

No doubt this consideration affects those cases which so often occur of the amputation of a finger for joint disease. It is true, if the finger be left to itself, after a time, longer or shorter as the case may be, ankylosis may take place, but it is after a time during which the possessor has been incapable probably of earning his living, whilst in his attempt to do so the finger has received all kinds of rough treatment, its condition thereby being aggravated. The result, after this long and painful waiting, is a finger utterly useless in most cases to its owner; and one cannot wonder, looking at these circumstances, that it is deemed better to amputate.

Now what I want to call attention to is that there is a far better plan than either of these, that results, in a comparatively short time, in a finger slightly shortened, but with a good movable joint, thereby saving a very useful member, and preventing the deformity that ensues from amputation: I refer to excision of the affected joint. Resection of the finger-joint is as applicable and as useful in proportion as resection of the knee-joint, and yet how often does one see what might be made a good and useful finger amputated for disease of one of the phalangeal joints, simply, I think, because attention has not been called to the preferable way of treating them by excision, and it does not occur to those who amputate. It may be considered a very trivial matter, but every detail in surgery has its importance, and cannot afford to be neglected; and to those whose fingers are the means of their livelihood the question of amputation or excision is to them often a matter of pounds, shillings, and pence. In the majority of the text-books of surgery I find no mention of the subject. Erichsen says, "Disease of the phalangeal articulations usually leads to amputation of the affected finger." Bryant, in his "Practice of Surgery," mentions excision of the phalangeal joint in the thumb as leading to good results, but does not mention the fingers, except in directions to obtain ankylosis with a curved finger instead of a straight one.

The operation for resection of a phalangeal joint is very simple. A vertical incision over the dorsal surface of the joint should be made, taking care to avoid the extensor tendon; then the heads of both bones should be exposed, and cut off cleanly with a pair of cutting bone-forceps, taking care to injure the extensor tendon as little as possible; the wound should be then closed with sutures, except a very small opening for drainage; the finger placed upon a straight splint, and passive motion adopted in from ten days to a fortnight.

I append the following brief notes of a case in which the result of the above treatment was most encouraging. F. G—, a French polisher, came to me in June, 1877, asking me to remove his finger, the first finger of the right hand. On examining the finger I found the whole of it swollen up to about double its natural size, œdematous and dark-coloured. He was unable to move it on account of its condition and the intense pain it gave him, which also prevented him from sleeping at night. There was a sinus by the side of the first phalangeal joint, from which oozed most offensive pus, and a probe passed into the joint struck against bare bone. There appeared to be total disorganisation of the joint, the first and second phalanges rubbing together with a grating feeling, as of two pieces of lump sugar. He had had the finger upon a splint, and it had been treated with lotions &c. for some time, and his medical attendant had advised him to have it removed. I made a vertical incision, found the heads of both bones completely denuded of cartilage, and removed them, taking care to injure the tendon as little as possible. I then closed the wound, placed a very small piece of twisted carbolised tissue in it as a drainage-tube, dressed it antiseptically, and placed the finger upon a splint. At the end of a week the wound was healed. After about ten days the patient was shown how to use passive motion, and at the end of a month he had a good serviceable finger, which he was able to use almost as well as any of the others.

THE deaths registered in London last week numbered 1433, representing a mortality-rate of 20.9, against 22.1 in the week ending the 17th inst. The death-rate from diseases of the zymotic group was 5.0 per 1000. There was a considerable decrease on that of the week previous. Also were 10 fatal cases of small-pox, 24 of scarlet fever, 10 of measles, 11 of diphtheria, 74 of whooping-cough, 16 of different forms of fever, and 195 of diarrhoea.

SUCCESSFUL OPERATION FOR STRANGULATED HERNIA IN THE MALE, AFTER TEN DAYS' STANDING.

BY WELLINGTON N. CAMPBELL, M.D.,
LATE HOUSE-PHYSICIAN AND SURGEON TO THE 99TH STREET HOSPITAL,
NEW YORK; LATE AMBULANCE SURGEON TO BELLEVUE
HOSPITAL, ETC.

ON the morning of the 22nd of December, 1877, I was called to see W. W. B—, aged fifty-three years, painter, and found him suffering from a tumour in his left groin, which, on examination, proved to be a strangulated hernia. The patient stated that the rupture first appeared about eighteen months before, after lifting some heavy merchandise upon a truck, but he had always been able to reduce it by lying in a prone position and performing taxis up to the 12th of December, 1877. When painting at a height that required an effort to reach he found that it had suddenly enlarged, and from which he experienced special pain for the first time. Upon going home he performed taxis, as usual, in the prone position, but was unable to return it. He vomited from this date (12th) to the 17th, when he took two cathartic pills, and placed a mustard plaster over the tumour; but finding no relief he applied to a physician in Jersey City on the 18th (at which time he had stercoraceous vomiting), and was advised to go to the hospital.

He came to New York on the 19th, and I saw him on the 22nd. I found him prostrated from protracted efforts to vomit, and deemed it inadvisable to use prolonged taxis in attempts to reduce it, on account of its having been strangulated for so long a period. Having called to my assistance Drs. Dennis, Williams, Schapps, Crawford, and Bargar, of this city, we immediately proceeded to etherize the patient, and when under its influence performed gentle taxis, but being unable to reduce the hernia, we proceeded to the operation without delay. Upon cutting down to the sac we found it deeply congested, being of a reddish-purple colour, and from the fact of strangulation having existed for so long a time we thought it safer to enter it, when we found, as we had previously diagnosed, an entero-epiplocele; a coil of the sigmoid flexure of the colon was enveloped by a segment of the omentum, and was of a purplish colour; but no signs of decomposition were perceptible, and there was scarcely any serum in the sac. The protruding mass was tightly grasped by Gimbernat's ligament. The stricture was divided by cutting upwards and inwards, and the contents of the sac returned with but little difficulty. Having cleansed the wound thoroughly, three interrupted carbolised silk sutures were applied, leaving the most pendant portion open for drainage, then a compress dipped in tepid water enveloped by a spica bandage. One grain of opium was administered every two hours during the night, and every four hours during the day as occasion required, until the 25th.

On the day following the operation (23rd) the pulse was 72, the temperature 99.25°. On the 24th the pulse was 70. On the 26th, the bowels not having moved, an enema of oatmeal gruel and castor oil was given, which produced a movement that evening. The patient was kept on a fluid nutritive diet, consisting of corn-starch and arrowroot, farina, barley-water, and ice for a day or two, then allowed beef-tea (cold). The sutures were removed on the fourth day, and a poultice of linseed-meal applied daily for three days, then renewed the warm water dressing with spica bandage, the limb being flexed and retained in that position to relieve all tension. There were no signs of any peritonitis, except slight tympanites, which, I presume, was due to the opium administered, and which readily yielded to the application of turpentine stupes applied over the abdomen. On Jan. 13th, 1878, the wound was healed, and the patient walking about feeling perfectly comfortable.

The peculiarities of this case are, as will be perceived, as follows:—1st. The fact of its being a femoral hernia in a man. 2nd. There being no gangrenous condition of the intestine, even after ten days' strangulation.

New York.