

many such examples in this book. Surely these few quotations would satisfy the most doubting mind as to the impropriety and inefficacy of the small incision; whilst retaining outside organisms never intended by nature for such a position, and the adherence of a pedicle stump to the parietes, is a relic of barbarous and bad surgery. After ovariectomy is completed the small incision has other disadvantages. In the large incision, coming well down towards the pubes at its lower end, there is no liability of accumulation in the abdominal cavity, simply because the lower part of the wound is slightly kept open by the ligature (in my mode of operation), and is an effectual preventive against accumulation of blood, serum, or other fluid. With the small incision such accumulations are more likely to occur. Mr. Wells's cases furnish us with many examples, a few of which will serve for illustration. Thus at page 2: "On two or three occasions, when the opening became plugged up accidentally [bad practice to allow it], the patient complained of pain, became feverish, &c.; but immediately relief was afforded by a free discharge," &c. Page 49: "A pint of dark fluid had gravitated into the cavity of the pelvis." This was a post-mortem examination of a four-inch incision. Again, at page 79, in a case announced as one of small incision, after death was found "four or five pints of reddish serum," which had not perhaps been cleared out, and had no means of getting away. Again, at page 85, a case of *usual incision*, at the post-mortem "showed turbid serum in the peritoneal cavity." And so on in many other places; but these are surely sufficient to account for death without attributing it to exhaustion or difference of race, as Mr. Wells, at page 191, wonders if being Celts and being in Dublin might be a cause of death." Another powerful argument against the small incision is the length of time occupied by the operation. Mr. Wells does not make any general statements under this head, and in four or five cases only is there any allusion to time. In the first case the influence of chloroform was continued *forty minutes*; in Case 17, three-quarters of an hour; in two others, twenty and twenty-five minutes. And it must be evident from other statements that the whole of Mr. Wells's cases, with one or two exceptions, occupied a considerable time, as they necessarily must, to lessen the tumour piecemeal, grope for, and break down a number of adhesions, and bring the sac through a small incision, also including the time of tapping the cysts at the time of the operation. The occupation of so long a period under chloroform, and the exposure to our atmosphere (considered by Mr. Wells as not of importance), are both, in my opinion, highly mischievous, even if the hand and scalpel were absent. In my own operations I have scarcely ever exceeded fifteen minutes, from the commencement of the exhibition of chloroform to the placing of the patient quite at ease in bed. In a very large majority the operation has lasted only from four to six minutes. One, at which Mr. Wells was present, did not exceed four minutes, so far as the operation was concerned, and the patient was in bed within ten minutes.

(To be continued.)

THE THERAPEUTICS OF CHRONIC CATARRHAL STATES.

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IN such a season as that through which we are passing, any suggestion for the treatment of the commoner forms of catarrhal diseases cannot be altogether unimportant. Acute bronchitis in the adult is not so frequent as the subacute and more chronic forms of the disease. It is the latter class of cases that I have in view—cases in which the attack is only the last of a series of similar attacks, or only an exaggeration of a certain catarrhal habit of the patient in the winter season, with little or no fever, but with severe cough, paroxysmal and troublesome at nights, with the breathing more or less short, the expectoration pretty free. This state is very harassing to the patient, implies weakness, and causes weakness, both of the part and of the system. It is well understood by medical practitioners that bronchitis soon becomes intolerant of depressing treatment; that it tends to take nervous and muscular tone out of the parts affected, making it difficult for them to recover themselves, and rendering them increasingly liable to future attacks. The system, too, is greatly depressed by the state of

chronic bronchitis. The loss of sleep and the rude muscular shaking of the system, and probably the imperfect aëration of the blood, produce a general state of nervous and muscular impairment, which react injuriously on the affected parts. And so the harassing set of weaknesses tends to perpetuate itself till a kindly change of season makes recovery more possible. The largeness of this class of cases, and the imperfect relief of which it is susceptible, are depressing to the medical attendant who is anxious about the efficiency of his art. They are especially so at our public institutions, where the medicine is expected to take the sting out of a state of poverty, and do the work of food and fires and blankets and summer. The state under consideration is one in which the more stimulating expectorants have been chiefly used, and undoubtedly in a considerable number of cases they do good service. Finding, however, many cases in which these medicines did not afford much relief, I cast about for another remedy. Observing the efficacy of dilute nitric acid in a case of whooping-cough, and being struck with the fact of a nervous element in the cases under consideration, evidenced by the paroxysmal character of the cough, its being troublesome mostly in the night, and the well-known efficacy of different agents whose influence is chiefly through the nervous system, I resolved to treat a few cases with the nitric acid, and without the expectorants. My general prescription has been: Dilute nitric acid, ten minims; spirit of nitrous ether, twenty minims; syrup, one drachm; peppermint water, an ounce and a half. Mix. To be taken every six hours. The result has been a valuable amount of relief—a less frequent cough, often a return of the ability to lie in bed, a more prolonged and continuous sleep, and general improvement of the patient. I refrain from all dogmatism. A more extensive experiment may qualify my own opinion, and still more that of others, of the value of the suggestion I make. I have, of course, discovered that it is not universally applicable. The state of chronic bronchitis is eminently one for eclectic treatment, according to its complications, the age and constitution of the patient, &c. I only know that in a certain number of cases the above prescription has afforded important relief after the failure of more common medicines, and that the season is opportune for any remarks which tend to increase our resources in the management of so common a disease as chronic bronchitis. It would be satisfactory to have a theory of the *modus operandi*. But this is really of secondary importance. I have a keen appreciation of a remark of Sydenham's: "I esteem any progress in that kind of knowledge (the cure of disease), how small soever it be, though it teach no more than the cure of the toothache or of corns upon the feet, to be of more value than the vain pomp of nice speculations." I append two or three cases in illustration of what I have advanced.

Mrs. T—, aged twenty-eight. Feb. 7th. Chronic bronchitis. Is obliged to prop herself up nearly all night in bed; spits a great deal of yellow phlegm; the breathing is very bad; respiratory sounds harsh, and for the most part dry. Has been taking medicine for a month, including ipecacuanha, chloric ether, ammonia, and squill, without much effect. To take dilute nitric acid and spirits of nitre as above.

Feb. 10th.—A great deal better. Has had two much better nights. "The last medicine seems to have done her much good."

17th.—The cough is wonderfully better. She considers the medicine has done her more good than any she ever had.

Mrs. P—, aged about thirty-five. Had bronchitis three winters ago, and has had more or less cough in winters since. This winter she was ill for about four weeks before coming under my care. She had the chronic bronchitis which I have described above, having very bad nights, "scarcely able to lie down." For several weeks she then took ammonia and squill without material relief.

Feb. 14th.—She has been for two weeks or thereabouts on dilute nitric acid, &c., as above. Scarcely coughs at all, and has good nights.

James W—, aged thirty-seven. Feb. 7th. Dates his cough from the fog. His aspect is anxious and pale, with a flush on the cheek as if he might readily drift into phthisical disease. The symptoms, however, are bronchitic. Coughs in fits; there is general wheezing over the front chest, with large crepitation at the base of the left lung posteriorly; the breathing is very short; sweats at night. To take the above prescription with no expectorant.

Feb. 10th.—Still looks badly, and tongue much coated with a brownish fur; but wheezing much less general. To continue medicine, and apply a sinapism to the left side.

17th.—Doing very nicely in all respects. Tongue almost clean, and promises to be soon well.
28th.—At his work.

ELIZ. G.—Feb. 10th. Pregnant five months. Is accustomed to have cough in the winter, but this year it is much worse than usual. To take the above medicine.

Feb. 14th.—Cough much better; does not come in such violent fits, and is not nearly so bad at night.

Compton-terrace, Islington, Feb. 1865.

A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. THOMAS'S HOSPITAL.

CASES ILLUSTRATIVE OF TRAUMATIC EFFUSION OF DIFFERENT KINDS FROM VARIOUS CAUSES; CLINICAL REMARKS.

(Under the care of Mr. LE GROS CLARK.)

CASE 1.—C. C.—, aged fifty-nine, admitted Oct. 1st, 1864. Six days previously he was struck violently on his right side by the fall of a cab. There were bruises in the groin, on the scrotum, and over the great trochanter. The right gluteal region was almost entirely occupied by a large fluctuating swelling, unaccompanied by pain or inflammation. In less than three weeks this extravasated blood was absorbed, and the patient was presented well.

CASE 2.—F. C.—, aged twenty-nine, was admitted on Dec. 25th. His leg had been crushed beneath an omnibus wheel, and this was speedily followed by swelling. On admission, the calf was very tense, but elastic, and not pitting on pressure. No fracture detected. Under cold applications, and rest in a horizontal posture, this swelling and tension have gradually subsided as the subfascial effusion has been absorbed.

CASE 3.—P. D.—, aged thirty-four, carman, was admitted on Dec. 24th. His arm had been severely contused by a fall, and the injury was immediately followed by swelling and tightness of the forearm. On admission two days subsequently there was vesication. Cold, and rest in an elevated position, reduced the tension. But after four days' treatment the tension again increased, accompanied by inflammation; and a small circumscribed slough appeared on the inside of the arm. A deep incision was then made through the fascia, with great relief, but no pus escaped. Since then the swelling was subsiding and the wounds were discharging.

CASE 4.—R. G.—, aged forty-eight, was admitted on the 26th of December. He had bruised and sprained his wrist on the 21st. On the following day there was considerable swelling, and when admitted this swelling was accompanied by redness and tension, with vesication, extending half-way up the arm. A deep incision was made on the front of the forearm above the wrist, and softening inflammatory exudation and pus escaped. The inflammation was thus limited, and the tension relieved, though the progress of the case has since been slow.

CASE 5.—T. M.—, aged thirty-eight, a carman, was admitted on the 14th of November last. His left leg had been crushed by the passage of a heavy cart wheel over it, the tibia and fibula being fractured in the middle third. He was brought to the hospital immediately; but already there was great swelling and tension of the calf of the leg, and venous blood oozed from a wound on the outer side of the ham. There was no superficial œdema; but the tension was evidently due to

subfascial effusion of blood. The limb was laid on the outside, in a flexed posture. Vesication soon followed, accompanied by deep-seated fluctuation. At the end of a week the middle of the leg was still tense; and this was accompanied by a red and purple appearance, and very great tenderness. At one spot the skin was gangrenous. The health and the age of the patient encouraged an attempt to save the limb. Accordingly a short, deep incision was made on the inside of the leg, giving exit to extravasated blood and softening inflammatory exudation. The limb was placed, semiflexed, on the back. On the eleventh day a large slough of skin and fascia, extending nearly two-thirds round the limb, had separated, exposing the muscles in the neighbourhood of the fracture. The parts were supported with strips of wetted linen, and a generous diet was continued. Under this treatment healthy granulations sprang up, and the wound rapidly cicatrized after the chasm was filled, union of the fracture going on simultaneously.

CASE 6.—W. P.—, aged fifty-two, a man of tranquil temperament and sober habits, was admitted on the 1st of Dec. last, immediately after having his left leg run over by a heavy van. Both bones were broken a little above the ankle-joint, and the pointed extremity of the obliquely fractured tibia threatened to protrude through the skin. There was much contusion of the soft parts, and the right leg was badly lacerated. Much swelling followed, both subcutaneous and subfascial, accompanied by extensive vesication in the fractured member. Sloughs subsequently formed, threatening to expose the fracture and to extend, so that it was necessary to amputate. On the 17th the leg was removed; but the patient sank ten days afterwards with pyæmic symptoms.

The following remarks were made by Mr. Le Gros Clark:—
“The foregoing cases illustrate several points of interest, which, though of daily occurrence, are not the less of practical importance. In all cases of fracture, and in most other lesions from violence, there is effusion; but this varies much in its character, and upon the diagnostic signs by which these varieties may be recognised the treatment depends. 1. There is the early effusion of blood around the fractured ends of the bone, which is usually limited in extent. 2. There may be effusion of blood into the superficial areolar tissue, from contusion. 3. There is the subsequent effusion of serum into the areolar tissue, producing a general œdematous condition of the limb. 4. There may be, though more rarely, extensive extravasation of blood beneath the fascia, and this may be either venous or arterial. 5. There may be excessive effusion of plastic matter beneath the fascia, or into the areolar tissue, constituting phlegmonous inflammation. The first and third of these conditions suggest no practical remark beyond the self-evident though often neglected one of avoiding any constriction of a limb by bandaging in the earliest treatment of fracture. Œdematous effusion, which may be certainly anticipated, does not take place until after the lapse of many hours, and a bandage, even loosely applied in the first instance, may prove a most serious source of constriction after the lapse of twenty-four hours. Severe contusion of the soft parts is a further reason for avoiding this constriction. Where there is extensive effusion of blood beneath the fascia the peril is greatly increased, as illustrated in the fifth case, in which sloughing of the soft parts resulted from the tension to which they were subjected. This can be met only by position and the employment of cold in the first instance, and the subsequent cautious relief by puncture or incision, where spontaneous relief appears imminent and inevitable, as thereby the loss of texture may be limited. Such extravasation from laceration of an artery is singularly rare, and when it occurs is usually fatal to the limb or life of the patient. Subfascial effusion of blood is also exemplified in Cases 2 and 3. In the latter the diagnosis was important. There was no fracture, but severe contusion, in this case, and the condition was one suggestive of acute phlegmon of the muscular areolar tissue, under which circumstances early and free incisions would have been indicated; but the history of the case, and the rapidity with which the swelling and tension followed the injury, proved that they depended on extravasation of blood, and that no surgical interference was at first admissible. Phlegmonous inflammation with fracture must be treated as under other circumstances. It is of course an evil to convert a simple into a compound fracture, but as this must occur spontaneously, the same reason exists as in other cases for limiting the destructive process, and thereby affording the best prospect of saving the injured member. As regards the treatment of simple extravasation of blood beneath the fascia or otherwise, nothing justifies operative interference except the conversion of the seat of