

This is a serious disadvantage in the immediate operation; nevertheless, with care, a very satisfactory joint can be made.

#### GANGRENOUS AND PERFORATED VERMIFORM APPENDIX.

At the last meeting of this Society I showed a gangrenous vermiform appendix nearly as large as the small intestine. The patient has made a good recovery. I have operated since that meeting in three other cases, with one death. In the fatal case, the abdomen was opened as a forlorn hope in a general peritonitis. Death took place in twelve hours. In this case, after the first attack, a year ago, the question of operation was considered. Almost before the patient's condition could be realized, in the second attack, a general septic peritonitis had developed, with vomiting and hiccough. Had I not seen at least one such case recover, I should have declined to operate. At such times operations offer so little hope that the question arises whether a surgeon does not owe something to his art and to his own reputation; and whether his duty requires him to interfere under conditions practically hopeless. After a long and varied experience in these frightful emergencies, I believe that the recoveries which occasionally result from operations undertaken in desperate cases justify the attempt in all where death is not absolutely certain; that interference is demanded in the strongest terms, and that the effect of the probable result upon the surgeon's reputation and upon the art of surgery is unworthy of serious consideration. The brilliant recoveries, though very rare, outweigh the harm, especially in a disease like appendicitis, which the lay mind looks upon as necessarily fatal if left to itself.

In another case a gangrenous and perforated vermiform appendix was situated behind the cæcum in a sac of healthy peritoneum, not shut off by old adhesions. The appendix was shelled out by passing the finger from the brim of the pelvis underneath the cæcum towards the kidney. The perforation was found at the tip, and under the gangrenous patch was the usual fecal concretion. In this case pus could escape only by perforating the cæcum or by breaking into the peritoneal cavity. There was a possible route towards the right flank. Drainage in these cases seems to me always exceedingly dangerous — an opinion borne out by not infrequent fatal results, whether the case be treated surgically or left to itself.

I have taken the time of the Society to show this specimen and to comment upon the case because I do not agree with the views recently expressed by several writers, that the surgery of appendicitis is being carried too far. As one of those who see the most of this formidable disease, while not as yet accepting any fixed rules of procedure — certainly not that of always operating — I cannot but be sorry to see the let-alone treatment encouraged, especially as this method is the one most agreeable to general practitioners. An enormous amount of good has been done in the past eight years by the agitation of this subject. Any relaxation of our efforts in this direction, particularly that sanctioned by high authority, is in my opinion to be regretted.

**EMERGENCY HOSPITAL AT WORLD'S FAIR.**—There were treated at this hospital 18,500 cases, and there were 23 deaths at the institution.

#### FURTHER EXPERIENCE IN THE USE OF CHLORALOSE.

BY F. GORDON MORRILL, M.D.,  
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A CONSIDERABLE experience has convinced me that in "chloralose" we possess an hypnotic of great value. I have prescribed it in twenty cases of insomnia, with good results in almost every instance — exceptions to be noted a little further on. Properly used in cases *uncomplicated by hysteria or alcoholism* (I have had no experience with the drug in locomotor ataxia, sonambulism or pulmonary phthisis, the presence of either of which conditions is considered unfavorable to its action), it has appeared to me to justify the claims of its discoverers: that it is safe, produces no "habit," does not require a progressive increase of dose, and is reliable in its action, that is, produces refreshing sleep attended by no disagreeable after-effects. In simple insomnia it certainly acts "like a charm," and is destined, I think, to replace chloralamid, than which drug it is more reliable.

A case which particularly impressed me was that of an old man with organic heart-trouble, whose nights were rendered wretched by dyspnoea, palpitation and fear of sudden death. A fairly large dose gave complete relief every night during the six weeks which he survived after my first visit.

In the case of an elderly lady with whom other hypnotics had failed, and who, in her desperation, had formed the habit of obtaining sleep by taking a tumblerful of whiskey at bedtime, chloralose gave quiet and refreshing nights, and eventually enabled her to conquer a most obstinate insomnia of long standing. In this instance it was necessary to abandon the whiskey and pass several sleepless nights before taking the remedy, as alcohol is distinctly unfavorable to the action of chloralose.

A young married woman, whose inability to sleep was due to her anxiety concerning the health of her only child, took chloralose in a fairly large dose (six grains), and after a good night's sleep suffered from marked inco-ordination of motion for an hour after rising. The same effects followed a repetition of the dose, and the medicine was discontinued. A distinctly hysterical attack which occurred a day or two later furnished an explanation of the disagreeable after-symptoms.

In somewhat the same category may be placed the case of an old gentleman with an enormous prostate and a very irritable bladder, whose complaints of suffering always increased to a marked degree in the presence of a certain member of his family. Here six grains of the drug produced a very peculiar effect, for after three hours of quiet sleep he awoke delirious, and tried hard to get out of bed. Being restrained from this, he crawled about the bed for an hour, and then went quietly to sleep, expressing great satisfaction next morning for so quiet and restful a night — evidently having no recollection of the alarm he had caused his attendants. The chloralose was afterwards resumed in divided dose (the second cachet of three grains being given when the effects of the first had passed), and the result was far more satisfactory than that obtained by full doses of chloralamid, which had been given as a substitute in the interval.

A fuller appreciation of mental characteristics would have led, in the lady's case, to refraining altogether

from exhibiting chloralose, and in the last-mentioned instance the divided dose only should have been given.

A brief analysis of Goldenberg's thesis (Paris, 1893) shows sixty-four cases in which the drug was used. Of the fourteen failures, eleven were cases of women. Five of them were hysterical subjects; two were alcoholics; one suffered from severe gouty pains; one was a consumptive; and one had pulmonary emphysema and a secondary heart. The cause of failure in the eleventh case is not mentioned. Three were male cases, with locomotor ataxia, paralysis agitans and nocturnal syphilitic pains respectively.

The best method of administration appears to be to give a cachet containing three grains (those made here are more convenient to swallow than the imported) an hour before sleeping-time, and repeat promptly when the time is up if no effects are obtained. In case insufficient sleep follows the first dose, it is repeated when the patient awakes. The largest dose I have given in a single night was twelve grains. As a rule, it may be assumed that three grains (repeated as above in some cases) will insure from five to nine hours of refreshing sleep in any case of insomnia which cannot be readily classed among the exceptions which resist the action of the drug. The results which I have thus far obtained certainly encourage me to persevere in giving this new hypnotic a more thorough trial. It is as certain in its action as chloral, and far safer; as harmless as chloralamid, and far surer, so far as I have been able to observe.

## Medical Progress.

### RECENT PROGRESS IN SURGERY.

BY H. L. BURRELL, M.D., AND H. W. CUSHING, M.D.

(Concluded from No. 19, page 468.)

#### SUTURE AFTER LAPAROTOMY.

Howitz,<sup>13</sup> of Copenhagen, at the recent Surgical Congress held at Gothenburg, discussed the comparative value of the methods and kinds of sutures which are used after laparotomy. According to him the abdominal hernia which occasionally occur after operation are dependent upon the manner in which the sutures are applied. Three factors determine the strength of the cicatrix: (1) The nature of the uniting surfaces; (2) the manner in which they are held together, and (3) the kind of suture used. As regards (1) the incision in the linea alba is not advantageous, since the conditions required for the formation of a sound scar are not present. In order to form a strong cicatrix the opposing surfaces of the incision must be fairly extensive and smooth, they should contain only a small amount of fat, and should be in apposition without much tension. In order to secure this condition of affairs the author advises that the incision should be made about two-thirds of an inch from the middle line, passing through the substance of the rectus muscle. As regards the method of suturing, he recommends the twisted suture, such as is used for harelip. In applying the suture a slightly curved needle is used, and only a small amount of peritoneum included in the suture. The sutures are made from silkworm gut.

<sup>13</sup> Sem. Med., July 12, 1893; British Medical Journal, August 12, 1893, p. 25.

After the operation the patient is kept in bed for three or four weeks, so as to allow the scar to become firm.

#### THE INDICATIONS FOR LAPAROTOMY IN ACUTE INTES-TINAL OBSTRUCTION.

Schlange<sup>14</sup> has successfully removed by primary resection 135 cm. of intestine. The laparotomy and resection was done to relieve intestinal obstruction. In discussing the indications for operation he divides these cases into three classes: (1) When there is abdominal distention and peristaltic motion exists (hence no general peritonitis since this paralyzes the intestine) with sudden onset, or symptoms quite persistent, the case is probably one due to local trouble and one should operate. (2) With marked tympanites and no peristalsis (paralysis, general peritonitis) operation only hastens death. The most one is justified in doing is to rapidly make an artificial anus. (3) When a limited portion of the intestine is affected while the rest is normal, this section becomes greatly distended, is paralyzed. The symptoms are always violent. The patient's strength decreases rapidly. There is not diffuse peritonitis. Here laparotomy performed early is the only chance for the patient's life.

#### FAT EMBOLISM FROM FORCIBLE CORRECTION OF JOINT DEFORMITIES.

Fritz Colley,<sup>15</sup> of Marburg, has reported a case where death followed fourteen hours after a forcible straightening of both knees, with symptoms of pulmonary oedema. The patient was twenty-six years of age. The clinical diagnosis was death from fat embolism. The autopsy confirmed this. The case differs from the usual cases of fat embolism in that without any bony lesion, the rupture of the cicatricial attachment to the femur of a fatty degenerated muscle allowed enough fat to enter the circulation to cause death. Also, that as a result of the filling of the heart capillaries with fat caused such an impediment to its proper nutrition that within fourteen hours acute fatty changes were produced. These conditions would suggest that *brisement forcé* is not free from danger as it has formerly been considered. That it becomes a serious operation when a muscle which has become atrophied and fatty degenerated from disease, is torn or a bone showing conditions of fatty osteoporosis is fractured.

#### DIAGNOSTIC AND THERAPEUTIC VALUE OF PUNCTURE OF THE SPINAL CANAL.

Pritchard<sup>16</sup> has published an interesting abstract of V. Ziemssen's article on this subject. The method of Quincke, of Kiel, which was first used for the purpose of decreasing the pressure in hydrocephalus, was used by Ziemssen in several cases of tuberculous cerebro-spinal meningitis, brain tumors, etc. The spine is flexed to increase the interspace between the vertebral arches. The patient is anesthetized. The fluid escapes with a rapidity proportionate to the pressure. The cerebral pressure was diminished by the operation. A case of tubercular meningitis was improved under this treatment. Quincke after operating twenty-two times found that the fluid reaccumulated rapidly. He found that hydrocephalic fluid contained less than 1% of albumen. Above 1% indicates that an inflammatory process is probable. Above 2% is sometimes found in tubercular exudations. He thinks puncture

<sup>14</sup> Berlin, Klin. Woch., 1892, No. 47.

<sup>15</sup> Deutsche Zeitschr. f. Chir. 1893, xxxvi, p. 322.

<sup>16</sup> Annals of Surgery, 1893, vol. xviii, 235.