

Fæces or fæculent smell. This is usually referred to a reversal of the peristaltic motion; but I do not think it necessary to resort to such a strained explanation. When we reflect that about twelve quarts of secretion is daily poured into the intestines, it is easy to see that you have only to stop the onward peristaltic wave and absorption, for the ilia to get overfilled, and for their contents to overflow upwards into the stomach. There they naturally produce vomiting, just as they would if swallowed. Such a paralysis of muscles and absorbents takes place in peritonitis, as well as in mechanical obstruction of the ilia, and consequently in peritonitis you have sometimes fæculent vomiting.

Fermenting matters in the vomit show the continuous retention in the stomach of some remains of the food or of vegetable growths in a constant state of chemical change. There is therefore present a quantity of adherent mucus capable of retaining them there.

Acid matters in excessive amount may arise from a similar state of things; but it appears as if simple torpidity of stomach, without necessarily the presence of mucus, can occasion it.

Pure unchanged food shows that the vomiting arises from the state of the nervous system, which is either *locally* irritable, from neighbouring anatomical changes; or *secondarily*, as in pregnancy; or *generally*, as in hysteria.

The remedial measures which I have found most useful in cases of vomiting are the following:—

Hydrocyanic acid, where it arises not from any fault of the stomach itself, but from the secondary condition of the nervous system, as in pregnancy, diseased heart, in abdominal tumour, in pulmonary consumption, in peritonitis.

Carbonate of magnesia, in the vomiting accompanying gastric mucous flux, with copious formation of acid.

Opium, in acute vomiting from gastric ulcer, from malignant tumour, in fecal vomiting from perforation, peritonitis, internal hernia—in short, wherever the vomiting is accompanied by much local pain.

Chloroform, in the vomiting at the commencement of fevers. It may be applied either on a cloth to the epigastrium, especially in choleraic vomiting, or taken by the mouth.

Leeches.—Very often the vomiting in cases of gastric ulcer will not be appeased till some leeches have been applied to the epigastrium.

Milk and lime-water, as a sole diet, will often alone stop chronic vomiting. Complete rest and absence from excitement must accompany it.

Brandy, in teaspoonful doses, is a favourite domestic remedy. It is suitable in acute cases for the nonce, and will often stop nervous vomiting from mental causes, but is obviously not adapted for chronic disease.

Creosote.—This is a whimsical remedy, and I confess I cannot at all satisfy myself what cases it is suited to. The vomiting certainly seems checked by it sometimes, sometimes is aggravated, more commonly is uninfluenced. The cases where it has done good have appeared to me generally dependent on nervous causes. For example, it has been beneficial in hysterical vomiting.

Valerianate of zinc I tried once, in hysterical vomiting, with good effect. But in these patients the most powerful remedy is the shower bath.

Ice is often most useful in acute vomiting in fevers, in chronic cases of gastric ulcer, and in all cases is an agreeable remedy in warm weather.

The administration of food in cases of chronic vomiting is a matter of much importance. You must not let your patient be starved. Even when milk and lime-water does not check the vomiting, it is by far the best diet. In teaspoonfuls at a time, it can almost always be kept down.

You must not suppose the being starved to death from vomiting an hypothetical fear. A young woman came under my care a few months ago who had been deserted by her lover. She had had violent hysterical fits, and an utter inability to keep anything on her stomach for some days; the pulse was failing, and the tongue getting dry and brown. An attempt was made to retain life by means of nutritive enemata, but in vain. At the post-mortem examination every organ was in a completely normal state, and the catamenia were flowing from the uterus. Clearly she had died of starvation only.

When sea-sickness goes to the extent of making a person seriously ill, it is worth while to stop it or prevent it, as you can generally do by a large dose of opium. But it is very far from being worth while for healthy persons, or even invalids, in ordinary cases, to take this preventive; for a small dose is useless, and the requisite large one makes the patient endure much more discomfort afterwards than the sickness during the

voyage would have caused. Chloroform does not arrest the nausea, but it certainly does seem to control the violence of the straining. The best remedy for healthy persons to take is very frothy bottled porter: if it does not in every case prevent the vomiting, yet the prostration afterwards is certainly avoided, and the ejecta are not so disagreeable.

ON

UNNECESSARY ORTHOPÆDIC OPERATIONS.

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(Continued from p. 29.)

The Treatment of Infantile Club-foot without Operation.

BEFORE passing to the treatment without operation of suitable cases of infantile talipes varus, I may stop to correct an impression existing in the minds of some surgeons—viz., that it is my opinion that whenever the operation is indicated, its performance should be postponed until the age of seven or eight months, so that the foot may be restored in form before the period at which a healthy child usually walks. Such was my opinion in 1839;* but whoever has done me the honour of attentively perusing my subsequent writings† will have found that I have gradually advocated operation at an earlier period when clearly necessary, until for many years past I have been accustomed to perform it, and recommend it to others, during the second or third month of existence.

The question of operation should be postponed until the approach of the age for walking in any case in which the surgeon believes in the practicability of cure by other means. The time employed by the practitioner, even in an unsuccessful attempt to cure by mechanical means, will, if he is not an adept, be well spent in acquiring tact in the management of mechanical treatment; the experience thus gained will be available when the operation indubitably appears to be necessary. Indeed, many good surgeons have bungled over their operated cases of varus through not being practically conversant with mechanical after-treatment.

In the slightest cases amenable to mechanical treatment the nurse may, by diligent rubbing, manipulating, or placing the feet in an improved position, remove the incurvation, even within the month. In cases somewhat more severe, in which a shortened condition of individual tendons is more apparent, the medical attendant may apply, by means of a roller-bandage, a well padded tin splint, bent to an angle somewhat less obtuse than that which the deformed foot naturally assumes, altering the angle of the splint from time to time as he finds the foot yield. The foot should first be covered with a few turns of the bandage.

The more decided is the incurvation of the toes the more necessary is it to direct attention to reduction of the varus to equinus (or pointed toe) before attempting to bend the foot.

The secret of success consists in applying the bandage and the splint with sufficient tightness to prevent its being continually displaced by the infant, but sufficiently loose not deeply to indent the limb, excoriate the integuments, or still worse, occasion sloughs upon the projecting heel or malleolus. It should be regarded as an axiom, that it is preferable that the apparatus should be repeatedly removed during the day rather than undue pressure be maintained, and that on no account it should be applied so as to cause crying, restlessness, or other form of suffering. Whenever the apparatus has become disarranged, soiled, or when purposely removed at least thrice in the twenty-four hours, frictions and manipulations should be practised. This part of the treatment may, and should be, conducted quite painlessly to the infant, and be gradually entrusted to an able parent, nurse, or assistant. The more frequently removal and manipulations take place, the less will the child complain of the process. It will be found, as a rule, in orthopædic practice, that the attempt to move any articulation, after it has been long retained in one position, is painful,

* Treatise on the Nature and Cure of Club-foot and Analogous Distortions, 1839. p. 171 *et seq.*

† THE LANCET, Lectures on Deformities in vol. i., 1843-44.—Treatise on Deformities of the Human Frame. 1853. pp. 234, 291, *et seq.*

and is usually more or less successfully resisted by the child, according to its age.

By mere removal, the attendant may observe how his pain-taking application of the splint has been endured by the limb, what alterations in the mode of application seem desirable, to what extent improvement has rewarded his labours, whilst the infant is indulged in temporary freedom of action of the part.

By frictions, congestion and engorgement are removed, and the temperature of the part equalized. By manipulations, working and stretching of contracted parts, the joint is maintained free from rigidity, no set of muscles is permitted to atrophy from disuse, or to become contracted whilst another set is being elongated, which is a common consequence of weeks' sojourn unmoved in an apparatus. Above all, the contracted parts are, by manipulations, actually elongated, and the improved limb fitted for a splint more nearly approaching the form of the healthy foot.

I would here lay down another axiom in the treatment of this and many other distortions—viz., that the apparatus should be employed almost less as a means of forcing the lapsed part into a good or a better position, than as a means of preventing its relapse into a bad position after use of manipulations.

Pasteboard, gutta percha, or moulded leather splints, may be used in lieu of those made of tin, but these are preferable. Every surgeon will employ with the greatest advantage that material or apparatus with the use of which he is most familiar. More depends upon his tact and diligence, as well as upon the perseverance of the patient's friends, than upon the apparatus selected.

If the case has not greatly yielded by the age of three months, or if difficulty is experienced in maintaining proper adaptation of the splint, a more elaborate instrument may be resorted to. The simplest, least expensive, and most effective is that modification of Scarpa's original instrument, sold by Ferguson under the designation of Dr. Little's thumb-screw movement shoe for varus.^{77*} It is less complicated, lighter than those manufactured with male and female screw, cogwheel, or ratchet-screw movements, and has the peculiar advantage of not impeding action of foot in one direction. It consequently permits manipulation of foot in one direction without removal of it. Viewed theoretically, this apparatus seems incapable of the same powers of adjustment to a required angle whilst on the limb as other instruments, but in practice it will be found that it is convenient, on the few occasions on which it is desirable to alter the adjustment, to do it when the apparatus is removed. I may mention that even in adults this thumb-screw movement is preferable in all forms of foot-deformity where the greatest rigidity does not exist, especially when walking exercise may advantageously be permitted. By pursuing the treatment with the help of this instrument, aided by frequent removal, friction, and manipulation, precisely as in the treatment by splints, the practitioner will be surprised and gratified with the result in cases which may not have appeared promising.

In the treatment of infantile varus without operation, as with its assistance, it is, I repeat, of first importance to obtain eversion of point of foot before attempting depression of heel—in short, to convert the varus into equinus. It will be observed that after the condition of equinus has been obtained, and the attendant considers that bending of the foot alone remains to be effected, a constant disposition of the foot to roll over on its external edge manifests itself. In such cases the practitioner should never advance the screw which bends the apparatus, unless he is certain at each stage that he has effectually conquered the varus tendency.

A common complaint of nurses and others is, that they are unable to keep the heel down. This is a certain sign of the apparatus having been advanced in the direction of bending more rapidly than the foot has yielded. It indicates therefore that the apparatus must be put back into a less bent position. The surgeon should continually have present to his mind the axiom, *arte non vi*—gentle compulsion should take the place of force; and on no account should he be tempted or betrayed into the use of such pressure and force as will occasion pain, excoriation, or sloughing, under any form of treatment. In the infancy of modern orthopædic practice, owing to a prevalent belief that a cure after tenotomy was absolutely required to be effected before the tendons were firmly re-united, the more haste led to the less speed, and such consequences as excoriation, &c., were common; and my ingenuity was much taxed to devise means of pursuing the treatment under such unfavour-

able circumstances, whilst for many years past, in my own practice, with patients of all ages, I have not once seen so much as an abrasion of cuticle. Nothing is so much calculated to embarrass the treatment, or even defeat it, whether or no the surgeon has resorted to operation, as the occurrence of a wound through undue pressure upon a part, the integrity of which is essential, as the fulcrum upon which all apparatus is called upon to act. Under instrumental treatment, wounds can only arise through ignorance, negligence, and impatience.

If the progress made does not correspond to the pains taken, and the essential characters of the talipes varus are almost as marked as at the outset, or are even more strongly marked, the surgeon must conclude that he has either selected an unsuitable case for instrumental treatment, or that some accidental or other cause has neutralized his efforts; and such causes are easily found amongst the difficulties of orthopædic practice, such as unfavourable health of patient, remissness or want of skill of nurse or parent, an unwonted leaving off of apparatus either by day or night; and he must therefore, without further delay, if the child is approaching the time for walking, perform the necessary operation, remembering that, as the operation is an important, or in severe cases, an indispensable adjuvant, he will have similar difficulties with the instrumental treatment after operation to those he has encountered before it. These difficulties are nevertheless surmountable by the surgeon who, with proper knowledge of his profession, and the necessary mental qualities, has the requisite time at his disposal.

(To be continued.)

A CASE OF HEMIPLEGIA; THE PARALYSIS ON THE SAME SIDE OF THE BODY AS THE PARALYSING LESION.

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J. G.—, aged thirty-four, a well-formed and average-sized man, by trade a plasterer, became a patient at the Norwich Dispensary, in September, 1856, on account of a recent attack of head symptoms accompanied by hemiplegia. His history was this: For many years previously he had suffered from occasional attacks of what he called rheumatic gout, the last having occurred only a few weeks before the present seizure. Although not exactly intemperate, he had always been in the habit of drinking freely of beer. Ten or eleven years ago he had chancres on the penis. Two years after this he had a slight attack of paralysis of the left arm, from which he soon recovered. Three years later he suffered from ulcerations of the scalp; and after these had healed he remained in good health until about five weeks since, when he began to suffer from headache, chiefly frontal, with drowsiness and disturbance of the function of sight. This was followed by an attack of sickness and diarrhoea; and after recovery from this, he, four days ago, suddenly found himself unable to articulate and paralysed in the left arm and leg. There was no hereditary predisposition to gout or apoplexy, and no known cause for the present attack.

Symptoms, when first seen by me on September 8th, four days after seizure: Hanging of left cheek; indistinct articulation; inability to whistle or blow with his mouth; slight numbness of the paralysed cheek; protrusion of tongue to the left side; paralysis of left arm and leg, complete as to motion, less absolute as to sensation; diminution of reflex action in paralysed leg; pain of head, referred to the vertex, with much heat of scalp; dilatation of pupils, these being equal, contracting considerably when first exposed to strong light, but almost immediately returning to their former state; laboured and weak pulse, at 60; easy respiration; consciousness unaffected, and intellectual power very slightly impaired. No signs of lead-poisoning or of heart-disease.

In the interval between the commencement of his illness and his death—a period of nearly eight months,—he suffered repeated exacerbations of the symptoms of congestion and pressure within the head. About a week after his seizure, he for a short time completely lost the sight of the left eye, the pupil becoming larger than its fellow, and the upper eyelid

* Represented in Treatise of Deformities by the author, 1853, fig. 119.