

## Clinical Notes, Suggestions, and New Instruments

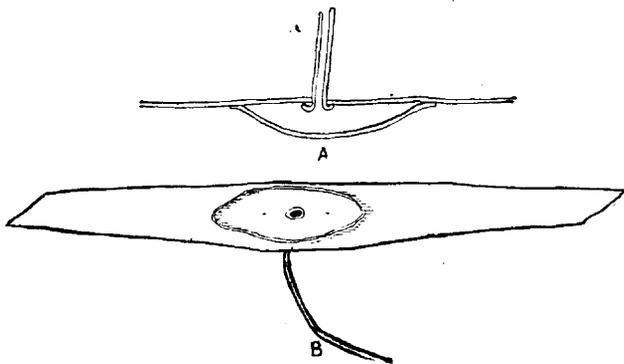
### POSTOPERATIVE DRESSING FOR CHOLECYSTOTOMY

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The dressing here described has been adopted in my work in gallbladder cases in which a rubber tube drain is left, for the purpose of eliminating the troublesome and messy pad. These cases, if they drain at all profusely, require changing of the pad from one to three times a day, and usually a large stack of dressings is found saturated with the discharge.

The dressing is made from the rubber umbilical belts made for the umbilical hernia of infants. This belt consists of a band of pure rubber, to extend around the abdomen, with a pneumatic pad in the middle. The pad is inflated by a rubber tube. A section is shown at *A* in the illustration. The rubber pouch which is cemented to the under side of the belt is trimmed away with a pair of scissors, leaving the belt with the tube attached, with the opening on the reverse side of the belt.

After the cholecystotomy case has progressed so far that all drainage can be withdrawn, and only a fistula is left, this belt is sterilized and fastened over the wound, so that the opening into the rubber tube comes just over the fistula. The band is held in place by straps of adhesive plaster. The



Postoperative dressing for cholecystotomy: *A*, diagram of air cushion on umbilical belt; *B*, umbilical belt trimmed for use.

discharge from the fistula is thus enabled to pass through the rubber tube, into a bottle, just as if the rubber drain were still in place.

This effects a great saving in time, trouble and dressings, as well as affording the patient a great deal of convenience over the old method.

### THE TREATMENT OF URETHRAL CARUNCLES BY FULGURATION

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Not having seen a report of the employment of the high frequency current in the treatment of urethral caruncles, we desire to direct attention to the value of this method of destroying these troublesome growths. Our first experience with fulguration thus used was about two years ago when we fulgurated a large caruncle which had persistently returned over a period of several years after excision once, destruction by the actual cautery three times, and treatment with various cauterizing chemicals. We, as well as the patient, were much discouraged with the results obtained. We explained that fulguration treatment might succeed in preventing a return of this painful vascular tumor, and the patient readily consented to try this method. The surrounding tissue was infiltrated with a 1 per cent. solution of novocain, and the d'Arsonval current was applied until all of the red growth was whitened. Less pain followed the treatment

than had followed any of our previous treatments, and at the end of two years there is no return. Slight bleeding occurred at times as the fulgurated mass separated from the surrounding healthy tissues. There has not developed any narrowing of the urethral canal. Two others have been treated in this manner. One required only a single treatment, as the caruncle was small. The other required two fulgurations, as the growth was massive and so surrounded the urethral canal that we were afraid to attempt a total destruction, as we could not determine the limitations of the growth until it was reduced in size.

The patients have all remained well, though sufficient time has not elapsed to permit us to say they are absolutely cured. We can say, however, that they appear normal, one after two years, one after six months and one after two months. The technic of the procedure is much simpler and easier than excision, and the inconvenience to the patient vastly less, as the fulguration may be performed under local anesthesia.

### INDIA INK INFILTRATION: A SIMPLE AND EFFECTIVE SUBSTITUTE FOR CORNEAL TATTOOING\*

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The method of tattooing corneal scars hitherto employed has consisted in making numerous needle pricks in the scar and then rubbing into them a paste of India ink. It is necessary to repeat this process many times with sufficiently long intervals to allow the inflammatory reactions to subside. This method has given such unsatisfactory results that corneal tattooing is now seldom attempted, either for cosmetic or for optical purposes. Moreover, it is open to the objection that it exposes the eye to serious danger of infection, and when the iris is caught in the scar, even to the danger of sympathetic uveitis.

Several years ago it occurred to me that a simpler, safe and generally more satisfactory method of darkening corneal scars would be to inject the pigment or coloring matter into the tissue by means of a hypodermic syringe. I therefore tried this method, but instead of making use of India ink, I employed a 20 per cent. solution of argyrol in the hope that permanent argyrosis would be produced. The result was most brilliant for about a week, at the end of which time the superficial layers of the scar were cast off, evidently because of necrosis from the toxic action of the argyrol. This made the scar thinner and much less noticeable, but of course was not the desired solution of the problem. It was noteworthy that the argyrol solution remained in the place it was injected and did not diffuse into the surrounding tissue to the slightest extent, thus proving that the penetrating power claimed for argyrol does not really exist.

Recently I have tried the method again in three cases, using India ink instead of argyrol, and the results have been entirely satisfactory. I made use of an ordinary small glass hypodermic syringe and a medium size needle (26 gage). A very small needle might tend to become plugged by the ink particles. The India ink, in stick form, was rubbed up in a small amount of physiologic sodium chlorid solution until a sufficiently black suspension was obtained. The fluid was then drawn up into the syringe through the needle, a piece of cork placed on the end of the needle, and the whole sterilized by boiling. The eye was then cocaineized and held firmly by fixation forceps. After the syringe had been cooled and all air carefully forced out of it, the needle was introduced into the scar near the margin and the point pushed just beyond the center. The fluid was then slowly injected until only a narrow rim of the scar remained unblackened. In two of the cases it was necessary to insert the needle in two or three places to obtain this result, owing to the large sizes of the scars. The reason for not forcing the fluid quite to the margins of the scars was to avoid the possibility of its suddenly breaking its way into the normal corneal tissue. The uninjected margins of the scars, however, in none of the cases were sufficiently conspicuous to interfere with the cosmetic results.

\* From the Massachusetts Charitable Eye and Ear Infirmary.

**Military Medicine and Surgery**

**PITCHING AND STRIKING THE UNITED STATES ARMY FIELD HOSPITAL**

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The ability to pitch or strike its field hospital in a very short time is a necessary accomplishment for every field hospital company. Speed in these two

Great care was taken not to force the needle into the anterior chamber.

Following the operation, the eye in each case showed a slight reaction which subsided in about a week. In the course of a few weeks, the blackening became more uniform so that the ultimate results were superior to those immediately obtained. These results were far superior to those of any tattooing operations I have seen, and owing to the large amount of pigment injected and its depth in the tissues, there is every reason to believe that the improvement will be permanent.

**DILUTING FLUID FOR COUNTING BLOOD CORPUSCLES**

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The need of a good diluting fluid for the purpose of counting blood corpuscles has often been impressed on me while working in the laboratory and in hospitals. Those mentioned in textbooks have many drawbacks. Some form a precipitate on standing; others while remaining clear do not permit of the addition of staining solutions so that the white corpuscles may be differentiated from the red corpuscles while making the count; still others destroy the red corpuscles if the diluted blood is permitted to remain in the counting pipet for some hours.

With the object in view of securing a fluid which will do away with the objections mentioned, I have done some work along this line and have obtained what I believe to be an ideal diluting fluid. This fluid permits of the simultaneous counting of white and red corpuscles; it keeps indefinitely without precipitating; it retains the normal shape of the corpuscles, and the diluted blood kept in the diluting pipet for over a week was as perfect as when first drawn. The formula is as follows:

Sodium chlorid .....	0.85 gm.
Sodium citrate .....	2.00 gm.
Azure II .....	0.001 gm.
Formaldehyd solution, U. S. P. ....	3 drops

Distilled water enough to make 100 c.c.

The sodium salts are dissolved in the water, the formaldehyd solution is added, the azure is added, and it is shaken well. It may be kept in any kind of a bottle.

The technic of using it is the same as with Toison's, Hayem's, or any other fluid. The findings are computed according to the degree of dilution.

**FRACTURE OF ISCHIUM**

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Fracture of the ischium is so rare that the following case is worthy of attention. The history of the accident as given by the patient is interesting.

W. S., a robust man, said that two days previously he had fallen in such a manner that he landed on the buttocks in the sitting position. A half buried brick protruded from the ground so that the force of the fall drove the brick against the right buttock. He tried to rise to his feet, and as he assumed the standing position there was a loud snap and he fell to the ground a second time. Thereafter he was unable to use the leg, and suffered intense pain when any effort was made to do so.

The man lay on the left side with the right leg flexed at the knee. Any attempt to extend the leg produced pain in the right buttock. Pressure over the region of the tuberosity of the ischium elicited severe pain.

Roentgen examination revealed a fracture through both rami of the ischium, the anterior being at about the junction of the ischium and pubic bone, the posterior extending through the acetabulum.

The patient was kept in bed on the left side with the right leg flexed at the knee. Recovery has been slow, but is good as far as function is concerned.

It would seem that when the patient's buttock struck the brick, only a partial fracture occurred, which was completed by the muscle strain incident to rising to the erect position.

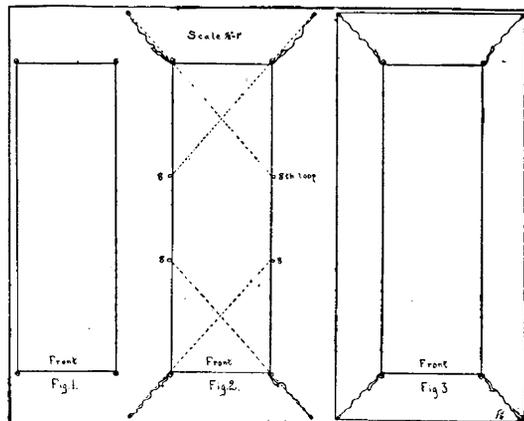


Fig. 1.—Pitching tentage, first step: Tent pinned to the ground by its four corners. Always draw wall taut and then slacken 4 inches before driving the corner pin.

Fig. 2.—Second step: The four corner guy pins added, and ropes placed over them.

Fig. 3.—Third step: Storm guys stretched for alining guy pins.

operations will often spell success in the evacuation of the wounded in time of war. As every civilian physician who joins a field hospital company will be

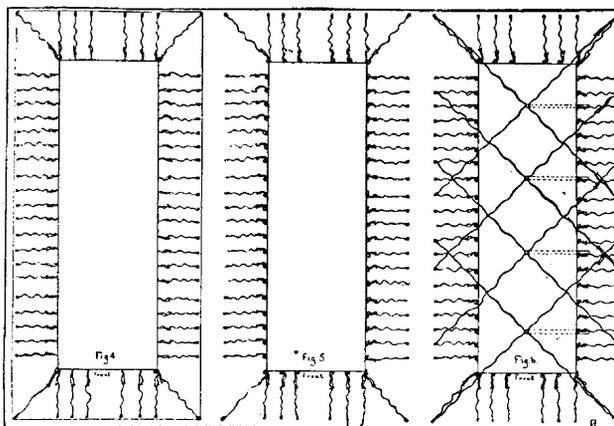


Fig. 4.—Pitching tentage, fourth step: Guy pins driven inside of ropes, opposite wall loops, and guy ropes, fully slackened, placed over pins.

Fig. 5.—Fifth step: Wall pins driven through wall loops on Sides 1, 2 and 3, and at (not through) wall loops on Side 4; wall loops removed at LECWP and LRCWP.

Fig. 6.—Sixth step: Uprights placed, hoods and storm guys adjusted; men creep under tent, raise, and then adjust uprights and ropes. Storm guy, a long rope over tent.

confronted with these necessary procedures, their anatomy will be presented in detail. The first essential is to learn how to pitch, strike and fold army tentage.

**PITCHING**

The field hospital company is divided into tent pitching squads, each of eight men and an NCO. Each