

On Dec. 4th, after the patient had been placed under the influence of ether and the right lower limb had been rendered bloodless through the application of Esmarch's elastic bandage, a long incision was made from above downwards along the inner portion of the popliteal space and over the most prominent portion of the swelling. On dissection of the stretched skin and of the subjacent soft parts, the tumour was exposed. This evidently consisted in an enlarged bursa, and presented a large oval sac containing fluid, and with a very thin and tense wall. The deep surface of the sac was in contact with the superficial surface of the inner head of the gastrocnemius muscle, and was connected with it by very loose and fine connective tissue; at its upper extremity it was continuous with a long and thick stalk which passed deeply down behind the inner tendon of the gastrocnemius and towards the joint. The lower extremity of the tumour was free and rounded. As the sac was being dissected away from the surface of the muscle it was accidentally ruptured and exit given to about four ounces of turbid fluid containing flakes of soft and pale-yellowish material. The collapsed walls were then cut away, together with as much of the pedicle as could be reached without any division of the inner head of the gastrocnemius. The operation was performed under antiseptic conditions, and the wound having been drained by horsehair, was covered by gauze &c. The limb was then placed on a McIntyre splint.

No disturbance of general health resulted from this operation. During the first five days after the operation the morning temperature was about 99° and the evening temperature at or below 100° . During the second week the temperature remained quite normal (98.4° every morning, and between 98.6° and 99.2° in the evening), although on the tenth and eleventh days there was considerable swelling of the knee, evidently due to intra-articular liquid effusion. This swelling was quite painless and rapidly and completely subsided in the course of the third week. The wound, which was dressed every fourth day, presented a very healthy appearance, but healed slowly, owing to separation of the flaps of skin and consequent formation of a wide granulating surface. At the end of January the patient was allowed to get up and walk. At first he was very lame from stiffness of the right knee, due probably to long confinement of the limb on a splint. On March 3rd, when the man was discharged as cured, he was able to move the right leg to almost the full extent, and the knee-joint was quite free from tenderness and swelling.

QUEEN'S HOSPITAL, BIRMINGHAM.

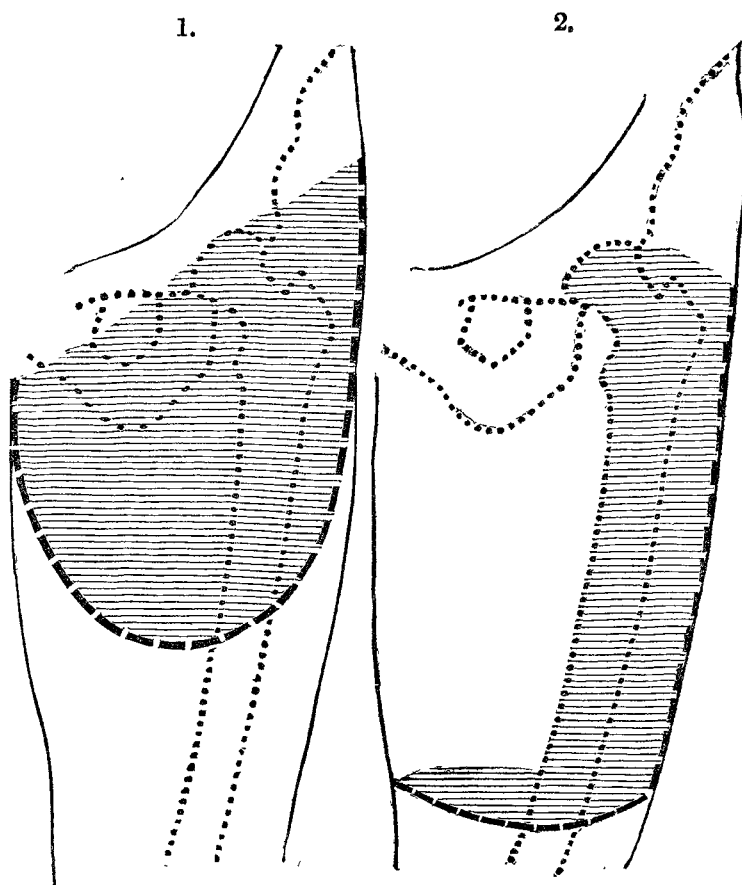
AMPUTATION AT THE HIP-JOINT BY A MODIFIED METHOD;
USE OF THE CONSTANTLY MOIST ANTISEPTIC SPONGE-
DRESSING; IMMEDIATE UNION; REMARKS.

(Under the care of Mr. FURNEAUX JORDAN.)

A YOUTH of sixteen years had had acute and extensive periostitis of the left femur. Several attempts had been made at various times to remove the dead bone, but the results had not been satisfactory. A few sinuses had refused to close, the limb remained useless, the hip-joint was involved (the thigh was quite immovable, and no tendons could be made tense under anæsthesia), and the general health was reduced to the lowest ebb. It was clear the patient left to himself had not long to live. After much consideration it was deemed desirable to amputate at the hip-joint, and to use every precaution against shock and hæmorrhage. A tourniquet was put over the external iliac artery, the limb having been exsanguined as completely as possible by Esmarch's elastic bandage and by position. A straight incision was made, and the trochanters and upper part of the shaft were freed from their muscular attachments, after which the capsule was opened, and some early, but unmistakable, bony union was broken through. Next the shaft was cleared downwards from all its attachments (which are here mostly loose and cellular) for a considerable distance, and then a few free sawing movements, with a long-bladed knife, through the thigh from which the bone had been removed, ended the operation. The integuments were simply drawn upwards, and the soft parts were cut straight through. No bone being left, the muscles quickly retracted, and were easily covered by the skin. Very little blood was lost. The larger trunks were tied with catgut. It was so important to save every drop of blood, that some

oozing between the acetabulum and the gluteal region was instantly checked by putting a sponge, soaked in terebene, on the parts, and leaving it within the wound. Adjustment was effected by deep silver sutures. The stump was then dressed by two large sponges (subsequently kept moist with terebene and water), firmly and evenly held in place by broad long strips of plaster, one strip being so carried over the opposite shoulder that the two ends overlapped the stump. The improvement was so sudden and marked that the next day he said he was "very well." There had been neither shock nor hæmorrhage. The "interior" sponge was left for three days. When the dressing was undone the whole stump had united, even over the sponge, the united parts requiring to be partially broken through for its removal. The later steps of progress were as favourable as the earlier.

Remarks.—Mr. Furneaux Jordan said that the principle of the operation which he had done now, and on previous occasions, might be thus described:—First enucleate the bone, then cut through the limb at any desired spot—the middle of the thigh, or below, or even near the knee. Compared with the ordinary operation of two large flaps (see first diagram), the wound was less severe, the cut surfaces



were less extensive, and, in a manner, further removed from the trunk; it was followed by less shock, less hæmorrhage, less opportunity for septic infection. The vessels were more easily dealt with. The thigh might be simply cut through with a circular sweep or a few free sawing movements. The boneless thigh should be firmly held, and somewhat flattened if cut across. The muscles may be cut on the same level as the skin; the bone being absent, they retract so strongly that the skin readily covers them, its vitality is less endangered, and a great cellular plane is not opened. A glance at the diagrams will show that the bulk of the soft parts of the thigh, especially near the pelvis, lies at the inner side of the femur. Why put a knife through these parts? It is better to enucleate the femur where it is most thinly covered, and cut across the limb where it is smaller and further removed from the trunk. In removing the thigh very low down, the area of the wound is no doubt increased, but even then it would be a much less dangerous wound in character and locality. The operation was of course more suitable for those cases in which the soft parts could be freely left than for malignant and other exceptional cases. The surgeon may, if he choose, make the circular sweep before the shaft of the bone is turned out, if precaution against hæmorrhage have been very complete. There ought to be no hurry; the patient is in a deep sleep, no large vessels are near, and the

femur may be patiently turned out of a bed that need neither be scored nor stabbed. If the thigh were to remain a soft, pendulous mass, it would be a small price to pay for greater safety, but it is a remarkable circumstance that the muscles do not rest until the longest thigh has become a short one. In hip-disease, with much acetabular mischief, the wound gives safe access and free drainage for any length of time. The principle of the operation might be adopted in amputation below the trochanters (a chain-saw being used), and indeed in amputations in other localities. The cut surfaces being moistened with terebene, the large sponges were kept constantly moist with the same antiseptic liquid. These kept up deep adjustment, gentle elastic pressure, cleanliness, antisepticity, and rest. When the sponges were removed the stump was as clean as a newly-washed face. It seems a paradox, perhaps, but the moist antiseptic sponge is constantly washing and cleaning, at the same time that it is constantly maintaining perfect rest and immobility. The second diagram suggests the principle of the operation—not the immediately ensuing retracted state.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

The Extraction of Cataract.—Traumatic Abscess of Brain treated by Trephining and Incision.

THE ordinary meeting of this Society was held on the 11th inst., Mr. J. E. Erichsen, F.R.S., in the chair.

The PRESIDENT, on taking the chair for the first time, expressed his deep sense of the honour accorded him, and of his gratitude to the Fellows for having elected him to fill the office of President. At the same time he was not unmindful of the responsibilities of his office, feeling them even more deeply because he was the successor of one who combined in so rare and admirable a manner great aptitude for business and the power of felicitous expression of sentiments which it became him as President to convey. For himself he could only say that he would do his utmost to deserve the honour bestowed on him, and to maintain, so far as lay in his power, the dignity and welfare of the Society.

Mr. CHARLES HIGGENS then read a paper entitled "Remarks on 150 Operations for Extraction of Cataract." The paper was accompanied by a printed table, in which were set down the sex and age of the patient, right or left eye, form of cataract, kind of operation, results, and remarks. The results were collected under three heads—successful, partially successful, and failures. Under the first head were 115, 76·6 per cent.; under the second 24, 16 per cent.; under the third 11, 7·3 per cent. So that in 92·6 per cent. of the cases the sight was improved by the operation. In 7·3 no improvement took place, or sight was worse than before. Three methods of operating were described—extraction by small flap, by linear section, by oblique corneal section. 104 cataracts were extracted by the first method, 25 by the second, and 21 by the third. The advantages and disadvantages of the various methods were briefly alluded to. Iridectomy at the time of extraction, or as a preliminary some time previously, was strongly recommended. The relative advantages of upward and downward section were mentioned. The after-treatment was given. — Mr. MACNAMARA said that the prognosis of cases of cataract operation was favourable in proportion to the dilatibility of the pupil by atropine. He had never placed much reliance upon iridectomy in cataract extraction, but his great aim was to remove the *entire* lens, making a corneal section of just sufficient size to admit of this. If any fragments of the lens are left behind they set up irritation. The disadvantage of iridectomy lay chiefly in the fact that it admitted too much light into the eye, so that vision for distant objects became blurred, whilst the most successful cases he had seen had been cases of the old flap extraction and central pupil. He had lately seen a lady in whom thirty years ago Mr. Guthrie had removed cataract from both eyes; she has perfect vision. Mr. Higgens' statistics were of value, and

would advance this branch of surgery—different from figures lately published by an eminent continental oculist, of 230 cases of cataract and no failures! It is notorious how figures can be misread.—Mr. HULKE commented on the number of cases in the table of young persons, a few even at three and five years, and many under twenty years. He would like to know the reason why the author had departed from the generally accepted practice of treating such cases, where the lens is soft, by some of the various methods of solution, assisted by suction. — Mr. SPENCER WATSON referred to a method, introduced by a continental surgeon, whereby the capsule is lacerated before the corneal section is made. In lacerating the capsule after such section, there is greater risk of displacing the lens into the vitreous, or of causing prolapse of the vitreous. He had performed the new method some twenty-four times, and with good result; and in some cases he had found it well to perform a preliminary iridectomy. He thought the upward section of the cornea often better than the downward. It was very important to use as few instruments as possible, and to avoid the scoop.—Mr. HIGGENS, in reply, said that removal of the whole lens was more easily effected with a small iridectomy than without. The old flap section, in favourable cases, was very good; no doubt it was so successful in past times because no cataracts were removed until they were "ripe." He fully admitted that several of his patients were young, and that his operations were often experimental. Needle-operations were tedious and dangerous.

The next paper was on a Case of Recovery after Evacuation of a Traumatic Abscess in the Brain by Trephining and Incision, by Mr. J. W. HULKE. An errand-boy, striking his forehead against a fence, grazed it, and was momentarily stunned. He continued to work for seven weeks, during which time he had more or less pain in forehead; then retching and hemiplegia supervened. The frontal bone was trephined at the seat of injury; a small fissure was recognised in its outer table; the dura mater seemed healthy. An aspirator trocar being pushed into the brain, pus rose into the syringe. The abscess was opened through the membranes with a knife, and in all about three drachms of pus let out. The patient recovered, but lost the sight of both eyes by optic neuritis. In conclusion, Mr. Hulke referred to the value of hemiplegia, as significant of disease in the brain rather than of arachnitis.—Mr. BRYANT congratulated Mr. Hulke upon his diagnosis and courage in puncturing the dura mater and the brain. The case, from the localised character of the injury, was clearly one most favourable for operative interference. In diffused injuries the results of operation are poor, but here symptoms of suppuration within the brain followed on local injury. The hemiplegia suggesting cerebral lesion, Mr. Hulke did well to puncture the brain, although the dura mater itself showed no change. The success of the case bore out the wisdom of the practice, and was most encouraging.—Mr. HOLMES related a case showing the extreme difficulty in the diagnosis of these cases. A man was admitted into hospital about a year after having struck his forehead on the right side against a barge in driving. Some time after a swelling occurred here, suppuration, and exposure of bare bone. Later he had several fits, and in one of them an attack of left hemiplegia, which was very complete, especially in the leg. Mr. Holmes removed the piece of necrosed outer table. At first he improved, but then his paralysis increased, his bladder became paralysed, and he had cystitis; so that Mr. Holmes was much tempted to trephine. But the man had been the subject of syphilis, and he has since gradually improved. The long interval between the blow and the brain symptoms was enough probably to put aside the traumatic cause, but the case showed what great care should be taken to avoid numerous sources of fallacy. He agreed with Mr. Hulke that the occurrence of paralysis some time after an injury was a sign of deep-seated cerebral lesion rather than of superficial inflammation. — Mr. BARWELL, congratulating Mr. Hulke on his success, boldness, and diagnosis, said that eighteen months ago he saw, in consultation, a gentleman who had received a blow on the head (to the left of vertex) seven weeks before. The wound healed, and no further symptoms appeared for five weeks, when right hemiplegia occurred. The scar was laid open, and a slight depression found, but nothing further was done. The patient died, and an abscess, the size of a hazel-nut, was found in the cerebrum, beneath the seat of injury. He asked whether Mr. Hulke laid aside the aspirator and took to the knife in his case, because of the former getting plugged, or because of