis.

The following are the conclusions at which I have arrived:—

1. The true bruit de pot fêlé is, in the adult, a certain sign of pulmonary excavation.

2. It is occasionally met with in *healthy* children, as well as in young subjects affected with chronic bronchitis or emphysema. It is also sometimes to be found in phthisical children during the first stage of their disease.

3. It is easily and very frequently confounded with another percussion sound, which is indicative of very different pathological conditions.

Let me therefore plead for the old bruit de pot fêlé. It has often served me, and I am convinced may be useful to others. Let it not be thrown aside as a vague and unmeaning sign; rather let its difficulties, if it seem to have any, be surmounted, that it may hold the position due to it amongst the physical evidences of disease.

Clarges-street, Piccadilly, March, 1857.

## NOTES OF SOME CASES IN PRIVATE PRACTICE.

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IN presenting the notes of some few cases to the readers of THE LANCET, I must claim their indulgence for the imperfect manner in which they are thrown together. I need scarcely plead, in extenuation of the faults, that the time of the medical practitioner in the country is often taken up in attending to a mass of trifling diseases, to which he is compelled to pay attention; that he has to traverse many miles of ground daily, thus giving rise to fatigue of body, and consequently of mind; so much so, that when the daily task is performed, he is only too glad to obtain repose, and to take advantage of every spare moment to seek "Nature's sweet restorer, balmy sleep."

Vastly different is the case with our metropolitan brethren, and those who are engaged in practice in large towns. With both, the work is more concentrated and more easily completed, and, in addition, they can refresh their memories by attendance upon hospitals, and other public buildings, seeing every variety of case, and having the valuable co-operation of other surgeons. In the country districts, moreover, the surgeon has to battle single-handed with disease, and oftentimes with almost invincible prejudice. He requires, not only a knowledge of his profession, but that knowledge must be combined with tact and a degree of shrewdness, so as to be able not only to manage the disease, but the patient also.

In these cases, it may be said that *all* the methods of treatment now in vogue have not been tried. Granted; and for several reasons: sometimes from want of sanction on the part of the friends; at others, when it would have been dangerous from the impossibility of watching the cases minutely, as in those where the chest has been implicated, and which, occurring as they did in numbers at one time, rendered it difficult to watch the remedies.

Before proceeding with my cases, I shall only draw the attention of the profession to one great stumblingblock which has been always before me since I began to think of private practice: this is, the opposition to the private, and especially the country, practitioner, exercising his own free will and judgment as to treatment of cases. He is thwarted in every way, both by patients and by friends, and this will account for the apparent mal-practice I have seen when connected with hospitals. I have frequently admitted cases, and have thought, "Well, this is curious treatment;" but now, I find that the surgeon cannot do as he pleases, and therefore arises the seeming want of skill. It is a lamentable fact that patients *will* loosen bandages in fractures—*will not* have abscesses opened, and deep-seated matter cut down on; and then, if the case does not turn out well, the unfortunate surgeon has to bear the onus of all the patient's misdoings.

Fresh from hospital practice of every kind, I confess that this appears the worst enemy one has to contend with—this prejudice and want of confidence. Where, then, is the remedy? Is it in endeavouring as much as possible to gain the confidence of those who employ you, and gently persuading them to follow your advice? or is it in saying, that unless they do as they are told, you give up the case? Of the two, the former is the one most generally practised; and perhaps your readers will agree with me, that until some prejudices are cleared away, the public is not in a condition to bear the latter.