

was probably in accordance with the needs of the injury. In four days' time—during which he had suffered intense distress—the splints were taken off, the hand being much swollen; they were afterwards re-applied. The splints were removed from time to time and gentle massage was done during 30 days, after which the splints were entirely left off. The hand, however, remained swollen for at least two months, and during this time he lost the nails of his first and second fingers. The thumb-nail also blackened, but it did not come off. When the swelling went down there was very little feeling in his hand, and his fingers and thumb were stiff and useless. About a fortnight after the accident two sloughs appeared—an extensive one over the outer side of the forearm near the elbow and a deep one over the tuberosity of the scaphoid bone. The resulting sores took respectively three and four months to heal.

The forearm was found to be fixed midway between pronation and supination; the thumb was strongly adducted with the terminal phalanx rigidly flexed, and the fingers were stiffly bent into the palm. On firmly flexing the wrist the fingers could be partly straightened, but the thumb was immovable and the hypothenar muscles were much wasted. Faradism gave no reaction, but galvanism set up strong contractions. There was considerable wasting of the hand and fingers. The outlook was not very hopeful, but the man readily accepted the treatment. It was decided that the thumb should be made to put slack in the ligaments, and most of the flexors by taking the thumb out of the axis of the radius and ulna. A splint could get his fingers straight, and the rotation of the forearm; the thumb was marked, and the tendons of the flexors were exposed.

In October the man had been in the hospital for some time, and seemed to be improving. The thumb was now straight, and the fingers were free to move. The forearm was now straight, and the rotation of the forearm was marked. The tendons of the flexors were exposed, and the man was able to move his hand and fingers.

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followed. Mr. J. E. Platt has collected 103 cases, and 21 of these the patients recovered.<sup>1</sup> This is a mortality nearly 80 per cent.

A well-nourished boy, aged 15 years, was admitted to the Park Hospital on Sept. 20th, 1900, suffering from an attack of enteric fever which was stated to have begun on the 16th. On admission he was found to be moderate ill: there were slight abdominal distension and enlargement of the splenic dulness, nocturnal delirium, headache, a slight diarrhoea. The temperature was  $39.8^{\circ}\text{C}$ ., the respirations were 25, and the pulse was 110. The mouth was very dirty, the tongue and gums being covered with dried mucopurulent secretion; there was one carious molar tooth discharging pus which was extracted on admission. He became worse and his attack ran a severe course which, however, with the exception of hæmorrhage from the bowel on Sept. 28th, 29th, and 30th, did not present any special features until the morning of Oct. 15th. On that day the respiration became stridulous and he rapidly developed symptoms of laryngeal obstruction; there was great distress and rapidly increasing cyanosis with very slight epigastric recession. In the afternoon, about 12 hours after the onset of the stridor, a high tracheotomy was performed after injection of eucaine subcutaneously, a general anæsthetic being required. A No. 5 Parker's tube was inserted, with complete relief of the symptoms. On the 16th day it was possible to see the larynx with difficulty as the swelling was found over the right arytenoid cartilage and the epiglottic fold; it was bright red in colour and was causing almost complete glottic obstruction. On Nov. 2nd he was able to breathe without the tube for a short time, a metal tube was replaced by a rubber one which he wore for gradually decreasing periods until his death, but he did not return at all. As seen with the laryngoscope the swelling appeared to be lessening gradually, but there was no sudden discharge of pus but the sputum was mucopurulent throughout. The temperature, which had been raised at first daily to  $40^{\circ}\text{C}$ . but had been controlled easily by tepid sponging, began to fall on Oct. 10th and reached normal on the 15th, the pyrexia having thus lasted 15 days. On Oct. 28th the temperature rose again and a relapse occurred, the second attack being considerably milder than the first and presenting no features of interest until the afternoon of Nov. 10th, when he vomited slightly, but was not otherwise worse. On the 11th, at 10 A.M., he became suddenly worse, the chief symptom being rapidity of breathing; there was no abdominal pain at all and the temperature, which ranged from  $38^{\circ}$  to  $39^{\circ}\text{C}$ ., did not fall. There was no marked collapse, vomiting, or hiccough. On examining the abdomen there was greatly increased distension, and the liver dulness, which had been normal at no time on the previous day, had completely disappeared; the abdomen was tender very slightly, and the diaphragm was not seen to move, but no gas escaped.

It was thought that perforation had occurred, and as the boy was much emaciated by his long illness, was not able to stand, it was decided to open the abdomen. This was done on Nov. 12th at 10 P.M.—probably six hours after perforation—by a vertical incision in the right linea semilunaris, chloroform being administered through the tracheotomy tube. The incision, which was four and a half inches long, the peritoneum was cut and the gastric artery was cut and was ligatured, bleeding was completely arrested. On opening the peritoneum gas escaped and a quantity of clear serous fluid was poured up, but there was no sign of pus; a coil of small intestine presented which was brightly injected on its surface. The appendix was felt, and on tracing it back a perforation was found, from which fæces were escaping, four and a half inches from the ileo-cæcal valve and about three inches from the presenting coil. The perforation was of the size of a crowquill and was situated in an ulcer one and a half inches long and three quarters of an inch wide. Lembert's sutures of fine silk were now passed so as to invaginate the entire ulcer and the intestine a quarter of an inch on each side, the stitch reaching to half an inch from each end of the visible ulcerated surface. As the boy's condition did not admit of a prolonged peritoneal toilette the fluid was sponged out gently as possible and the abdomen was sewn up with silk worm gut, a gauze drain being left at the lower angle of the wound. The whole operation lasted an hour and 20 minutes.

<sup>1</sup> THE LANCET, Feb. 25th, 1899, p. 505.

some distance between the layers of the sigmoid mesocolon, completely surrounded both kidneys, and separated the layers of the mesentery of the small intestine for one or two inches. The bladder was small, firm, and contracted, and on passing the finger into it two spicules of bone could be felt projecting through the inferior wall. Both kidneys were absolutely uninjured though buried in clot which completely filled up the hilum extending even between the calices of the pelvis. The spleen and the rest of the abdominal viscera were free from injury, as also were the abdominal aorta and its main branches. It was impossible to make out the vessels from which this large amount of blood had escaped, but it seems probable that the fracture of the horizontal rami had caused rupture of the obturator vessels, the blood first filling the pelvis and then ascending beneath the peritoneum on the posterior abdominal wall.

*Remarks by Dr. BROOME.*—The above case may prove of interest from the difficulty of diagnosing the injury to the bladder. This was due to the nature of the injury, the inferior extra-peritoneal surface being obliquely perforated by two spicules of bone in such a manner as to render the apertures valvular so that they became tightly closed when the viscus was distended.

## Medical Societies.

### MEDICAL SOCIETY OF LONDON.

#### *Ischæmic Contracture.—Typhoid Fever.*

A MEETING of this society was held on Jan. 28th, Mr. J. H. MORGAN, the President, being in the chair.

The CHAIRMAN referred to the irreparable loss that the nation had sustained since the last meeting of the society and proposed that the humble expression of the profound grief of the Council and Fellows and their extreme admiration of the many virtues of Her late Majesty should be forwarded through the proper channels and joined with an expression of their deepest sympathy to His Gracious Majesty King Edward VII.

Mr. EDMUND OWEN showed a man who, when living in the Transvaal, had sustained a Fracture of One of the Bones of the Left Forearm. He had been treated by splints and bandages. The latter were bound tightly and caused sloughing of the skin and loss of the nails. This was followed by the condition described by Volkmann as ischæmic myositis. In order to remedy the fixed flexion of the fingers and thumb Mr. Owen elongated the tendons and excised one inch of both bones of the forearm. The bones failed to reunite. Later he removed an additional portion of each bone and wired the ends together. In spite of every care non-union again resulted and the patient still had an almost useless hand. An account of the case is given in our "Mirror of Hospital Practice" this week.—Mr. F. C. WALLIS had experience of a similar case where the condition was attributable to an Esmarch's band having been used for one and a half hours during an operation.—Dr. WILLIAM HUNTER thought that the trophic disturbance probably began in the nerves rather than in the muscles.—The PRESIDENT referred to a case in which the ulnar nerve had been divided by a bullet in the present war. The patient, invalided home, was treated by freshening the ends and grafting in a portion of the sciatic nerve of a freshly-killed sheep. A return of nearly normal sensation had resulted and muscular power was beginning to return.—Mr. OWEN, in reply, said that in cases like the one which he had brought forward there was no localised nerve-lesion, so that from a practical point of view after milder measures had failed the only hope was in treating the effects of the fibrosis and shrinking of muscles.

Dr. F. J. SMITH then read a paper on the Treatment of Typhoid Fever which is printed *in extenso* on p. 312 of this issue.—Dr. SIDNEY PHILLIPS agreed that no routine treatment applied to all cases of typhoid fever. He was the first in this country to bring forward fatal cases of typhoid fever in which necropsies had shown that there had been no appreciable intestinal lesion. The stress of the disease might fall chiefly on the central nervous organs, the lungs, or the kidneys. Marked tremor, as Jenner had taught,

was frequently associated with deep intestinal lesions, but it might also result independently from toxæmia or pyrexia. As to the dietary he would be guided rather by the patient's power of digestion than by the appetite. He had not found it necessary to cut down the amount of milk to two or three pints; if the condition of the digestion allowed, as much as five or six pints could be given. He doubted the propriety of giving solid food. For hæmorrhage he had in some cases given tincture of hamamelis with advantage; for this complication opium remained the chief resource, but its effects should be watched so that it did not produce tympanites. He had noticed that dilatation of the stomach was sometimes mistaken for tympanites. The latter was of grave augury and he attributed it to severe toxæmia. He agreed with Dr. SMITH that the ambulant cases were the worst.—Dr. G. WASHINGTON ISAAC had been disappointed with the results of tepid sponging as a means of keeping down pyrexia.—Dr. CAMPBELL POPE suggested a trial of suprarenal extract in case of hæmorrhage.—Dr. WILLIAM HUNTER thought it impossible to gauge the extent of the intestinal ulceration, and it was therefore impossible to make this a criterion for choice of diet. The dangerous ulcers were due, he thought, to ordinary septic as distinguished from typhoid inflammation. Hence he agreed with Dr. SMITH in valuing antiseptic treatment, and to this end he preferred calomel or perchloride to salol and other artificial antiseptics.—Dr. W. J. HADLEY thought that pulmonary lesions caused a fatal issue more frequently than intestinal complications. Heart failure was usually the result of toxæmia and pyrexia.—Dr. SMITH, in reply, said that he doubted whether solid food caused perforation. For pyrexia he had employed a bath at 100° F. with good results. The patient might remain in it as long as he liked. Constipation often kept up pyrexia and sulphate of soda he found to be the most generally useful remedy for this.

### CLINICAL SOCIETY OF LONDON.

#### *Exhibition of Patients and Apparatus.*

A MEETING of this society was held on Jan. 25th, Mr. A. PEARCE GOULD, Vice-President, being in the chair.

The CHAIRMAN explained that the President, Sir R. Douglas Powell, who had discharged such important duties during the last illness of their late Sovereign, did not feel able to be present at the meeting. As this meeting was of a purely scientific character it had been decided to hold it. He felt, however, that the society could not meet without some expression of the personal loss which the members shared with the whole empire. The greatest monarch of modern times had been taken from them. During her reign great advances had been made in scientific medicine. The late Queen had always placed implicit confidence in her medical advisers. She was the first member of our Royal Family to be vaccinated. When prejudice was against the boon of anaesthesia being afforded to women in the hour of their greatest need she had availed herself of it and so removed the prejudice. To antiseptic surgery she had set her seal by granting to Lister the highest honour ever given to a medical man in this country. When the country was threatened with an epidemic of cholera Her late Majesty had taken the greatest interest in the measures successfully adopted against it under the guidance of the late Sir R. Thorne Thorne. He was sure that to these reflections all would add with devout feeling, "God save the King."

Mr. STANLEY BOYD showed a female patient, aged 31 years, on whom he had performed Oöphorectomy for Recurrent Mammary Cancer. In 1898 the left breast was removed for cancer. In 1900 operation for recurrence was contemplated and abandoned. In August, 1900, the patient was emaciated; there were recurrence in the scar, two outlying subcutaneous nodules, considerable enlargement of the left supra-clavicular and substerno-mastoid glands, the latter rather fixed, many large hard glands in the right axilla and a few in the right neck. The left vocal cord was paralysed and the patient had great difficulty in swallowing fluids. On August 8th Mr. Boyd performed double oöphorectomy. Improvement was rapid from the day of operation. On Sept. 8th the nodules and glands except one beneath the sterno-mastoid had disappeared. On Dec. 4th the voice and swallowing were normal. The patient had gained one and a half stones in weight.—Mr. CHARTERS SYMONDS remembered