

Before closing this report, I must not forget to mention that the only objectionable symptom caused by my plan of treatment has been the necessity of having frequently to pass the catheter; and though, *à priori*, one may suppose the kidneys were inactive, such was not the case, as each catheterism drew off a fair quantity of good urine.

TEN YEARS OF OPERATIVE SURGERY IN THE PROVINCES.

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VI—ORTHOPÆDIC AND AUTOPLASTIC OPERATIONS.

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THE remaining cases of this group are instances of deformity where operations were performed to relieve it; but no skin was transplanted to fill up the gaps.

CASE DCLXXXI. F. S., aged 19, exploded an ink-bottle full of gunpowder eight years before I saw him, and destroyed the right eye, producing, at the same time, a fissure through the upper lid, with adhesion between the edges of the cleft and the cut sclerotic. Besides being much disfigured by the deep notch in his lid, the irritation of the adherent parts and of the eyelashes rendered his other eye so weak that he could not see to work.

I divided the adhesion between the sclerotic and the edges of the cleft, so as to free the lid, and pared the edges of the fissure. A fine pin was then passed in along the margin of the lid, so as to obliterate the notch by a twisted suture. Everything healed well; and a few days afterwards, I cut away, with the aid of the tenaculum and scissors, all the red granular conjunctiva to which the lid had adhered; and he went out very shortly much improved in appearance, and with his other eye becoming very much stronger.

CASE DCLXXXII. E. G., aged 20, had a notch in the upper lid of the left eye in consequence of a cut. The gap was of a triangular form, and produced considerable deformity. I pared the edges, and introduced a pin close to the margin of the lid, and it was withdrawn on the third day, and the patient remained well.

CASE DCLXXXIII. W. D., aged 21, burnt both his eyes, destroying completely the right, and producing adhesion between the lower lid and cornea in the left eye. I divided the cicatrix thoroughly, so as to free the lid, and applied some oil to the surface. After a few days, I touched the divided surface with nitrate of silver, and he went away much relieved.

CASE DCLXXXIV. B. D., aged 15, burnt his right eye, and produced adhesion between the two lids at the inner canthus for about one third of their extent, and also adhesion between the lower lid and the globe of the eye. I operated in this case under chloroform, although the other operations about the lids were all performed without chloroform; and merely divided freely the united lids, and dissected away the scar between the globe and the lower lid, introducing two sutures to keep the parts properly in place. He went home in a week much improved.

CASE DCLXXXV. H. B. came under my care many years ago. As a child, she had a tumour on the outer part of the frontal bone near the orbit on the left side, and a seton was passed through it, producing absorption of the tumour, and subsequently of the bone, with destruction of the skin of the lid, and the result was that, when I saw her, she had complete eversion of the upper lid, with adhesion to the edge of the orbit, and some of her eyelashes presented just above the orbital edge of the frontal bone through a hole which had been formed in it. Her cornea had become slightly opaque from inability to close the eye. I dissected the lid down, and turned it over into its place; but it was much too large,

overlapping the lower lid considerably. After a short time granulations sprung up, and contractions began again, ultimately reducing her state exactly to what it was before.

As the patient had good courage, I operated again, and removed a considerable quantity of red and loose conjunctiva, and then dissected the lid down again. I also took off a small notch at the outer canthus, thus lessening the aperture between the lids, with a view to keep the upper lid down in its place. For a time, she improved; and then appeared likely to become as bad as ever; but the ultimate result of the case was that the lid fitted well, and she regained a clear cornea, with the power of opening and shutting her eye. I saw her again many years afterwards, and found everything in a satisfactory state.

CASE DCLXXXVI. This and the following two cases were treated with the seton—a plan at one time much recommended.

W. S., aged 20, had a strong band of adhesion between the lid and globe, encroaching on the cornea and impeding his vision. I passed a seton through the lower part, and tightened it at intervals; and in a week it cut its way out. The eye was much freed, and he went away well satisfied with his improvement.

CASE DCLXXXVII. J. H., aged 37, burnt his left eye with melted iron, producing, as in almost all the foregoing cases, a slough inside the lower lid, involving the conjunctiva covering the globe as well. The cicatrization of the wound produced a firm adhesion or *symblepharon*. I treated him with the seton, and he was much improved.

CASE DCLXXXVIII. T. E., aged 14, burnt his left thigh and abdomen when a child, producing a scar which interfered with his work. The cicatrix was a broad triangular flap extending from the abdomen to the thigh, under which three or four fingers might be concealed. I passed a thread through it, applying traction to make it cut its way out; but he did not improve, and one day, becoming discontented, he went away (seton and all); and, after many months, was admitted again as an inpatient under one of my colleagues, who divided the scar, and transferred into the gap a piece of skin from the thigh, and cured him completely.

CASE DCLXXXIX. B. L., aged 30, met with a severe mining accident, by which his right arm was disabled, his cheeks and face burnt, his left eye destroyed, and the right eye so lacerated and contused that, on recovery from the general effects of the injury, his eye was found to be *entirely* adherent to the lids. He could distinguish light from darkness. He was very anxious to try to get relief; and I therefore operated, although his state was almost hopeless. I dissected the lids from the globe, and at last freed it, although the process was excessively tedious, lasting an hour, without chloroform.

It was just possible to make out the position of the cornea, which was covered with hard tissue, and very opaque. I divided the outer cartilage, and made a slit through the upper lid, so that I could partially keep it out of the way by a suture. Oiled lint was introduced between the globe and the lids.

He went on well for a little more than a week; and, when he went away, he could move his eye freely; and his sight was so much improved, that he could see more light.

I never heard the result of this most unpromising case; but, in all probability, there was some amendment in his condition in consequence of the operation.

The three following cases cannot well be classed with those just narrated, but must be narrated separately.

CASE DCXC. A. J., aged 22, received an injury by gunpowder, which resulted in the formation of a blue patch under the skin at the inner angle of the left eye. She was very anxious for an operation to remove the deformity. I dissected out the skin and the gunpowder stain, bringing the wound together by the fine pins. It

partly healed by the first intention, and a satisfactory cure resulted.

CASE DCXCI. H. R., aged 20, cut her right forearm with a piece of broken crockery, about two years before I saw her; and the skin adhered to the fascia and the tendon of the flexor carpi ulnaris, producing considerable induration and pain, so that she was unable to work. At the operation, I made an incision across the scar in the direction of the tendon, about two inches in length; and separated the adhesions between the skin and the fascia, and then brought the skin together by two sutures, straps of adhesive plaster, compress, bandage, and splint. The wound healed entirely by the first intention, and she was cured at once.

CASE DCXCII. J. J., aged 11, was admitted under my care in consequence of the existence of a congenital web about half-way down between the middle and ring fingers of each hand. At the operation, I dissected back a little flap from the palmar surface of each web, and turned it up; then, after dividing the web throughout, I passed the flap between the fingers, and kept it in place by sutures. The hands were rested upon a splint made with separate fingers, so that the ring and middle fingers were kept apart from one another; and they were both treated in the same way. All the wounds healed well, and he went out cured.

REMARKS. It is impossible to lay down precise rules of treatment that would suit every case in patients requiring an autoplasmic operation for the relief of deformity, either produced accidentally or of congenital origin. The entire direction must be left to the operating surgeon, who must rely upon his ingenuity to hit upon the best mode of relief for his patient; and a surgeon who does not possess the requisite ingenuity is not likely to undertake these cases.

It is scarcely necessary to say that everything must be minutely planned beforehand, either in the surgeon's mind, or in black lines upon the patient's skin. The scar is to be divided first, and the flap to fill up the gap is to be prepared as the next step; and it is required that a piece of skin that will live and adhere be introduced somewhere in the line of the contracting scar, so that the contraction may drag upon and stretch the new skin, instead of the neighbouring parts. A flap, to live, must be large and loose; and it seldom is too large, and, in dissecting it up from the subcutaneous cellular tissue, care should be taken to leave the pedicle wide enough to nourish it; and, whenever it is practicable, attention should be paid to the normal arterial distribution of the part, leaving the flap attached at that side whence the vessels flow. The bleeding ought to be stopped before the parts are adjusted; the new wound, whence the skin is taken, is to be brought together first, and the flap should be attached in its new place by many sutures. I have frequently seen skin adhere at the point of suture, and not elsewhere. The dressing should be light and firm; and warm-water dressing, with oil-silk, answers well for the first two days; and, if the flap of skin lives until that date after the operation, all anxiety about it may generally cease.

Many of these operations are tedious and painful; and, for these reasons, chloroform is generally used; and to refuse its aid would be against the spirit of the age. I have, however, very little doubt that my two principal failures, as they may be called (for, although both were relieved, my object in operating was not fully effected), were due to the vomiting and straining, with depression and loss of appetite, which the chloroform brought on. The cases to which I allude are 673 and 679.

I have never seen any records of autoplasmic operations where the skin of the lid was used to replace the lost conjunctiva, besides my own; but the cases where such an operation is applicable are far from rare. If a piece of melted metal finds its way between the lid and

the globe, a slough must be formed, and this must result in adhesion and contraction of the cicatrix. It is more than probable that other surgeons have operated in like manner; and I will only add, that I have always performed this operation without chloroform; that every case has been successful; and I believe that, under chloroform, the various steps would have been accomplished with much greater difficulty; and, moreover, that if vomiting or collapse had followed the use of the anæsthetic, the success would not have been so great.

Progress of Medical Science.

CONTAGIOUSNESS OF TYPHOID FEVER. In his Report to the Privy Council (April, 1861), Mr. Simon says: Since I last reported generally on the subject of typhoid fever (Report, 1858), an addition has been made to the literature of that disease, by the publication of a series of papers by Dr. William Budd, of Bristol. Dr. Budd's opinions, as regards the causation of typhoid fever, are as follows:—That the fever is essentially contagious; that the living human body is the soil in which the specific poison breeds and multiplies; that all the emanations from the sick are infectious; that by far the most virulent part of the specific poison by which the contagion takes effect is cast off by the diseased intestine of the fever patient; that the characteristic affection of the bowel in the disease is, in reality, the specific eruption of a contagious fever; that the sewers and other places into which all this virus passes are the principal channels through which the fever is propagated; that they propagate it solely in consequence of being the channels for the diffusion of this poison; that it no more is the offspring of common sewage than mildew is the actual offspring of damp and decay; and that "by placing two ounces of caustic solution of chloride of zinc in the night stool on each occasion before it is used by the fever patient, the intestinal discharges may be entirely deprived of their contagious powers." To anticipate some arguments which might be urged against parts of this doctrine, Dr. Budd observes, that typhoid fever scarcely ever re-attacks a person who has once suffered it; and that, "like malignant cholera, dysentery, yellow fever, and others that might be named, this is one of the great group of diseases which infect the ground." The facts which Dr. Budd adduces from his own experience, and from that of other observers, are, in my opinion, sufficient to prove that the contagion of typhoid fever is importable by persons who have the disease. Indeed on this point Dr. Budd's history of the North Tawton fever and its offshoots is more conclusive than anything previously known to me. And his arguments are also, I think, cogent to this general effect—that specially the bowel-discharges of the disease are means (yet not therefore necessarily the sole means) by which a patient, whether migrating or stationary, can be instrumental in spreading the infection of typhoid fever. Provisionally these conclusions must be acted upon in their present unqualified form. But doubtless it is of practical importance to learn, as exactly as possible, whether it is in all states and under all circumstances, or only in certain states and under certain circumstances, that the bowel discharges of typhoid fever can effect what is here imputed to them. Typhoid fever seems to be, in its causes, as in its nature, very intimately related to other diarrhoeal affections.

SUCCESSFUL REMOVAL OF THYROID GLAND. Dr. Voss, at the New York Pathological Society, gave the history of a lady, aged 54 years, from whom he had removed a hypertrophied thyroid gland. At the age of twelve she first noticed an unnatural fullness of the throat, which gradually became more marked and defined up to