

absence of parasitic germs not only influences the prognosis but occasionally the treatment.

After the uterus has been once thoroughly cleaned, a continuance of the fever indicates an extension of the infection beyond the surface of the endometrium. Further efforts at local treatment are in vain. When the uterus and adnexa are tender the trouble may be localized or confined to their region. The appearance of peritonitis shows the extension of the infection through the uterine walls. In the not uncommon condition of absence of local tenderness, with symptoms of profound general intoxication, we have to do with bacteremia.

Cases of pelvic and general peritonitis are best treated with hot moist dressings to the abdomen and measures to overcome distension and paralysis of the intestines. Local treatment of the uterus should be at once suspended. General septicemia or bacteremia is also quite beyond the reach of any local treatment. Here we should institute tonic supporting treatment, with most careful attention to nutrition and protection from all waste of energy.

It is necessary to refer to two measures to combat sepsis that have been recommended for use in puerperal fever or that are more or less in vogue, viz., the anti-streptococcus serum of Marmorek and the silver preparations of Credé. It is only necessary to say, in regard to the former, that experience with it has been unsatisfactory. Reports from the Credé treatment of sepsis are much more encouraging. Both the unguentum Credé and the more recent collargol used hypodermically have proved of value and are not dangerous in their employment.

Finally, I must say a word about the subject so often discussed at present: hysterectomy for puerperal fever. I believe its field is exceedingly limited. It is indicated only when the infection is confined to the uterus and when Nature is incompetent to combat the infection. It is evident that the difficulties in diagnosing this condition are so great that they are practically insurmountable. Therefore, I believe this operation may be omitted from our list of measures to be employed in the management of puerperal fever. The surgical treatment, consisting in the evacuating of a puerperal abscess, whether located in the abdominal cavity, the pelvic connective tissue or elsewhere, is, of course, indicated whenever this condition is determined.

## FLATFOOT IN INFANTS AND CHILDREN.

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The subject of flatfoot in children has received but little attention and the condition is often overlooked. The former opinion that all children were flatfooted at birth has been rendered untenable by the investigations of Dane, who demonstrated that a normal arch exists at birth, but that in well-nourished children a pad of fat is present in the sole of the foot which fills up the natural hollow of the foot and leads to the appearance of flatfoot. In thin children this pad does not exist and the imprint of the foot then resembles the adult type. Section of the bones shows that the arch of the foot exists from birth.

### FLATFOOT IN INFANTS.

Heavy children who walk early, and especially if they have any grade of rickets present, are apt to show soon after beginning to walk a tendency to tread on the inner border of the foot, which is likely to attract attention.

The boots are run over to the inside and the leather of the upper is soon brought in contact with the ground, and the whole boot, being of soft and yielding leather, is twisted to the inside and its abnormal shape is noticeable. This, of course, makes the inner malleolus more prominent than it should be, and seen from in front the foot is markedly displaced outward in its relation to the leg. Children of this age rarely complain of pain, but they walk with the feet wide apart, with a somewhat unsteady gait; they are obviously clumsy and they trip easily and have many falls. On examination the foot is normally moveable in all directions and can be readily put back into the normal relation with the leg. There is no tendency toward fixation in the abnormal position as in flatfoot of the same grade in adults. The knees are generally lax and when fully extended permit marked lateral mobility. When the child stands, on account of this lateral mobility the tendency to flatfoot is exaggerated. The combination of lateral mobility in the knees with the tendency to walk with the legs apart it is easy to see tends to exaggerate the disposition to throw the weight onto the inner border of the foot. When seen standing without shoes or stockings such children present an appearance of marked flatfoot with a suggestion of knock-knee.

Such children are not necessarily feeble or debilitated, but often of the most robust and heavily-built type. The cause of the difficulty is obviously a disproportion between the weight to be borne and the muscular power, and even a slight grade of rickets seems to relax the muscles and ligaments to an extent which strongly predisposes to it.

The affection is invited by the bad shape of many children's shoes. Until lately they were all made the same for each foot, rather narrow in front, wide and roomy at the middle of the foot, with no support to the arch and little or no heel. Of late years shoes have been made better suited to the foot, but still far from perfect. These shoes have a straighter inner edge, with more room in front, and tend to hold the foot adducted rather than in a position of abduction. They are still deficient in having little or no support for the arch of the foot and of being so yielding that they afford little assistance to the muscles.

To diminish in children with this trouble the support to the muscles by prescribing the use of moccasins or by ordering walking in the bare feet seems unphysiologic, because the weight comes on a foot still less supported to bear weight than if a fair boot is worn. The same is true in a measure of the use of low shoes and slippers when there is a tendency to flatfoot. A lacing about the ankle makes it easier for the muscles to exert their force, and a good boot will improve a flatfooted child's standing position as soon as it is put on and hold the foot in better position as long as it is on. The argument that the muscles should be left free to develop in the feet of such children is negated by the fact that the muscles in question are already stretched and overfatigued and require support rather than further freedom and increased demand on their energy.

In the treatment of these cases the mildest measure that will suffice to hold the foot in a correct relation to the leg is the best suited to the case. The muscles should be as little cramped as possible and rigid support is to be avoided if possible. In the mildest cases the use of a proper shaped boot may be enough to correct the trouble if the child has been wearing boots of the old pattern, but such boots are easily stretched out of shape,

and new boots correct much better than old ones. Making the inner edge of the sole and heel thicker than the outer edge by  $\frac{1}{8}$  or  $\frac{1}{4}$  of an inch will in some cases throw the weight more onto the outer border of the foot and correct the deformity, but this method is open to the objection of throwing the outer border of the foot strongly against the outer leather of the boot and often causes a corn on the little toe, the foot simply sliding down the incline onto the outer side of the boot.

The most generally useful method of correction in infants is by means of a graduated pad of leather or felt incorporated in a thin leather inner sole, which raises the arch of the foot and holds the foot on its outer border. It has the advantage of not making the sole of the boot rigid and allowing a proper use of the muscles on which the ultimate cure depends. This pad should reach at the inner border of the foot from just behind the ball of the great toe to a point in front of the heel. It should extend the whole width of the foot. At its edges it should rise gently to its greatest height along the middle section of the inner border.

In the severer cases a flatfoot plate of metal or celluloid is required; celluloid is preferable as being lighter and less rigid and generally is sufficiently resistant to last a reasonable time.

In the severest cases of all some outward pull on the inner malleolus is required, and in these cases a steel sole plate jointed at the ankle to an upright running up the outer side of the leg to the upper part of the calf is necessary. From this upright a circular leather strap runs around the inner malleolus to pull it outward. Fortunately, this apparatus is seldom required.

The length of time that treatment will be required varies. In the milder cases the use of a pad for a few months will often effect a cure. In the severer cases it is likely that some form of support will be required for several years.

Massage to the muscles of the calf and sole is of much benefit in the treatment.

#### FLATFOOT IN CHILDREN.

In older children the treatment does not differ essentially from that of adults, inasmuch as plates are generally necessary as a means of support rather than the soft pads described for infants. In children, however, rigid flatfoot is rare, and the lax and yielding foot is the rule, which requires accurate and definite support.

Pain is rarely complained of by children in flatfoot or pronated foot, and the commonest symptoms are prominence of the inner ankle, bending over of the boots or uneven wearing of the heels. Knocking one ankle against the other is often found. Corns and caluses are rare.

In children from 5 to 15 the occurrence of lax pronated foot should lead to an inspection of the back, as scoliosis very frequently coexists as a result of the same muscular laxity that causes the deformity of the foot.

Two matters in treatment are essential: The foot should be supported in the correct position and the child should be trained in the use of the muscles supporting the arch and should be drilled in correct standing.

For the support a light steel plate is most often useful, although celluloid is more serviceable in children than in adults. This plate is most often to be made with an outside as well as an inside flange to keep the foot from slipping off, and the plate must be seen every four months if it is to be kept efficient as the child grows.

The prognosis in both infants and children is in general excellent as to complete recovery, but exercises must form a part of the treatment to bring about this result.

### THE PRESENT POSITION OF GALLSTONE SURGERY.\*

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Over a quarter of a century has passed since Marion Sims did the first planned operation for gallstones, and sufficient time has now elapsed to permit a fairly correct judgment as to the present position of gallstone surgery. But before gallstone surgery will show its best results the profession as a whole must recognize that there are no solvents which will dissolve gallstones in the gall bladder and bile ducts, and must, furthermore, recognize their own culpability if operative interference is delayed until the vital powers are exhausted. No field of surgery gives greater relief from agonizing pain, or gives greater capacity to do one's normal work than judicious early operations for gallstone disease. Not for an instant would I be understood as advocating operation in every case of pronounced gallstone colic. But when the attacks recur frequently, show a tendency to increase in severity, and become more and more incapacitating, then an operation is imperative and should be done before the recuperative powers are greatly impaired.

#### THE FALLACY OF INTERNAL MEDICATION.

In the advance which gallstone surgery has made in the past 26 years, the surgeons have been obliged to lay several popular and professional errors. The first in magnitude and, unfortunately, still prevalent among the profession is that stones can be dissolved by internal medication—a heretical doctrine which yearly claims its hecatombs of misguided victims. It is the more deplorable because any one with an extensive experience knows that long periods of time sometime elapse between attacks. I know of one case of over 19 years' interval and another in which six weeks before his fatal attack a brother physician boasted to me that he had dissolved, by daily doses of soda, the gallstones from which he had formerly suffered, and for nine years had been absolutely well. Within six weeks of that day he died from perforation of the gall bladder, and 153 stones were found therein.

#### THE REAL CAUSE OF THE COLIC.

Right here it is well to recall the present teaching that it is the associated inflammation which occasions the pain and cramp and not the mere presence of the stones. This seems a rational explanation of the quiescence of stones found at autopsy in so many persons who never have suffered from gallstone colic or other condition commonly associated with gallstone disease. It furthermore explains the fact of putty-colored stools often preceding for a day or two the appearance of gallstone colic. This last fact I, with apprehension, noticed many times in my own case. The profession is and has been slow to learn that pronounced jaundice is not a common symptom of gallstone disease. On this Lawson Tait laid great emphasis, and also that when jaundice was very deep and persistent it pointed rather to a malignant complication. This experience of Tait has been borne out by that of Mayo Robson

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