Pals
A

Report of Cases in Practice with Commentaries.

Illustrated by Casts in Plaster of Paris.

being

M. D. Graduation Thesis, 1st August 1880

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On a Case of Cavernous Nævus.

The Report.

Mrs P. aged 35 years and residing at Ferrier Street, Leith, consulted me on 4th Nov. 1879 concerning a Growth situated on the proximal joint of the little finger of her right hand; saying that she desired it removed before her approaching confinement because it had been the cause of much trouble to her during her three previous lying-in periods.

The tumor is about the size of a walnut, the skin over it is not implicated, the Growth is quite soft, and with a little press are it can be emptied of the sanguineous contents till the two folds of skin are approximated, on leaving of the pressure 20. minutes are required before the tumor resumes its former distended condition.

Stethoscopic examination fails to detect any bruit in the swelling.

See the Plaster of Paris Cast. No. II

History of the Nævus.

The patient informs me that she was born with the growth, but that it was only the size of a pea and scarcely raised above the skin; it continued much in the same state till she was 29 years old when it began to trouble her at each menstrual period by attacks of Redness and swelling.

The patient married when 30. years of age, and her first baby was born 11. months afterwards, during the latter 3. months of this Pregnancy the Growth acquired its present large dimentions and was very painful.

The day after her labour the patient could not close her hand owing to the painfulness and swollen state of the Tumor which was like the size of a Hen's egg.

The Treatment adopted consisted only of Poultices and in 10. days the growth fell to the size of a Walnut.

The second baby was born 19. months after the first, and the Tumor again swole to the size of a Hen's egg after the Labour.

The third baby was born 2. years after the second one and here again after this birth, the Tumor went through the same stages of swelling and subsidence.

I should mention here that the patient suckled her ~~babies~~ Babies till she found herself in the pregnant state so that the effect of Menstrual Periods on the Tumor cannot be ascertained, at least during her married life.

Treatment.

I considered Electrolysis would be the most suitable measure in this case and according got Dr. John Duncan's opinion in the matter who agreed with me in the Diagnosis and the proposed Treatment.

Operation 8th Nov. 1879.

Dr. Duncan inserted two needles one connected with the positive and the other with the negative Poles of a Leclanche's Battery 5 to 10 cells in strength, each pole being insulated to prevent slonghing of the skin, and continued the current for 7. minutes till the contents were coagulated. A longer application was not carried

ered expedient in a case like this where the skin over the Tumor is so thin and delicate.

It should be observed that before beginning the operation I applied a small elastic band round the cardiac aspect of the finger to arrest the circulation and prevent the carriage of any clots into the general current.

The Patient at one period of the operation experienced more pain than is usual in these cases and what is more curious this painfulness did not begin with the insertion of the needles & starting of the Galvanic Stream, nor did it commence when the strength of Current was raised but appeared suddenly about 4. minutes after the start of the operation and continued till the needles were withdrawn at the end of the 7. minutes.

This done the elastic ligature was removed, and a Pad of Bracic Lint applied to prevent haemorrhage from the holes made by the needles, then a bandage was carefully adjusted to keep the pads in position. The patient to return in three weeks.

It is curious to note that although the elastic bandage was very firm indeed around the finger during the operation, yet nervous sensibility was not removed by it.

17th Nov. I visited Mrs P. to-day and find that she has experienced no trouble after the operation or pain. The growth is very firm and hard particularly at its base where a distinct coagulated mass can be felt.

29th Nov. To-day I examined the tumour and find it is getting quite soft again and therefore suggested another operation at once,

but Mrs P. declined because she had to go to Peebles where Her husband ~~to~~ had obtained employment. So that treatment was in her case discontinued owing to her removal.

Commentaries.

Although this case is incomplete in the subject of Result of Treatment, yet I consider it deserving of record in this Thesis owing to the light and additional proof it throws on the subjects of the Increased vascular Tension during Pregnancy, in the Puerperal State and also most likely in the Menstrual Motimen.

The only other points in the case to which I will briefly refer are the reasons for choosing Electrolysis in the case as a Treatment, the disintegration of the Blood Clot and the unusual Painfulness experienced from the Needles.

I. The Vascular Tension in Pregnancy and in Childbed.

The proofs which have been as yet forthcoming in this subject may be here shortly mentioned.

A. Cardiac Hypertrophy.

In the Archives Generales de Medecine, V^e^ serie, tome XIII. p. 291, 1859 are recorded Larchers post. partem examinations and views which show that during the last months of Pregnancy the Left Ventricle is thickened one-third as much again as is normal.

B. Liability to Pulmonary Inflammations.

McDonald in his work on "Heart diseases in Pregnancy tells us at page 202. "there appears to be engendered by the Pregnant condition a special liability to chest affections" this being increased in cases of mitral Stenosis.

The reason of these inflammatory attacks being so obstinate during Pregnancy is due to the Tension in the Pulmonary Circuit being kept up by the Hypertrophied Ventricle.

C. Varicose Veins during Pregnancy.

At page 22. of the same work Dr. McDonald says "The great tendency to various varicosities during Pregnancy, indicating as it does exalted venous tension, cannot be overlooked, as substantiating the opinion that the circulation is conducted under abnormally high tension during this period".

D. Accidental Hæmorrhage before Delivery.

If a patient with Mitral Stenosis become pregnant and dilation of the Right side of the Heart ensue, then the Placental Cells may rupture and Abortion be induced. Here we have an example of the increase of Venous Tension produced by the Physiologically hypertrophied Left Ventricle aggravating the Stenosis and producing its own cure by terminating the Pregnancy.

E. Parenchymatous Nephritis and Albuminuria in Pregnancy.

For long these diseases have been regarded as produced by increased Pressure

in the Renal Vessels but Dr. MacDonald thinks that some cases at least where there is no fever are examples of Degeneration of the Epithelium of the Tubes induced by the State of the Blood in Pregnancy.

Next I come to the evidence afforded by the Inflammation of the Nævus in my patients case and there is a similar kind of case recorded in the Edinburgh Medical Journal by Taik namely Inflammation of the Thyroid Gland, so that we may group the evidence given in this way as:-

I. Inflammation and Swelling of Vascular Growths and Organs in Pregnancy.

The evidence is so complete in the report that I need not dwell on it here but proceed to the other parts of the case.

II. The Treatment by Electrolysis.

The reason for electing this method in the first is the same as determines its choice in cases of nævus or circoid on the Face namely in exposed parts of the Body elect that mode of Treatment which will avoid a scar, even although more troublesome, tedious or uncertain so long as repetition will effect a cure. These various hints have been suggested in a paper by Dr. J. Duncan in the Edinburgh Medical Journal on "The Treatment of Nævus" February 1876.

III. The Unusual Painfulness during Operation.

The most probable explanation of this occurrence is that the needle came in contact, during some movement of the patient's hand, with a branch of nerve.

IV. The Softening and Removal of the Blood Clot.

This seems to be caused not by the action of absorbents but by melting of the clot from being surrounded and washed constantly by new alkaline fluid blood, and we also know that Blood does not coagulate in a solution of Potash or Soda.

This fact is the foundation of the Treatment of Polypi in the Heart and Vessels by Ammonia or other Alkali, and for the administration of Alkaline Salts in cases of Disease characterized by Hyperinosis.

Post. Script.

I observe upon consulting Hamilton's 'Outlines of Midwifery' page 91. That the pains of a labour may be the starting of Inflammatory Action in the Thyroid ending in Bronchocele. That is a condition very similar to the action excited in the Epiescenk Nævus.

On a case of Hydramnios

The Report.

Mrs C. aged 35 years and residing at Balf-our St. Leith sent for me on evening of 7th Dec. 1878. to confine her of the third baby. Her previous labours had all been easy and natural but this time she had constantly refrained from going abroad during pregnancy owing to her gigantic dimentions and as she expressed it "I was ever looking at herself in the mirror wondering if she was carrying twins". The only other complaint was Breathlessness.

Upon instituting a vaginal examination I found the os fully dilated and to my astonishment found the membranes presenting as a great, thick, smooth and fleshy mass, through which it was quite impossible to make out any presentation, and I found Ballotement or Bobbing of the foetus perfectly impossible.

I could not imagine this fleshy substance to be anything else than the after-birth and thought this was a case of that fell disease — Placenta Praevia.

Accordingly I enquired for a history of haemorrhages but found none there upon examining the abdomen I found the Uterus very large, tense and fluctuating but could not detect any part of the foetus nor hear the foetal heart sounds.

I was now satisfied that my case was one of hydramnios with very oedematous membranes and as the pains were very weak and ineffectual I ruptured the membranes, having previously furnished myself with a wash-hand basin to receive the waters, I kneaded the uterus from above and the first gush 3/4 filled the receptacle. This was followed by stronger pains and to save unnecessary suffering and delay I applied the forceps to the head which was now entering the pelvis. The child was a full grown Female, its abdomen enormously ascitic and the limbs very oedematous, it only lived some 30 minutes or so.

I removed the placenta by Expression; it was three or four times the usual size, very soft, oedematous and so pulpy that the finger tore it down readily.

I then examined the Heart for Valvular Disease, and the abdomen for Ascites and found neither. Nor was there any dropsy of the ankles in this patient.

It only remains to be added that the woman made a steady recovery without any attack of Inflammation or trouble whatever. And that having procured the foetus and placenta I exhibited them to the Members of the Obstetrical Society.

The Commentaries.

The points of Interest which this case suggested to my mind as deserving of investigation were 5 in number:—

I. What causes the Breathlessness?

II. How is the excess of Liquor Amnii produced?

III. What diseases are likely to be mistaken for Dropsy of the Amnion?

IV. Have we any Statistics of its effect on the Mother and on the Child?

V. Are authorities agreed about the Treatment of these cases?

I. The Breathlessness.

That this symptom is produced mechanically owing to a real diminution of the chest cavity is demonstrated by the cyrtometric measurements of Dohrn[I.] which shows that the vital capacity of the lungs is constant throughout Pregnancy and that this is attained by an increase in the transverse diameter, compensating for the diminution in the perpendicular axis of the Thoracic Cavity which occurs in Pregnancy owing to the elevation of the Diaphragm.

But wherever a pathological condition is superadded like Ascites or Hydramnios diminution of the Breathing space is induced.

I. Monatsschrift für Geburtskunde Bd. XXIV. S. 414.

Gueserow[II] holds that the Induction of Premature labour is therefore quite a legitimate and even scientific procedure in a bad case of Ascites or of Hydramnios.

But, he says, to try and get rid of the suffocation from causes entirely restricted to the chest such as acute Pneumonia or Congestion from initial Obstruction, by procuring Premature Labour is illusory because the Pregnancy does not diminish the chest Cavity.

Now although I believe what Gueserow has stated is correct, yet we find that nature in these last cases anticipates our art and invariably herself produces Labour.

Again we know that after Labour is over the arterial tension[III] which is high in Pregnancy falls coincidentally and therefore the obstruction to the cardiac muscle must be correspondingly relieved, and the compensatorily hypertrophied Left Ventricle[IV] will then be no longer required and will begin like the Uterus to undergo fatty degeneration, all which will tend to relieve the chest symptoms.

II. Monatsschrift für Geburtskunde Bd. xxxii. S. 88.
III. MacDonald. Heart Disease during Pregnancy.
IV. Larcher. Archives Generalles de Medicine, 5e serie, tome XIII. p. 291. 1859.

II. What causes the Abnormal amount of Liquor Amnii?

This question leads us to an examination of the membranes and Placenta and foetus in any cases. I can find recorded by authors on this disease also to an account of the few cases of Post. Mortem examinations.

First of all, then, What is the normal amount of the Amniotic waters?

Dr. Tanner[I] tells us it is sixteen ounces. Merriman[II] gives us an account of the estimates made by various authors, thus Lowder, Burns and Hunter state the quantity at one pint. He also informs us that Van der Bosch[III] regards 8 ounces as the very utmost.

Dr. Hunter at a dissection measured ½ a pint Wrisberg measured in two cases at the full time and got respectively 14 and 18 ounces.

Merriman on dissection of a case of Hydramnios measured 8 English pints and says Dr. Harvey had a case were 10 pints were spilt.

We may conclude therefore that the average amount is 16 ounces, but that in Hydramnios it may reach two Gallons as Merriman found in a case wear the foetus was monstrously formed and diseased.

I. Signs and Diseases of Pregnancy. Page 152. Dr. Tanner
II. Difficult Parturition. Merriman.
III. Scheel de Liquore Amnii. Hafniæ. 1799. Vander Bosch

What state are the Membranes in?

Dr Tanner[I] says M. Mercier attributes the disease to inflammation of the Amnion, but that of late years cases examined show absence of anything like special inflammatory action in the Membrane, though almost in all some diseased condition of the entire Involucra or of the placenta or Foetus existed rendering the child incapable of support life after its birth.

Dr McClintock[II] tells us that in exceptional cases the Amnion is opaque and thickened, again at page 378 he informs of the state of the Amnion membranes if the woman be pregnant of Twins, viz that the Amniotic sac of one child only is engaged in the disease and that this is the Amnion of the second born Twin.

Dr Murphy[III] describes the Amnion as thickened and marked with broad patches of a white colour, as if lymph had been effused between it and the chorion. This thickening of the membranes and Dropsy of the Amnion generally accompany each other.

It would therefore appear that in many cases at least this disease is an Inflammation of the Amnion, and pathological facts bear greater testimony in favor of this local origin of the disease than in support of a Constitutional origin, although it has been occasionally ascribed to Death. McClintock found no Syphilis in his experience which embraced that of 33 cases.

I Tanner. Signs and Diseases of Pregnancy

II McClintock. Diseases of Women Page 376

III. Murphy. On Parturition. Article Dropsy of Amnion.

What is the state of the Placenta and the Foetus?

The authors seem agreed that the after-birth is large, inform and that on auscultation during labour the uterine soufflet is seldom heard either owing to the frequency of the labour being premature or the foetus being dead.

The foetus is not necessarily destroyed by this disease, it may both be born alive and get on all right, but McClintock experience shows (see page 382) that it is a common cause of the death of the foetus and of early abortion even to the extent of 13 cases out of his 33 being Premature Deliveries. Moreover he shows that the morbid action is unfavourable to foetal life as 9 out of the 33 foetuses were born dead. He demonstrates its association with multiparity and very markedly with Female Sex, the proportion of Female children to Male ones was 25 to 8. which is more than a mere accidental association.

Some of the children were acephalous but some were Ascitic, Anasarcous or Hydrocephalic.

This now brings us to the third great point of interest namely—

III. What Diseases are we most likely to confound with Hydramnios?

The Text books and the authors I have already mentioned say:—

I. Twin Pregnancy.

II. Abdominal Ascites, and I purpose to add the interesting and at first grave mistake I was about to entertain in my case namely

III. Placentar Presentation.

I The Differential Diagnosis between Hydramnios and Twins.

Dr. McClintock gives us the following hints:—

1. Internal Examination. The expanded state of cervix in Hydramnios, also the extreme tension of the lower segment of the uterus and of the membranes if the os be open.

2. The easiness with which the child can be displaced. But one case occured which showed that this dropsy can co-exist with immobility of the foetus.

3. The Inaudibility of the Foetal Heart. Many cases because child is dead, in others because labour is premature.

4. The Difficulty in detecting foetus through tense abdominal Tumor, its limbs are not made out in Hydramnios.

II The Differential Diagnosis between Ascites and Hydramnios.

That this part of the subject is of practical importance will readily be allowed by my reader when I state upon the authority of Dr. Tanner[I] that the abdomen has been tapped in this disease by a surgeon for Ascites while all the time Hydramnios was the real complaint and the operation resulted in the woman's death.

Professor Playfair[II] throws out the following suggestions:—

1. Ascites is recognised by the superficial position of the fluid.
2. The difficulty of feeling the contours of the uterus which is obscured by the surrounding fluid.
3. The Co-existance of dropsical effusions in other parts of the Body.

I Tanner. Signs and Diseases of Pregnancy. Page 152-3.
II Playfair. Science & Art of Midwifery. Hydramnios

III. The Differential Diagnosis between Hydramnios and Placenta Praevia.

Sir James Y. Simpson[I] in his Selected Obst. Works. at page 12. says " on examining per vaginam the inferior segment of the uterus is much expanded, ballottement is unusually free and distinct. Now in the case I have reported Ballottement or bobbing the foetus was quite impossible and no part of the foetus could be felt anywhere whatever nor any idea got of the presentation till the membranes were ruptured.

The great point is the absence of Haemorrhage during Pregnancy and during the Labour and that combined with the signs of Hydramnios got above the Pubis is sufficient to settle the question.

Before leaving this question of Diagnosis I wish to point out that the Presentation of Swollen and Fleshy Membranes may be neither Placenta Praevia nor Dropsy of the Secundines from Hydramnios but that it may be the disease recorded by Merriman[II] under the name of 'Thickness of Membranes'. He describes the feeling of this as like the naked head of the child which appears pastied and distended with Fluid; the roughness of the surface of the membranes resembling to the touch, the scalp, when the cuticle and hair is abraided by the Pressure of the Fingers

I. Simpson. Selected Obst. Works page 12
II. Merriman. On difficult Parturition. Obstetric

more careful investigation showed it to be the membrans and after the placenta was expelled he found the Thickness of the decundines was 1/6 of an inch and no other disease present.

IV. What Statistics have we to show its Effect on the Mother and child?

The best are those date given by Dr. Cl[illegible]ock[I] who experience embraced 33 cases.
He points out that the pains are weak and unavailing and consequently the latter in the first stage is prolonged by inertia due the distention weakening the contractile coats whose expulsive force is expended over a much larger surface than natural.

He make it plain that the effect to the mother is very grave 4 deaths in 33 cases or 12 per cent. One woman died from Rupture of the Uterus, a second from Puerperal Fever and two women from Exhaustion, other Three females recovered after having smart attacks of Uterine Inflammation.
J. Matthews Duncan[II] tells us the effects of the excessive uterine expansion may produce Placenta Membranacea and what is worse Detachment of part of the placenta.

I Dis. of Women. Dr. McClintock page 384
II. Mechanism of Natural and Morbid Parturition p. 345.

his experiments by which he has estimated the strength of the uterine pains as exerting a force of 35 pounds on the square inch or 5 lbs the expulsive force of an ordinary Labour shows what power is required to Rupture Amnion and therefore what is absent below the mark in Hydramnios and the reason for the frequent necessity of artificial aid by tearing the membranes and then turning the uterus above the Pubes.[1]

The effect of Hydramnios on the Fœtus I have already had occasion to mention. Mc Clintock 9 born dead in 33 cases, many born alive but not live, some being anasarcous, hydrocephalic etc. But some are healthy.

V. The Treatment.

If the distress during Pregnancy is positively unbearable, we are recommended to rupture the membranes. In Labour which may also be often Premature we must rupture the membranes to allow the uterus to act at free advantage, do it high up to prevent sudden emptying and then knead the uterus with the hand above the Pubis to secure thorough contraction of the uterus and prevent Flooding which is to be feared in all cases of Inertia.

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[1] Mechanism of Natural & Morbid Parturition page 65.

On Ganglion

The Report.

Margaret H.... aged 19 years, a domestic servant, residing at Restilrig, Leith, came under treatment on 13th November 1879 for a tense, fluctuating and circumscribed thecal swelling about the size of a large marble (see cast No. III of this patient's hand and disease as taken before the Treatment) and situated among the extensor tendons on the dorsal aspect of the wrist joint.

The History of the growth is that she has had it over 12 months and that she attributes it to her employment, having been much occupied in washing and ringing clothes.

Treatment.

I took a fine, clean needle dipped in Carbolic acid and made a hypodermic puncture through the cyst wall and without withdrawing the needle tore the cyst wall in several parts. I then applied a pad of Boracic Lint and squeezing this with my thumbs caused the cystic contents to be driven into the adjoining textures, nextly I applied a bandage and dismissed the patient till the 17th November.

When she returned I found that she had experienced no pain or trouble and the disease has entirely disappeared.

The Commentaries

The interesting points suggested by a case of this kind appear to be seven in numbers and I think may be arranged under the following heads, each of which we may take up and briefly discuss in turn:-

I. The Sex of the Patient.
II. The Employment of the Patient.
III. The Situation of the Ganglion.
IV. The Pathology of the Ganglion.
V. The Consequences of the Ganglion.
VI. The Differential Diagnosis of the Ganglion.
VII. The Treatment adopted in this Case.

I. The Sex of the Patient.

The fact of my patient being a female naturally led me to enquire whether or not Sex has any influence in the production of Ganglion. Now upon inquiry I find that it is mentioned by several surgical authorities as having some such influence, among whom I may quote Miller and Syme.

Miller[I] says 'females are more frequently affected than males' and Syme[II] tells us that 'females are more liable to it than males'.

Now what I want to make out here is that is not the sex of the patient in itself that determines the frequency of ganglia in females, but rather the frequency with which females are employed in certain duties which are liable to excite the disease. Consequently I now pass on to a consideration of some of these employments.

I. Miller. Principles of Surgery p. 517. II. Syme. Prin. Surg. p. 284.

II. The Employment of the Patient.

In this section I wish to state and try to show by other similar diseases and the experience of several surgeons that the Ganglion on this woman's wrist was due to her employment causing strain of the synovial sheath in the process of ringing and washing.

Also that these Ganglia are seen more frequently on the wrists of females for exactly the same reason that Distention of the Bursa Patellæ is mostly seen in domestic servants and Distention of the Bursa over the Olecranon mostly seen in workers Underground, the one being termed Housemaids Knee and the other 'Miners-Elbow'[I], showing that it is the occupation and not the part which determines the disease. Women are mostly employed at present in washing and are thus most predisposed to strain of the extensor tendons at the wrist joint as men are mostly occupied in low-roofed mines lying upon their elbow and so frequently become the subjects of Bursitis in that situation.

The experience of Spence[II] is to show that it occurs in those whose occupation requires continuous use of the fingers such as playing at the Piano, Drawing and Knitting.

Druitt[III] tells us it is due to a strain or rupture of fibres, or to irritation from pressure or friction or to Rheumatic change in the lining membrane of the sheath of the tendons

I. Sir W. Ferguson System of Pract. Surgery. page 254.
II. Prof. Spence. Lect. on Surgery. Vol I. page 287.
III. Druitt's Surgeon's Vade Mecum. Page 213.

III. The Situation of the Ganglion.

Professor Spence[I] says the anterior aspect of the wrist is the most frequent site of Ganglia.

Erichsen[II] tells us it occurs usually on the back of the wrist but also on the dorsum of the foot.

Sir W. Fergusson[III] describes Ganglia as seen by him on the knuckles, they are very small and situated on the back of the joint between the first and second phalanges. He finds that they occur mostly in patients afflicted with the Gout and that similar Gouty Bursitis is seen at the Olecranon Process.

Professor Annandale[IV] mentions similar little ganglionic swellings at the side of the joints of the digits and refers to Key[V] who found they were often so painful as to be mistaken for Neuromata.

I think we will usually find that if the Ganglion is situated about the wrist as in my patient's case there will be a History of Traumatism and if on the digits a constitutional vice such as Gout and Rheumatism. While if on the dorsum of the Foot we will perhaps discover tight lacing of the Boot across the instep as the exciting cause.

I. Spence. "Lectures on Surgery" Vol I page 281.
II Erichsen. "Science and Art of Surgery." Vol II. page 281.
III Sir W. Fergusson. "System of Practical Surgery" page 254.
IV. Annandale. "Diseases of Fingers and Toes" page 112.
V. Key. "Guys Hospital Reports. Vol I.

IV. The Pathology of Ganglion.

In this section I wish to try and bring out that the Ganglion under my care was a Tumor arising from rupture of the synovial sheath of the extensor tendons caused by the frequent and violent twisting the wrist joint is subjected to in the process of ringing clothes, and that in the part of the sheath so-weakened, the albumenious fluid accumulated distending it and after the inflammation excited by the rupture had glued the the corneous membrane together, this secretion remained circumscribed and tensely bound down.

From the authorities which I will now quote in favor of or against my statements. It will at once be seen that there are probably two varieties of Ganglia about the wrist quite similar in appearance but the one with a History of Traumatism like my patients and the other a quite new Formation with no such antecedents.

Lizars[I] adopts a pathology similar to that given for my patients Ganglia for he says 'they are either partial strains, the fibrous and synovial sheaths being torn or these sheaths are attenuated and distended by the albumenious secretion.

Druitt[II] also refers some cases to Rupture of Fibres.

Cooper[III] in the Surgical dictionary tells us they often occur unpreceded by any accident, but just as often from bruises and violent sprains.

Erichsen[IV] refers to Paget's opinion which regards Ganglion as a Neoplasm, a Cystic Transformation of the cells enclosed in the fringe like processes of the synovial membrane lining the sheaths.

I Lizars "A System of Surgery." Vol. I page 185.

II. Druitt. "Surgeon's Vade Mecum" page 213.

III. Cooper. The Surgical dictionary. article "Ganglion."

IV. Paget's opinion. see Erichsen "Science and Art of Surgery Vol II. page 281.

Holmes[I] quotes Boyer[II] who says Ganglia do not appear to communicate with the sheaths of the tendons, but are formed in the dense tissue investing the sheaths of the tendons or the capsule of the joints.

It will be seen from these references that Ganglia about the wrist have not yet got their Pathology cleared up and that there are as many good observers on one side as the other. The one group holding with Lizars that they are Traumatic and the other with Paget that they are New Formations.

I. Holmes "System of Surgery" Vol III. page 655.
II. Boyer "Traité des Mal. Chir. Vol. XI.

V. The Consequences of Ganglion.

Lizars[I] tells us that Ganglia are oftener a disfiguration than impediment and in the cases I have reported the only trouble the disease caused her was its unsightliness and for that reason alone it was that the patients demanded Treatment. But Erichsen[II] informs us that they sometimes come under Treatment for the pain they are causing the subject and he says this pain is due to their mechanical pressure upon neighbouring nerves, those about the wrist causing this trouble by pressure on branches of the Musculo-Spiral Nerve.

Druitt[III] assures us that after they have lasted some time and been subjected to Inflammation they may suppurate and open spontaneously.

I. Lizars. "System of Pract. Surgery" Vol I page 185
II. Erichsen. "Science and Art of Surgery" Vol II. " 281.
III. Druitt "

Cooper[1] in his surgical Dictionary tells us of a Ganglion on the dorsum of the foot in which situation it caused much weakness. He also informs us that a Ganglion may grow so large as to cause inconvenience by obstruct-ing the motion of the part.

This same gentleman refers his readers to the Medical Journal Vol V. where it is shown that if a Ganglion be much irritated it may become a very malignant dis-ease and that Malignant Fungoid Granulations may be thrown out as the result of the irritation set up by some forms of Treatment such as the intro-duction of a seton.

1. Cooper. "Surgical Dictionary" art. "Ganglion" p. 528.

VII. The Differential Diagnosis.

In the case under my charge I can't think of any disease with which I could have confounded it, but if a Ganglion be situated about the styloid process of the Radius it may at first be supposed to be an aneurism of the Radial Artery or of the Superficialis Volæ, a case of this kind of mistake is men-tioned by Cooper in his Surgical Diction-ary, article Ganglion page 529.

VII. The Treatment of Ganglion.

If one is forced to temporise he may order the swelling to be rubbed with Oleum Origani and this friction will, according to Cooper,[I] much lessen the contents but when ever discontinued the fluid usually gathers again. Next one may prescribe Pressure with a coin or piece of sheet-lead and alternate friction with Camphorated Mercurial Ointment which has cured some cases. But when one is asked to cure the disease at once, the safest plan to adopt is to cure the disease without exposing the synovial sheath to atmospheric contact, this may be accomplished by Sir Astley Cooper's Treatment viz: give the Tumor a smart blow with a book, according to Spence[II] this does not invariably succeed as the torn cyst may soon heal up.

In my patients case this is the Treatment which from its safety I wished her to have but she declined saying it looked rather coarse surgery so I was compelled to adopt the method recommended by Spence[II] namely Rupture hypodermically with the needle. This method is also advocated by Lizars.[III]

Boyer[IV] dissected out a Ganglion which he had failed to cure by compression and by Seton. But we have already shown that any Treatment like Seton involving Irritation is bad from the risk of Inflammation or Fungus disease so engendered. Lizars says if they are laid open violent inflammation ensues and is often serious.

I. Cooper Surg. Dict. article Ganglion.
II Spence Lect on Surgery. art Ganglion
III. Lizars. Syst. of Pract. Surg. art Ganglion.
IV. Boyer. Traité des Mal Chir. Vol IV.

Regarding excision of Ganglia Sir W. Fergusson[I] makes the following statements "I have often succeeded in removing Ganglions from the back of the wrist without dividing any tendons although the tumor lay close upon the carpal bones, he adds, I wish it understood, however, that I do not recommend operations in such cases unless there is some good reason, for at all times there is danger of severe inflammation coming on which may leave the wrist stiff ever after.

Holmes[II] tells us on the contrary "that these cysts can't be removed entirely by operation, the attachments cannot be removed from the tendons so that they will return unless the wound be kept open to the last".

This is the treatment which Boyer[III] adopted when he excised a Ganglion, namely, leaving the wound open and dressing it with lint so that it might heal from the bottom.

When a Ganglion ulcerates Cooper[IV] recommends the skin be excised by an oval incision along with the growth. The grand object being not to allow a particle of cyst to remain in fear it throws out a fungus and prevents a cure.

I. Fergusson Sys. of Pract. Surgery. page 254
II. Holmes. Sys. of Surgery. Vol III. " 657
III Boyer. Trait des Mal. Chir. vol. XI.
IV. Cooper. Surgical Dict. page 529.

On Spontaneous Puerperal Pulmonary Thrombosis.

The Report.

Mrs. Margaret C..., Leith Walk, sent for me at 7 a.m. on 19th August 1879, to attend her in Labour of the first child.

I had not seen my patient beforehand and on entering her Bedroom expressed my astonishment at her anaemic state, saying "If you had called those 9 weeks ago instead of your husband to engage me, I would have ordered 'Steel' for you all this time"

Thereafter, I applied my stethoscope to the root of the neck, on the right side, and found on moderate pressure, a loud Bruit de Diable.

The Labour proved one of the easiest I could wish, every texture expanding readily before the light pains.

The child presented the vertex, occiput to the mother's right side and anterior; and within an hour the patient was delivered of a fine healthy girl, before the head was born I gave one drachm dose of Liq. Ext. Ergot.

The uterus remained flabby and badly contracted in spite of my kneading attempts to get it grasped in the palm of the hand.

At the end of about 20 minutes I had it sufficiently contracted to enable me to squeeze out the Placenta by Credé's method, with this there followed a great gush of Blood, seeing which I grasped the organ firmer than ever but in spite of this blood continued to ooze out more freely than I

had ever seen in any previous labour I had att
ended. And whenever I through fatigue released my
grasp the uterus just as surely relaxed itself, so
that I sat kneading the organ in my hand
for some 3/4 of an hour, about which time
I got the nurse to dip a towel in cold water
and with this I struck the abdomen suddenly,
this manoeuvre was followed by contractions suff-
-icient to make me think the patient safe. So
I proceeded to apply a pad and a binder and
gave another dose of Ergot.

When I returned in 3 hours to see my
patient she said "I am comfortable but the
cloths are very wet", when I removed one it
was saturated and I ordered a mixture of
Iron Alum, Ergot, Sulphuric Acid and Cinnamon, but
in spite of my endeavours the sanguineus
discharge continued above my desires for at least
3 days.

The patient lay very quiet in bed in
the prone position till the afternoon of the 9th.
day, up till which time she made no compl-
aints except of Weakness and Disinclination to
sit up.

On the afternoon of the 9th. day she rose
to try reclining on the sofa for a change, but
the upright posture and movement brought on
such dyspnoea that she never reached the couch
although only in an adjoining room, but request-
-ed to be helped into bed again and I was sent for.

On proceeding to the house I found the patient
in bed with the head low, pulse soft, easily compressible
and thready, numbering 120 per. minute, the
respiration quick and deep and frequent, the patient
had also got the nurse to throw open the window
although the Bedroom was quite cool. The patient

is restless and dissatisfied with every posture she assumes. The temperature in the axilla is 101°. There is no cough nor does percussion find any dullness in the Lungs, but the stethoscope shows that air is entering freely everywhere also that there is an occasional moist rattle. The Cardiac action is very fast but also very feeble, there is no murmur to be heard in the Pulmonary Area.

No Tenderness in the Pelvic Region nor any varicose veins in the legs is found, also no pain in the calves of her legs or in the groins.

Ordered Brandy and Egg Mixture for her Support and ℥j doses of Spirit. Ammoniæ Aromat. in water every Two hours.

I also explained the case to the husband and gave an unfavourable prognosis, guarding it however by the statement that I knew of several recorded instances of recovery from the disease under strict repose and the above Treatment.

In the evening I found the patient still very short of breath, and that the Brandy and Egg Mixture was the only food that would remain on her stomach.

Ordered the Ammonia to be continued throughout the night in ℥ss. doses every hour and a half.

Next day Nov. 9th Morning Visit.

Patient has spent a very bad night, has had to sit up in bed propped up by pillows and can't lie down, pulse 125, thready and soft, patient perfectly conscious and asks for and takes the Brandy and Ammonia greedily.

Evening Visit.

The patient has had several very bad paroxysms of dyspnœa to-day, the lips are blue and the Sterno-Mastoids have the chest in a

state of full, fixed inspiration, but the stethoscope shows air entering quite freely.

Nov. 10th Morning Visit.

Patient says she feels a little easier and breathed easier through the night, although she could not lie prone but sat up all night propped up by the pillows.

While she speakes these few words, I notice the monosyllabic style in which she utters the sentence, each word requires a new breath.

Afternoon Visit.

I was hastily called to see her and find her gasping for breath with cyanotic face and tumultuous cardiac action. I administered a strong dose of Ammonia and Brandy and waited for some effect, but in vain; turning to me, the patient, who was perfectly conscious, said, "You have done all in your power for me; but the medicine has quite lost its former good effect" asking for her baby she kissed it and then fell back dead.

The Commentaries

The interesting points in this case may be discussed under nine heads: -

I. The Diagnosis.
II. The Anaemia.
III. The Uterine Inertia.
IV. The Three Days Sanguineous Discharge.
V. The Ease in the Recumbent Posture.
VI. The Sudden Dysnœa on Movement.
VII. The Moist Rattles in the Lungs.
VIII. The Absence of Basic Pulmonary Murmur.
IX. The Temporary Comfort from Treatment.

I. The Diagnosis.

At the very outset of this enquiry we are met by the opposition of such authorities as Virchow and Berlin (see 'Berlin des Embolies' page 46) who maintain that spontaneous coagulation of the Blood in the Right side of the Heart and in the Pulmonary Arteries is a mechanical and physiological impossibility. They explain all cases on the Embolic Theory.

Against these theoretical objectors we have first the anatomical point insisted on by Humphrey (see "On the Coagulation of the Blood in the Venous System during Life") that "the artery breaks up at once into a number of branches which radiate from it; at different angles to the several parts of the lungs. Consequently a large extent of surface is presented to the Blood, and there are numerous angular projections into the current, both which conditions are calculated to induce spontaneous coagulation of the fibrin."

Next we have the record of 25 post-mortem examinations by Professor Playfair ("On Thrombosis and Embolism of the Pulmonary Artery as a cause of death in the Puerperal State— Lancet 1867") which shows that cases of Embolism and those of Spontaneous Thrombosis can be separated by a clear line of demarcation, depending on the period after delivery at which the fatal result occurs.

In cases of Embolism of the Pulmonary Artery death does not occur before 19 days after delivery.

In cases of Thrombosis it very often occurs on the 2nd or 3rd and never after 14 days past delivery.

Professor Playfair (see the 'Science of Midwifery' page 339) thinks the reason of this is that time is required in the former for disintegrative changes taking place in the deposited Fibrin leading to the reproduction of an Embolus.

While in the latter the Thrombosis corresponds in time, and to a great extent no doubt in cause, to the original peripheral thrombosis from which in the former the embolus was derived.

Having now brought sufficient evidence to show the frequent occurrence of Spontaneous Puerperal Pulmonary Thrombosis and also pointed out the mode of diagnosing its presence by the period after delivery when it is met with. It will be at once apparent that the case of Mrs C. beginning on the 9th and ending fatally in the 9a day after labour plainly falls under the term Spontaneous Puerperal Pulmonary Thrombosis.

We will next discuss one of the factors favouring the occurrence of this Malady.

II. The Anaemia.

To demonstrate the effect of the anaemia of Pregnancy, when more particularly as in Mrs C's case it goes to excess, in the production of Pulmonary Thrombosis, I need on refer to the analyses of Becquerel and Rodier[I] which show that in Pregnancy the number of the red corpuscles is much diminished there being 111·8 instead of 127 as they estimate for the unpregnant female.

But what is of more importance in so far as the present inquiry goes is that these analysts also find the Fibrin and Extractive are at the same time much increased.

How after delivery this naturally hyperinotic state becomes aggravated by the amount of effete matter cast into the circulation by the fatily degenerating uterus.

The analyses of Andral and Gavarret[II] give us a more thorough idea of the exact extent of the Hyperinosis of Pregnancy.

They state that in the last months of uterogestation the blood contains an excess equal to one-third or more of the average amount present in the non-pregnant state.

Again Richardson[III] tells us the Fibrin alone may separate in the form of concretions during life, owing simply to a relative increase of the fibrin itself.

Therefore I may briefly state that the anaemia in Mrs C's case through the amount of fibrin it entails in the blood, was the first factor favouring the occurrence of her fatal disease

I. Pathological Chemistry edited by Speer. page 97.
II. Analyses of Blood. Annales de Chimie Vol. LXXV.
III. On the Coagulation of the Blood. page 37

III. The Uterine Inertia
and
IV. The Sanguineous Discharge.

The condition of Uterine Inertia is considered to be merely a part of that lax habit of body induced in our patients by their mode of living and that it is one of the evil effects of civilisation upon them (see Playfair "Science and Practice of Midwifery" article Post partum Haemorrhage)

This gentleman also believes that there are occasionally to be met with cases in which this laxity of muscular texture is so great as to justify the term 'Flooders' being applied to some such women (see at page 150)

I do not here intend in any degree to excuse myself by assuming that I had to deal with one of these creatures in the interesting case of Mrs C., but if I did wish to prove Mrs C... a 'Flooder' I would proceed in the following way and exhibit some strong such arguments as follow and then quote one or two good obstetric authorities in my support, thus:-

(1) Because the ~~uterus~~ third stage of labour was properly conducted and the uterus kept tightly in the grasp of the hand from time to time over a period of 3/4 of an hour.

(2) Because it relaxed again and again each time the kneading was discontinued.

(3) Because the Ergot seemed to possess no effect in increasing or lengthening uterine contractions.

(4) Because after getting Tonic Contraction and applying Pad, Binder and Ergot, it must have relaxed again as the next three days history shows too much bloody discharge,

(5) Because such obstinacy to haemostatic change and to tonic uterine contractions are of all cases most rarely seen in a Primipara, particularly if she be like Mrs C. a young woman of 23 years.

Then not content that my own reasoning justified the designation 'Flooder' being applied to Mrs C. I would refer to some great obstetric authorities who maintain that they have seen cases of haemorrhage from a firmly contracted uterus thus:—

Sir James Y. Simpson[I] (see Selected Obst. works) maintains that there is some other cause in operation besides firm, continued uterine contraction in preventing hemorrhage "and that these contractions are not probably so essential a part in the mechanism of the prevention of Haemorrhage from the open orifices of the uterine veins as we might a priori suppose" He has occasionally had cases of haemorrhage to deal with after obtaining firm uterine contractions.

Next we have the Testimony of Gooch[II] who asks "What is this circumstance that has so great an influence that its presence can cause a moderately contracted uterus to bleed profusely and its absence can cause an uncontracted uterus to bleed scarcely at all"?

Velpeau and Rigby seem to have had similar cases under their care.

Dr W. Playfair thinks some of these patients may be the subjects of Haemophilia.

Now with regard to the case of Mrs C. I maintain quite a different opinion explains the case, and I have been taught and believe with Matthews Duncan that so long as the uterus is firmly contracted bleeding is an impossibility

I. Selected Obst. Works Article Placenta Praevia.
II. Medico-Chir. Trans. Vol XII. page 157.

also that a non-contracted uterus does not necessarily imply a bleeding uterus, but that it invites hæmorrhage to occur.

Therefore instead of being content with getting uterine contraction in Mrs C. case, I should have, when I saw her lax habit of body and disposition to uterine relaxation, continued to maintain it firmly contracted say for an hour afterwards.

I would explain away Simpson's cases in this manner, in any of them where he made an intrauterine investigation he found Hour-Glass Relaxation of some part, thus showing that the Hæmorrhage was coming from a relaxed part. And proving that it is not enough to merely get moderate contraction because if the uterus relax bleeding is invited.

Gooch explains his own cases if he could only have seen that. Thus he tells us that he had to pass his hand into the uterine cavity to remove clots. Could he have done that with tonic contractions present? No. It shows that after obtaining tonic contractions the uterus subsequently relaxed and invited hæmorrhage.

All this shows us that it is not quite enough to get contractions we must wait and especially we in delicate women that the first few hours are free from all hæmorrhage

Playfair's statement about Hæmophilia is quite possible but requires investigation in each case.

To my wail concerning the Treatment of the Uterine Inertia in Mrs C.'s case, some accoucheurs might reply:- The Gush of Blood was trivial compared with what we sometimes see in real cases of Post Partum Hæmorrhage, and as

for the three days sanguineous discharge many women lose more and are none the worse for it.

To this I would reply, the deadliness of a hæmorrhage is in every woman's case merely a relative matter, the quantity lost is the most trivial of the matters, the great point being the amount left in the individual and the state of health of the subjects before the loss. We are too apt to look at discharge and forget the state of the patient.

What would have been to any ordinary or otherwise young female a comparitively small concern was to Mrs C. I hold, a very powerful factor in inducing her fatal illness.

Viewed in this light the treatment of the 3rd Stage of Labour becomes more important than ever and it will become us to maintain long contraction especially when we have to deal with chlorotic females who can ill spare even a small discharge.

The effect of Uterine Inertia in assisting through the hæmorrhage so permitted, in bringing about a Pulmonary Thrombosis is borne out by the experience of some eminent accoucheurs such as Leishman [I] who says of the analogous disease Phlegmasia alba dolens 'In no class of cases has it been so frequently observed as in women whose strength has been reduced to a low ebb by Hæmorrhage either during or after labour', and this no doubt accounts for the observation of Merriman [II] that it is relatively a frequent occurrence after cases of Placenta Prævia.

I. 'System of Obst.' page 710
II 'On Difficult Parturition' page 131

Dr. Richardson[I] in the book already referred to says "There is a condition which has long been known to favour coagulation and fibrinous deposition, I mean loss of blood and syncope or exhaustion induced during impoverished states of the blood.

The mode then in which the hæmorrhage favoured the Pulmonary Thrombosis in Mr. C's case was by inducing great weakness and so slackening the Cardiac Action that the circulation was rendered comparatively stagnant. This stagnancy facilitating the deposition of Fibrin particularly in certain situations the two most common sites as found by Dr. Richardson[II] being The appendix of the Right Auricle and the Root of the Pulmonary Artery.

I. On the Coagulation of the Blood page.

II. " " " " " page 66

V. The Ease in the Recumbent Posture
and
VI. The Dyspnœa on Movement.

These two points may advantageously be considered together and it appears to me that the most rational explanation of the Phenomena is this.

So long as the patient keeps quiet there is no dyspnœa when the case is one of spontaneous Thrombosis because the change going on in the arterial contents is gradual and unfelt; but the moment she moves there is a call made for freshly aerated blood to provide for the Transformation of Potential into Kinetic Energy necessitated by these movements; and as enough Blood cannot pass through the lungs owing to the blocking up of the vessel, the patient acquires an air-hunger proportionate to her needs and the difficulty of supplying them.

In Embolism the case is somewhat different and the air-hunger may be manifested at once without any preliminary movements provided the plug be sufficiently large to shut off a great enough extent of lung. if not, the case will follow the above enunciated law

It will at once be seen that this explanation accounts for Mrs C's case as one of Spontaneous Thrombosis, the reason of her want of complaint up till the 7th day when she began movements being thus explained. The want of Tenderness over the uterus and the absence of a corded or varicose Condition of veins in the limbs also tends to exclude Embolus.

VII. The Moist Rattles in the Lungs.

This is a sign I do not find recorded by any author I have consulted in compiling my commentary. I will therefore venture to offer what I consider a reasonable explanation founded on the state of the lung as examined in these cases in the dead-house.

After a vessel is plugged up there is a retrograde circulation into the embolic area, and in this congested part where the fluids are in excess and circulation is stagnant, the moist rattle will manifest itself as the result of oedema.

VIII. The Absence of Basic Pulmonary Murmur.

This murmur was heard in the Pulmonary area by Dr. Walsh[I] in the case of an old gentleman and its connection with Thrombosis of the Pulmonary Artery verified by post-mortem inspection.

Dr. Playfair[II] describes it in a few cases but in the majority he could not hear it.

The existence, of course of the Systolic Basic Pulmonary Murmur requires two factors. (1) Narrowing of the Pulmonary orifice (2) Efficient propulsive force on the part of the Right Ventricle.

The first factor occasions the formation of Fluid Veins, the second gives them a sound producing force.

I Walsh "Dis. of Heart 4th Ed. page. 550. Paragraph. 858.

II 'Science of Midwifery' article Spont. Puerp. Pul. Thromb.

Therefore we may expect it to be absent in cases were the clot only occupies branches of the artery and when the cardiac action is very feeble, but if the clot extends backwards to the orifice of the artery and the Ventricle retains moderate contractile powers we may expect to find the Murmur.

IX. The Temporary Comfort from Treatment

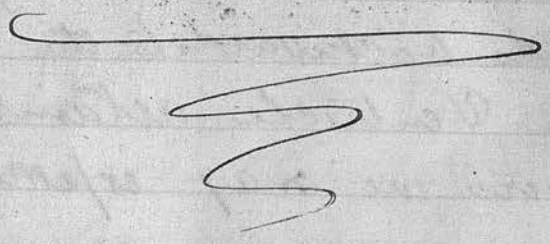
The cases reported by Playfair[I] show that recovery does occur and the Treatment consists in absolute repose to diminish the demand for aerated blood, secondly to support the powers of life sufficiently long to allow of disintegration and absorption of the Thrombus. Humphrey[II] says 'it appears that the blood is almost sure to revert to its natural in process of time'.

The Third point is to give Ammonia to maintain fluidity of the Fibrin and so prevent more deposition and supply the clot with its natural solvent.

Richardson[III] says in this point, the alkalies have been shown to be the most powerful of our remedies as they are all capable of leading nitrogenous matter into solution. The Volatile one only differs in first exciting the Heart, arteries and muscular system, he also says (page 440) its use in Syncope is both legitimate and invaluable acting as an excitant to the Heart its whips on the

I. Science of Midwifery page 341.
II. Medico Chir. Trans Vol XXVIII. page 14.
III. Coag. of Blood. page 435.

the circulation while the blood is at the same time supplied with its own normal solvents



On Two Cases of Fracture of the Radius.

Report of 1st Case.

Mrs S. aged 89 years and residing in Morey St sent for me hurredly on 19th July 1879 as she had sustained a fall on her left hand which she found painful, distorted and functionally useless.

On examination I find she has been a cripple for 7 years on the left limb owing to the Intra Capsular Fracture of the Femur and that her crutch having slipped from under her armpit, the present condition of matters was acquired.

Appearance of the Hand and Forearm.

Her hand is being supported by the other and is in the prone state, the styloid end of the Ulna is markedly prominent; there is a depression on the dorsal aspect of the Radius a small way above its Styloid Process. On Coaptation I can very easily detect Crepitus.

Diagnosis – Colles's Fracture of Radius.

Treatment – I caused extention of the Forearm to be made and the friends to hold it in that condition, halfway between pronation and supination, then I got Gooch's Splints from my House and cut a small piece out of the anterior one which was to lie on part of the Fractured part, these well padded, and interosseous pads inserted were applied after first Bandaging the Hand to prevent oedema.

I soon found that the powerful restraints exercised by this retentive measure

was more than the poor old woman could bear and that it caused her to be very fever ish and irritable.

I took the paste-boards of a large book and cut them into suitable splints for her, these exercised less restraint but were borne by her for 14 days when I found she could not tolerate their presence any longer. Fearing non-union I insisted on the use of the interosseous pads which I caused to be well pressed down between the Bones in front and I also insisted on the posterior splint being continued till the end of the third week.

At the end of this time I removed all apparatus and simply placed the arm in a sling giving her injunction to keep its perfectly quiet for other 14 days. At the termination of this time I found we had got a good firm union and the patient has the tolerable use of her limb again.

Report of 2nd Case.

Master A. aged 11 years. residing in James St. was placed under my care on 1st November 1879 owing to a fall from a swing, his father says the appearances lead him to think that his boy has dislocated the wrist.

I put a couple of Gooch's Splints &c in my Pocket and proceeded to the house On interrogation I find that the boy came down on his knuckles and that his forearm doubled up under him.

I see the following appearances.

The left forearm is pronated and is being supported by the sound hand, there is a swelling in the middle of the same forearm about as big as a hens egg, with some ecchymosis over it.

On comparing the Radius of one arm with that of the other by measurement from tip of the Styloid Process to Elbow I get a shortening of ½ an inch in the affected arm.

My investigation as yet consisted of Interrogation and of Sight, as now I proceeded to inquire by touch and on extension of the arm and slight movement of the Radius I get Crepitus in the midst of the Bulging.

Diagnosis - Fracture of the middle of the Radius.

Treatment - The arm being got fully in extension I bandaged the hand and applied two Internasseum pads and then Gooch's Splints from Elbow downwards completely commanding the wrist joint by extending to the knuckles. These were secured by loops of Bandage with the knots tied over the splints to prevent pressure on the skin. The forearm was maintained in a state halfway between Pronation and Supination and slightly flexed and laid in a sling.

It is only necessary to add that I took care not to disturb the Fracture for a week when I merely tightened the retentive apparatus as the Swelling went down, and that I only saw the case once a week for 6 weeks when he was discharged with a good useful arm again.

The Commentary

The only points these cases have caused me to enquire into are:-

I. Why is Fracture of the Radius almost invariably preceded by Fall on the Hand?

II. Is it necessary that Infallible Retention be adopted in every case of Fracture?

I. Why is Fracture of the Radius almost invariably preceded by a Fall on the hand?

Miller[I] says on this question "The Radius being mainly concerned in the Carpal articulation, to that bone the shock is chiefly and directly conveyed, and solution of continuity is extremely probable, more especially if any degree of Twisting have been at the same time applied"

Syme[II] merely refers to the fact without accounting in any way for it thus he says "The accident is usually occasioned by falls on the Palm of the Hand"

Cooper[III] explains the fact in this way, he says "The Radius is much more liable to Fracture than the Ulna because it is articulated with the hand by a large surface and all the shocks, received by the latter part, are communicated to it"

I. Miller Pract of Surg. p. 282.
II Syme Principles of Surg p. 189.
III. Cooper. Surgical Dictionary p. 517.

Again at page 518 Cooper[I] goes on to explain this question for us more fully " fractures of the Radius are the most frequent of those of the forearm. The Radius being almost the sole support of the hand, and placed in the same line with the humerus is for both these reasons more exposed to Fractures than the Ulna.

" Fractures of the Radius, whether transverse or oblique, near its middle part or extremities, may be caused by a fall or blow on the Fore-arm or, as happens in most cases, by a fall on the palm of the hand. When likely to fall, we extend our arms and let the hands come first to the ground, in which case the radius, pressed between the hand & the ground, and the humerus, from which its receives the whole momentum of the body is bent, and, if the fall be sufficiently violent, broken more or less near its middle part"

II. Is it necessary that an Infallible Retentive Apparatus be applied to every Fractured Forearm?

The easiness with which I got a successful union of the Radius in the old woman's case shows that the Retentive means are to be measured by the strength of the Displacing means; and at the two extremes of Life, the muscles are comparatively weak, so that at infancy and old age the apparatus may advantageously be rendered more slight than in the prime of Life.

I Cooper Surg Dicts p. 518.

The restlessness of children, however, forbids us attempting to cure their fractures in the forearm without splints; as I think might have been accomplished in the case of the old ~~Lady~~ Mrs. S., by the means presently to be described.

But the weakness of the child's muscles permits us to cure their fractures with very slight retentive means.

In the Lancet[1] a mode of treating these fractures has been purged without any splints and as I think the case of Mrs S., owing to her irritability, the weakness of her muscles and the readiness with which she could be made to keep the arm quiet, was just the kind of case for treatment of that kind I will detail the modus operandi of the cure:-

"The hand having been brought into a position
"of slight flexion, the forearm is placed,
"pronated, or an oblique plane with
"the carpus highest, the hand being per-
"mitted to hang freely down the perpendicular
"end of the plane"

1. Lancet. 1236. p. 487.

On Two Cases of Rheumatoid Arthritis.

The Report.

Mrs H. aged 78 years, residing at London St. came under treatment in November 1878 for lameness of the right lower limb.
On examination I find her limping with the right leg and making complaint of pain in that Hip Joint.

On examining the external aspect of the right hip, I find it swollen, tense and painful on pressure, abduction and adduction of the limb aggravate the pain. On further inquiry I find her complaint is increased by changes in the weather, and that she is worse at night and often sleepless with the pain in the Joint.

This Hip is the only one of the large articulations of her body which is affect-ed, but all the small joints of hands are nodose, swollen and stiff, also giv-ing pain on attempting flexion of the fingers.

My patient terms her complaint 'The Rheumatisms' and says she has been a sufferer for 20. years, but that the extention to the hip is a recent matter of but a month or so, and it is for the Pain of this new addition that my help is sought.

My patient denies ever suffering from Rheumatic Fever, nevertheless

I detect a distinct systolic murmur at the cardiac apex but the compensation seems good as the old woman makes no complaint of Dyspnoea neither is there oedema of ankles or eyes.

I may add, although it has no bearing on this disease I am now discussing, that in January 1880. after the cure of the Hip complaint I attended her for Mitral Disease and Dropsy of which she died.

The Report of 2nd Case.

Mrs C. aged 68 years residing in albert Street sent for me on 11th December 1879, when I found that owing to a fall on the ice 2 days before she had dislocated her shoulder into the axillary cavity. I gave her a few whiffs of Chloroform and with my left foot in the armpit reduced her dislocation.

On further examination I find the small joints of both her hands are all nodose and perfectly immovable and the hand has a marked abduction and fixedness in the Ulnar direction. (See my plaster of Paris Cast. No. I.) This disease has existed 10. years during the last 7. years there has been no pain in the hands probably owing to the complete anchylosis. But during the first three years while the articulations were yet capable of motion and the bodosities were being developed, her suffering were very great. The History of her disease is that before

the complaint began she was much subjected to sudden heating and chilling of the Hands caused in the following manner; Keeping a fish shop she would frequently come from a back room with her hands steaming from a washing Tub and plunge them into ice water for the fish to serve her customers.

The next curious point in her case is that the large articulation — the shoulder joint — has now become attacked by the disease owing apparently to being weakened by the local injury. It is very painful, it can be used with any freedom and is getting stiff. It is the only articulation of magnitude which has been attacked by the disease.

The Treatment.

1st Case —

(1) To use a Crutch.
By this means the limb acted as a weight and the surfaces of the Hip Joint got a complete rest.

(2) To get Sleep at nights and obtain Diaphoresis by a 15 gr. dose of Dover's Powder.

(3) Fomenting the Hip by Flannels wrung out of Hot water and Turpentine during the first 10. days or so.

(4) Counter Irritation by Lin. Iodi.

(5) The Continuous internal use of Fowler's Solution of Arsenic for 3. months.

The effect of this Treatment was that at the end of the third

month she could dispense with the crutch and walk about her house free of pain.

Treatment of 2nd Case

Nil.

The joints being anchylosed and all pain gone it was impossible to advise any Treatment.

The patients being content to put up with the hip & shoulder joints as it is, I have not got an opportunity of trying to remove the pain by Arsenic

The Commentaries

In pondering over these two cases a few curious points are suggested:—

I. Is Rheumatoid Arthritis a Constitutional or a Local Malady?

II. What is the Cause of Rheumatoid Arthritis?

III. What points distinguish it from Gout and Rheumatism?

IV. Who discovered this Disease?

V. Who introduced Arsenic as a Remedy for the Complaints?

VI. Why so common in Females?

I. Is Rheumatoid Arthritis a Constitutional or a Local Disease?

Dr. Robert Adams[I] gives his opinion which is that the malady is constitutional" when we observe it affecting all the joints in the same individual on both sides symmetrically, we may feel assured that the chronic articular affection in such a case has proceeded from some deep constitutional taint"

Dr. Tanner[II] appears to believe in its being sometimes a purely local complaint "he says" it may arise from an accident or from the over-use of some particular joint"

Renfleish[III] in his Pathology refers to Horses which are very liable to the Disease in the Carpus and Tarsus and thinks that it is due to Pressure of cartilaginous surfaces one on another. But that theory won't account for it in the Human Carpus where such pressure is absent.

My own idea is that the disease is invariably constitutional and its appearing symmetrically in both hands seems to me conclusive of that origin. If it be asked why it attacks both hands in preference to both shoulders or any other two similar joints, I respond that its primary manifestation in any given situation is determined by local exciting causes as the alternate heating and chilling of the hands in my second case; but I think there is first required a constitutional element determining the effect produced by the local excitants.

The involvement of the Shoulder Joints

I. Treatise on Rheumatic Gout. London 1857.
II Dr. Tanner. Practice of Physic.
III. Pathological Anatomy.

in the Rheumatoid Inflammation in my recent patient's case plainly show that the disease is only liable to extend to other joints upon suffering some cause of excitement.

II. What is the Cause of Rheumatoid Arthritis?

On this difficult point I may simply quote a passage from Dr. Tanner at page 183 of his V.I. where he refers to Dr. Todd's Opinion "that the disease is an abnormal nutrition occasioned by the presence of a 'peculiar matter' in the nutrient fluid; what this matter is we do not know, but this we do know, it is not uric acid, and there is as little reason to believe that it is lactic acid."

III. What distinguishes Rheumatoid Arthritis from Gout and Rheumatism?

I. Rheumatism.

Firstly in regard to Rheumatism, Rheumatoid arthritis may be known by the fact of there being no remission or intermission in its symptoms, and secondly the Rheumatism is as common in one sex as another but not so with the 'Nodosity of Joints' as it is almost peculiar to the Female.

II The Gout.

Here you will find the skin inflamed and painful, secondly we know it comes in paroxysms of a few days duration and lastly it is as much confined to males as the Nodal complaints is to females.

IV. Who discovered this Disease?

Nothing is more uncommon in Medicine now than to hear of the discovery of a newly described disease but the one under consideration is almost a new complaint not more than 70 years old, previous to that date it passed no doubt under the guise of Rheumatism or Gout or Rheumatic Gout and in many mens minds and practice does so still.

Haygarth[I] claims to be the first recorder of this disease in 1805, and read an account of it to his fellow practitioners pointing out its characters and points of distinction from Gout and Rheumatism and its almost invariable occurrence in the Female Sex. His Book is mentioned below.

V. Who introduced Arsenic as a Remedy for Rheumatoid Arthritis?

This must be a very late matter indeed as no mention is made of it by Haygarth who knew only of hot waters leeches and Guaiacum. The furthest back author I can find is a reference to Arsenic in Rodsity of the Joints by Christian[II] in 1848. And I find by a letter from Dr. G.W. Balfour that he is also unable to trace Arsenic further than Christian himself.

P.S.

See next page where I have been enabled to settle this point

I. Haygarth "Clinical Report of Fevers and Rheumatism 1805.
II. Christian " Dispensatory 1848.

VI. Why is Rheumatoid Arthritis mostly seen in Females?

Dr. Tanner[I] says because they are mostly liable to get the health reduced by causes connected with parturition or menorrhagia. He also sees and in start at the critical period of female life and also in girls at Puberty in connection with disordered uterine functions.

Post. Script

Since writing Commentary V. I have been able to discover who introduced Arsenic[II]:-

"Mr. Jenkinson has more recently extended the"
"use of Arsenic to certain painful affections of the bones,"
"cases of very long standing, attended with great debility,"
"and local affection, not of the Muscles and integuments"
"only, but of the ends of the Bones, Cartilages &"
"Ligaments or all these together. He thinks it"
"useful in recent affections unless there is distinct"
"intermissions. And in the Disease described"
"by Dr. Hayfarth under the title of Rodesity"
"of the Joints" extracted from Dr. Duncans Dispensatory p. 51 art. Arsenic published 1819.

I Practice of Medicine Vol I. 81.

II. Edinb. Dispensatory Page 51. Article Arsenic Edited by Dr. Duncan Prof of Mat. Medica in Edinb Univ 1819.

On Potts Fracture of the Fibula.

The Report.

Bridget Hendry was carried into my consulting room in an unconscious condition on 11th December 1879. The Bystanders tell me she was knocked down by a Van the wheels of which crossed both her ankles.

On examination of the Right Ankle by a little rotation I elicit crepitus and cause pain a little way above the external Malleolus. On examination of the other ankle I find nothing but Bruises.

Having got the Right leg extended and its and the foot held for me out firmly I applied Mr. Dupuytren's Splint well padded to the Inner Aspect of the Limb and having got it secured there by Bandages removed her on a Sheet by Four Policemen to her house close by in about St. On calling next day I find my patient unable to employ a Nurse and consequently I procured her admission to the Royal Infirmary.

Hospital Report.

Bridget Hendry a native of County Mayo, Ireland, but for 7 years resident in this Town is 67 years of age and was admitted into the house on Dec 12th 1879 suffering from the result of an accident.

History

a. Personal.

Seven years ago the patient

contracted an attack of Bronchitis which was at
erly neglected - for in enormous doses of Beecham's
pills she put all her Faith and the disease
was permitted to pass into the Chronic State
from which she now suffers.

B. Present Accident.

On the 11th Dec. 1879 that is on
the day before admission the patient was
crossing Leith Walk carrying some light par
cels in her arms, a van was driving up
just as she was crossing, the horse knocked
her down and the wheel passed over both
her legs fracturing the fibula about one
inch above its lower extremity. The left leg
being merely bruised.

Diagnosis.

Simply Potts Fracture.

Treatment.

This consisted in applying two
poro-plastic splints with foot-pieces and
firm bandaging. A few vesications which
are often found about fractured limbs were
pricked and dressed with Carbolic oil in the
usual manner.

For the Bronchitis she has been taking Ammon.
Carb. Scilla and Chloric Ether with much
fresh advantage and free expectoration.

At the end of the 5th week the splints
were removed and waterglass Bandages substi-
-tituted and by the end of the 6th week the
patient could bear very considerable pressure
on the limb and was
discharged on 22nd January 1880 with a good
strong leg.

The Commentaries.

This being a simple example of Potts Fracture produced by Direct Violence the only point in it which I think worthy of study is:—

I. Is Dupuytren's Splint the best means of Preventing Backward Displacement caused by the Muscles of the Calf?

In my patient's case there was great care taken by Dr. Duncan by frequent measurements from the tip of the Malleolus to the Tip of the heel being compared with the sound leg similarly measured, to prevent Backward displacement. And I feel convinced that the Two Paraplastic Splints with foot pieces well padded etc is the surest way of fixing the ankle and preventing the Contraction of the Calf. Muscles particularly if the Internal Lateral Ligaments be ruptured.

Syme[I] says that a case of the kind with a backward displacement could not be successfully treated in the "ordinary way" he says, sometimes along with this fracture the foot is found displaced not to the side

I. Syme. Principles of Surgery P. 182.

but backwards, in which case the heel is remarkably elongated and the instep shortened, after the parts have been adjusted by suitable extension and pressure the same apparatus (that is Dupuytren's Splint) is to be used with this difference, that the cushion and splint are to be placed in front."

Even Dupuytren himself it appears did not rely on the internal application of this splint in cases with this marked tendency to Backward Displacement but differed again from Syme in applying the splint to the Back of the Leg.

It will be seen from these quotations that this backward displacement is not uncommon and that it will be advisable for the Surgeon wherever a case of Pott's Fracture comes under observation to use determined means of Preventing the occurrence by the use of means employed by Dr. Duncan in my patients case namely Two pro plastic splints with foot pieces firmly moulded and so fixed as to press the Heel well forwards securing the complete depth of the instep and then tight Bandaging for 5 weeks, always upon redressing the case taking care to make exact measurements from Malleolus to Heel to see how be is succeeding in his endeavours —

Case of Talipes Equino-Varus.

The Report.

Helen G. aged 3 yrs and 9 months, residing in Morey St, came under my care for Club-foot on 18th February 1880.

History.

The mother says the girl was born with its foot clubbed, and that when the baby was 3 months old, it was operated on for the complaint in the Royal Infirmary. The child was taken to the Infirmary several times weekly over a space of 9 months during which period the splints were carefully used.

After this the child contracted some severe illness and the doctor called in ordered the splints to be removed for a month. On recovery it was found that the complaint had relapsed in all its former severity and the parents being disappointed postponed all further Treatment till the child fall under my notice on the above date.

Before beginning Treatment I took a Sliced Cast (see Cast No. V.) which shows that the child walks on the Dorsum of the foot and also elevation of the Heal is well shown. It moreover plainly exhibits the way in which the Tubercle of the Scaphoid Bone becomes approximated to the Internal Malleolus.

Operation on 19th February 1880 by Dr. John Duncan.

The little patient was anæsthetised and Dr. Duncan first divided the Tendo Achilles

then the Tibialis Posticus and next the Anticus which was rendered somewhat difficult of hypodermic section owing to its being found adherent to the skin at its former site of division when the child was 3 months old. Lastly Dr. Duncan found it essential to make a division of the internal aspect of the Plantar Fascia.

The Antiseptic Spray was used in this case as Dr. Duncan's experience of these operations includes one case of Tenotomy after which Suppuration set in. A gauze bandage was applied till the irritation of the cuts had subsided, and then the foot is to be put up in strapping plaster.

After Treatment.

The foot was left untouched for two days when a plaster of Paris splint was put on, the foot having been previously pulled into as good position as was possible. At the end of a week the splint had become quite soft from being frequently wetted with the child's urine, and, being then useless, was removed.

The skin was considerably excoriated so that we were unable to renew the splints for a few days, the foot being however bent into position twice each day.

The second plaster splint also became useless for a similar reason, and then Dr. Duncan proposed the use of Paraffine splints which would resist the action of the water. These have been applied ever since that time and have been found to answer fairly well, the objection being that urine tends to pass down the child's legs and lodge inside the splint and produce a ruffling of the skin.

The result of the application of these splints has been that instead of the child walking on the dorsum of the foot - as the cast will show she did - she now walks on the outer edge of the foot and gets part of the ball of the great toe down as well. With very slight pressure the foot can be put into its normal position and in a few weeks Dr. Duncan hopes she will be rid of her deformity

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Commentary

The only subject, I think, which this case not really suggests to me is —

I. What is the true place that Tenotomy holds in the Cure of Club-Foot?

My acquaintance with and experience of many doctors leads me to believe that they regard Tenotomy as <u>The Cure</u> of Club Foot, now I maintain that its position in the Treatment of that malady is this —

Tenotomy is that measure by which the cure of Club-Foot is rendered a possible undertaking.

The Cure itself consists in Retention for a sufficient time in a proper position. Tenotomy is a preliminary measure rendering the second and all important part possible.

We can do whatever we like with our fibrous textures, only granting that we begin to stretch them when we are young enough, witness the Acrobat who ~~can sit~~ by early practice has so elongated the capsules of his joints that he can sit in a position that would dislocate any other person's hips.

So it is with Club-Foot — the

shortened fibrous textures must be elongated and the elongated ones must be contracted.

The contracted tissues can only be elongated by division which allows them to come into useful function, and the elongated textures can only be shortened by giving them rest in a position which will render their further elongation impossible and allow their fibres to contract.

But this is not all – the Scaphoid Bone is changed to a very wedge, that is to say the osseous textures on the inside of the foot atrophy and the Scaphoid Tubercle is approximated to the Internal Malleolus, while the osseous structure on the outside of the foot is expanded.

Therefore the cure of the case is not complete till the child can walk with the foot flat on the ground, which is the position in which this expansion on one side and atrophy on the other side is equally balanced, and the foot becomes a functionally useful member.

On Two Cases of Laudanum Poisoning with Recovery.

Report of 1st Case.

Mr. G... albert St. came for me at 10. p.m. on evening of 15th January 1879 to assist him in rousing his wife, who, in some domestic quarrel, had drunk two drachms of Tincture of Opium.

On reaching the house I found Mrs. G. lying on the floor of her bedroom and in a semicomatose condition, but her whole muscular system was relaxed, the pupils did not seem much affected by the poison, and the mustard which the husband had administered had not been sufficient to cause Vomiting.

I mixed up a Tablespoonful of Mustard and warm water and got it over her throat by means of the Spout of a small cream jug; while this was being administered I ordered a fire to be lighted and a quantity of very strong Coffee got ready.

In about 15. minutes Vomiting began and encouraged it by turning her on her side. When this subsided I kept up Emesis by Filling the Stomach with warm water and continued administering it till the water came back quite clear and clean.

By the time the Coffee was got ready an hour had elapsed, but when she had had two good Teacupfuls down for ½. an hour she began to express herself as better and desired to be allowed to take sleep, but whenever she was permitted to lie undisturbed she closed her eyes & tended to become drowsy. I therefore got her placed between the arms of her husband and another man and walked her up and down the floor till her senses cleared up a little more and she could stand alone. This result was got by

12. p.m. when I next got her comfortably dressed and with the two male guardians sent her off for a good walk.

Next day when I called, I found they took her to the Haymarket Station and returned home at 3. a.m. with the patients Epileptic rights.

Report of 2nd Case.

On the forenoon of 12th Novr. 1879, about 11 a.m. I was hastily called to see Mrs C... model Buildings Leith Walk. The account I received ran thus:- The brother, a farmer, having come in from the country to pay her a visit found her at 10.30. a.m upon the floor retching, and the floor here and there covered with vomited matters clad the woman quite unconscious. His opinion was that she was suffering from a bad bilious attack.

The only other person in the house beside this woman was the husband and he was a bed-fast cripple and could therefore lend no assistance. But he had informed the messenger that he had not seen his wife take anything that morning which could disorder her stomach.

On reaching the house at 11.30. a.m. I found Mrs C. on the floor retching but with little effect, her face was very markedly flushed, the pupils contracted to something like the size of a pin's head, and the woman quite unconscious, her chest heaving violently and the whole muscular system relaxed. I could find no smell of alcohol in her breath and the husband maintained that she did not touch spirits.

From the unconscious condition of the patient together with the contracted pupils I believed that it was a case of one of two things, either hemorrhage into the Pons or Opium Poisoning, and the woman's age was against the Apoplexy. So I instantly caused a search to be instituted for traces of Laudanum in the House.

At the same time I sent off for 30. grs. Zinci Sulphas and administered it, in about 20. minutes she vomited her breakfast and I continued keeping up the vomiting for some time by giving Mustard and warm water; the rest of the treatment consisted in slapping the face and chest with a towel wrung out of cold water, but this did not rouse her nearly so well as when the same treatment was applied to her calves soles of her feet and her buttocks.

About 12. 30. p.m. the search that I had instigated though the house was rewarded by us finding a bottle of "Laudanum — Poison" with a trace of the drug in the phial, this had been taken and then the empty bottle put into a press and the press door locked so that no one could see what she had taken.

While this search was going on I had sent to my house close by for Liq. Morphis B.P. and the hypodermic syringe and injected into the patient's arm 4. mins = $\frac{1}{30}$ gr. of the alkaloid which is considered an antidote.

Shortly afterwards her articulation became intelligent and then I administered ℥i of Spirits of Sal Volatile and ordered Coffee to be given frequently and ~~then~~ thereafter left the house at 1 p.m.

Returning at 2. p.m. I found her still on the floor but the friends had given her another

a second ℥i. of Spirit Ammon Aromatici and several spoonfuls of Coffee.

At 4.30. p.m. I found her able to sit up at the fire-side.

In the evening when she was more composed I got the following narrative from her:-

" I took my breakfast at 9. a.m; at 9.30. I sent a neighbour's child for Laudanum, my own girl having refused to bring it, knowing that I wished to destroy myself. I drank the Laudanum 2d. worth (i.e. ℥ii = 8½ grs. Opium.) And then locked the empty bottle in the press that no one might know what I had taken; I had thought of using a Razor but laid it aside preferring the Laudanum."

She likewise expressed herself as wishing to repeat the attempt to-morrow unless I put her under restraint, and finding that she had been formerly in the Asylum and was only three months discharged, I got her sent in again on 17th Nov. 1879.

She says the desire to commit suicide begins each morning when she rises and that she can exercise no control over herself.

The Commentaries.

These two cases taken together contain a few subjects worthy of our study:—

(1). To what is the Recovery of the first case due?

(2). To what circumstance is the Recovery due in the second instance?

(3). What are the means of Diagnosing between Opium Poisoning and Cerebral Hæmorrhage?

(4.) That the Acts of the Insane sometimes evince the same forethought and preparation as those of the Sane.

I. To what is the Recovery of the First Patient due?

Here we have have a case of Two Drachms of Laudanum or 8½ grs Opium taken on an empty stomach which quickly began to produce its narcotic influence and would no doubt have soon proved fatal, had not the husband come when he did for advice; the recovery was due to the removal of some of the Laudanum from the stomach by the Treatment and partly to the Stimulation subsequently of the patient.

II. To what cause is the Recovery of the Secnd Patient due?

This patient got breakfast at 9 a.m. and took Two Drachms of Laudanum at 9.30. a.m. how, what was it that rendered her recovery possible at the time I first saw her, at 12 o'clock noonday?

Undoubtedly it was the hindrance to absorption of the Opium caused by the existance in her stomach of the Breakfast.

If she had not taken any food there would have been more laudanum absorbed by midday than any treatment could have counterbalanced and she must have perished, as it was, her recovery was a miracle. But the Vomiting excited by the Zinc Sulphate prevented further absorption of Laudanum being possible and left us a chance of contending with what was absorbed.

III. What are the means of distinguishing between Cerebral Hæmorrhage and Opium Poisoning?

As you will see this arose in the second case reported:- A patient is found lying on the floor insensible and there was no extraneous source of information to guide one. The fact of a patient being able to be roused is against cerebral hæmorrhage, also unequal pupils is in favour of apoplexy, but in the case under consideration

the pupils were markedly contracted and patient incapable of being roused, now in Hæmorrhage into the Pons contracted pupils exist and the patient can't be roused, so that in this case symptoms entirely fail the practitioner and it is knowledge of such a case that stands him in good stead and caused me to instigate a search for traces of Laudanum in the house.

Suspecting is everything in these cases.

IV. The acts of the Insane sometimes evince the same forethought as the actions of the Sane do?

Here in the Report of the second case we find a patient insane and affected by suicidal tendencies cunningly employing a neighbours child to bring her laudanum and drinking it at a time and situation unknown to the husband; then carefully placing the empty phial in a press & locking it there to evade suspicion of the true cause of her illness. All these acts show forethought equal to that of a Sane person so that a doctor requires to know that such preparations are occasionally made by the Insane.

If the same preparations had been made under an insane impulse to destroy her child instead of herself, it would have looked rather difficult at first to see that the cause was Insanity.

Case of Hanging with Recovery.

The Report.

At ¼ to 12 o'clock on the evening of 16th February 1880, Mr. S. Leith Walk Summoned me to his wife's aid, whom he had just cut down from the door of the kitchen and laid on the bed.

Stale on Inspection.

Face dusky, lips blue, tongue swollen and protruding from mouth, heart beating and Radial pulses perceptible; Conjunctiva insensible to even coarse fingering but pupils slightly contractile to the light of a match, Respirations stertorous and numb. 10. per minute. Sense of Hearing extinct to the loudest shouting, legs and arms cold, all muscular power is lost. Distinct mark round the neck on the level of the Thyroid Cartilages and is of a brown tint very like brown parchment paper.

Diagnosis.

I said to myself this patient is comatose owing to the amount of Black Venous Blood in the Brain threatening sanguineous apoplexy, but owing to the persistence of the Heart's action and the response of the pupil to light, I told the husband that with determination in Treatment we might get a Recovery.

Treatment.

With the assistance of two women I got two pillows placed under her shoulders and her head and neck thrown well back over these so as to give chest expansion and tracheal expans in full play, next having taken my pocket case with me I seized to tongue with the artery forceps

and drawn it well forwards, entrusted that organ to one of the women while the other female took me arm while I took the other in practicing artificial Respiration on Dr. Henry Silvester's method. This Treatment was continued till the arrival on the scene of Dr. Littlejohn who on examing the pupil at ½ to 1. a.m. passed it as his opinion ~~that~~ I owned by patient endeavours gain for myself the credit of a Recovery from Hanging, a thing which he had never known to occur ~~daily~~ during his 25. years of official service in Edinburgh although he had read of it in Medico-legal literature.

Continuing therefore the above Treatment till 1.30. a.m. we were rewarded by seeing the first signs of returning animation viz:- returning of the muscular effort, the patient occasionally moving her legs and attempting to lift her head. The next sign of improvement was that on fingering the conjunctiva the lids were shut as if to expel the intrusion of the foreign Object.

At this time I tried an experiment on my patient and showed Dr. Littlejohn that the Breathing can be made much deeper by simply compressing both nasal orifices with the fingers and making the patient get all her supply through the mouth alone.

At 2. P.M. Retching and nausea began and this gave me much spirits as I have noticed it as a favourable sign in my cases of Opium Poisoning. I encouraged it by rolling my patient on her sides alternately which also practiced at the same time the Artificial Respiration of Hall. The vomiting I also found much aided by kneading and squeezing of the Epigastrium.

At 2.30. Vomiting was free and I left off artificial respiration to count her breating and found it numbered 16. per. minute.

Her recovery was about this time so apparent that I left her in the care of the friends to practice the Treatment for a few hours more.

Next. Morning at 8 o'clock I called and find that she sat up in bed at 5. a.m. and that they allowed her to sleep as her recovery was apparent.

On awakening her from her sleep she recognises me but can't understand why a doctor is in her house before she is out of bed but takes my visit as complimentary me. I am the first person to whom she has spoken and she is quite ignorant of last nights proceedings and will not believe that her headache and sore neck are due to suicidal hanging. She does not know how long she hung near the door last night.

The after Treatment was simple - rest in bed for 3. days and forces of sleep. no leeches were put on her head and her Recovery is very complete.

The Suicidal act of Temporary Insanity was very much due to ill usage by an habitually abusive and very intemperate husband.

Commentaries.

There are two subjects which this case has caused me to enquire into:-

I. What are the best means for sucking the Black Venous Blood out of the Cerebral vessels in a case of Hanging where Coma enters so much into the cause of Death?

II. What where the favourable circumstances in this case which caused Life to be prolonged sufficiently to give us hopes of effecting a Recovery?

I. To this first question, I think the only satisfactory answer is that the most powerful means is the employment of the suction power of the Lungs as used in artificial Respiration by which Blood is drawn into the Right Side of the Heart not only from the Abdomen but also out of the Neck and Head.

II. To this second question we have to answer:-

I. The absence of the Weight of the Body as it simply consisted in the feet resting on the Floor, in fact, no drop.

II. The situation of the Rope being around the neck on a level with the Thyroid Cartilages which is more resistible than the Tracheal rings.

On Laxity of the Capsule of the Meta-carpo-Phalangeal Joint of the Thumb.

The Report

Mary A. aged 4 years, residing at James St, Pilrig, came under my care on the 25th Dec 1879 for what was familiarly known to her parents as a bad case of "Double Jointedness" of the right Thumb.

On examination I find there is such a Laxity of the capsule of the Joint situated between the right metacarpal bone of her thumb and 1st phalanx that the child can by the use of the extensors Tendons cause the head of the phalangeal bone to project very considerably into the palm of her hands. The Thumb is marked atrophied when compared with the other, and this is even apparent when we examine the cast in Plaster of Paris taken just before commencing the Treatment. See Cast No. IV

The Treatment

The first object of Treatment in a case of this kind is to cause such a contraction of the Fibrous Textures in the front of the Joints as shall be sufficient to prevent further protrusion of the articulating surfaces.

In order to accomplish this object in my little patient, I simply therapeutically flexed her thumb across the palm of her

hand and strapped it down in that position for six weeks with adhesive plaister, renewing the straps once a weeks as they were slacker. After confining the joints for this duration I was rewarded by finding the front of the joints so firm that the little girl could not protrude the Head of the Bone as before and she can now manage to thread a needle and sew with it both of which nice proceedures were formerly impossible.

The Commentaries.

I have given this disease a place in my Thesis not because of its severity ~~but~~ nor because of its rarity but because it has been entirely overlooked by English Surgeons and because I am unable to find any description of it in our ordinary Text-Books or even in those professing to deal entirely with Diseases of Fingers and Toes.

The only drawback caused by this Disease not being described in our Text. Books is that it may be mistaken for a Contraction of one set of Tendons and an operation proposed or carried out for its cure.

I have no doubt the Double Jointed Complaint arises from practice - the child either sees other practicing peculiar tricks with the fingers or is taught unwittingly by the father who soon discovers that the little angel can quite surpass him at the trick of protruding the joints.

The reason for this readiness of semi-dislocation is not very difficult to comprehend when we remember the pliableness of the textures in infants and the readiness with which contractions become permanent in their hands and feet after Dental and Cerebral Complaints.

The only reference to this disease by any author I can discover is the following:-
Nelaton. Pathologie Chirurgicale V. 941. It is a Quotation from A. Berard's Dictionnaire de Medecine. "On observe deviations chez des enfans habitués a faire claquer leurs doigts. Les tiraillemens qui resultent de cet exercice répété dislocquent en quelque sorte l'articulation que se relache et permet au doigt de se devier soit en dedans soit dehors"

Finis