Dr. Simpson recommends the application of direct stimulants to the interior of the uterus—nitrate of silver, cantharides, or iodine—by means of a *porte-caustique*, the application to be made at the time when menstruation should occur, and repeated at monthly intervals. The same authority speaks highly of a kind of dry-cupping of the interior of the uterus, and of the employment of galvanic intrauterine pessaries of peculiar construction in the form of amenorrhœa now under consideration. With respect to the efficacy of galvanism, Dr. Simpson considers its continued application by the use of pessaries more serviceable than the occasional application by the ordinary methods. Dr. Althaus states, however, that he has in many cases found great benefit from Faradisation assiduously and properly applied; and, in the very few cases in which such direct local treatment by galvanism or by other measures of an analogous kind is necessary, the latter method is to be recommended as the preferable one.

# Illustrations of HOSPITAL PRACTICE:

**METROPOLITAN AND PROVINCIAL.**

## LONDON HOSPITAL.

### INGUINO-SCROTAL TUMOUR OF RIGHT SIDE.

Under the care of G. Critchett, Esq., and C. F. Maunder, Esq.

J. A., aged 32, a healthy-looking countryman, had been ruptured twelve years, and worn a truss during the last seven. He said that, on August 25th, he was kicked by a horse upon the pad of the truss, and knocked down, when the rupture redescended, and could not be returned by himself. On admission (Aug. 28th), a pyriform tumour, base downwards, occupied the internal half of the inguinal region and right side of the scrotum; it was firm, elastic, not translucent, painful just below the external abdominal ring; and corresponding with the position of the latter a slight bulging and distinct impulse occurred on coughing. This impulse was communicated, but with much less intensity, to the whole swelling. The abdominal viscera performed their functions healthily. He was ordered to keep in bed, with an evaporating lotion to the tumour.

Sept. 1st. The tumour was much the same. In the absence of Mr. Critchett, and in order to determine the diagnosis, Mr. Maunder put the patient on a diet of bread and potatoes only, with two pints of fluid during the four-and-twenty hours, with a view to promote absorption of adventitious substances which might possibly conceal the nature of the swelling. The patient was ordered to take a dose of house-medicine every morning.

Sept. 3rd. The tumour was smaller, and was now divided into two portions by a depression about its middle, giving it the appearance of being composed of a hydrocele below and a hernia above. The testicle could not be felt. Mr. Critchett tapped the lower swelling, and evacuated several ounces of fluid, well charged with blood. The testicle, smaller than usual, could now be felt; and extending up from this gland was an elongated mass, which received an impulse on coughing. The component parts of the mass, enlarged, indurated, and knotted, could be passed in review by the finger and thumb (doubtless a varicocele).

Sept. 14th. The tunica vaginalis, having refilled, was tapped, and several ounces of straw-coloured fluid were evacuated. It was then washed out with a strong solution of iodine; and on the 19th the patient, being desirous of going home, was allowed to leave; but before reabsorption of the effusion, consequent on injection, had taken place.

Remarks. This case is interesting, firstly, because it shows how cautiously the opinion of the patient must be received, even though, as in this case, he be "quite sure" that the hernia descended into the scrotum at the time of the accident, when the evidence is in favour of its not having advanced lately beyond the external ring; secondly, "impulse given to the whole tumour" is in favour of hernia, especially when the state of the cord cannot be known; while, thirdly, the sudden appearance of a tense, elastic, not translucent swelling of the scrotum, concealing the testis, was in favour of an effusion of blood (hæmatocele) into the previously healthy tunica vaginalis, but which, on tapping, did not contain sufficient blood to support that opinion, more especially as the patient afterwards admitted that "perhaps the purse had been larger than natural for some time", and in all probability had contained a hydrocele previous to the accident.

# Original Communications.

## ON CHRONIC SUPPURATION OF TENDINOUS SHEATHS, SIMULATING AFFECTIONS OF JOINTS.

By Richard Barwell, F.R.C.S., Assistant-Surgeon to Charing Cross Hospital.

Acute suppurations of tendinous sheaths are so well known to every surgeon, they are accompanied by so much pain and constitutional disturbance, the situation and boundaries of the disease are so clearly defined, that the diagnosis is perfectly easy. But a slow inflammation of these structures is much less distinguishable from a chronic disease of the neighbouring joint. In theory, the one malady should be perfectly different from the other; we ought to find the fluctuation and swelling in each case confined within certain bounds, and extending in each instance in different directions; the patient's health should suffer very much in the one case, and not at all or but very little in the other; in fact, there should be well marked distinctions, which no novice could overlook, and the one disease should be by no chance mistakeable for the other. He who expects, however, to find the diagnostic symptoms of local affections as clear and definite as they are described in systematic treatises, will be hugely disappointed when he comes to bed-side practice, and more especially when he has to do with chronic disease.

The parts most liable to be affected with suppuration in a tendinous sheath, are of course the neighbourhood of the wrist and ankle. The process is often extremely slow, and may commence at once as a chronic disease; but it more usually begins in a more or less acute form from injury or other cause. The pain, lameness, tenderness, and swelling, are at first pretty severe and defined; but in a little time they all diminish, and become more diffused. The patient, however, does not get thoroughly well; he may be able to use the limb a little, but some pain and quaggy swelling continue, which again slowly increase. This swelling has never, after the first acute or subacute stage of the disease, a defined clearly marked boundary; it fluctuates more or less obscurely, and through a mass of thickened infiltrated tissue. After a time, the matter points, and may be evacuated by the knife, or may find its own way out;

in either case, there is usually left a troublesome tortuous sinus, which will not heal.

This disease, by the lameness it produces and by the position of its swelling and by its protracted progress, causes great anxiety to the patient; and it is therefore of much importance to distinguish such cases from joint-affections, even before the matter has escaped, and a sinus has been formed. The difficulty in this diagnosis is increased by the general diffuse character of the swelling; also by that strumous state of the constitution, which gives rise to both the bursal and the articular inflammation; and because the general health suffers no more in the one disease than it frequently does in the other. We all know how a depraved and strumous diathesis will of itself produce such debility, that the local suppuration, wherever it may be, does not add to the general evil. I have seen this impassive constitutional state in joint-diseases frequently; chiefly when joints of the second magnitude are affected; but it will occur even in diseases of the hip and knee. Thus there is no positive sign whereby we can distinguish a chronic suppuration in a large tendinous sheath or sheaths about the wrist and ankle from a chronic inflammation in those joints; but there are negative signs quite sufficiently significant to render our diagnosis, if carefully carried out, perfectly certain. The points of distinction will be best exemplified by the following cases; the first of which, occurring several years ago, was of great interest and value to me.

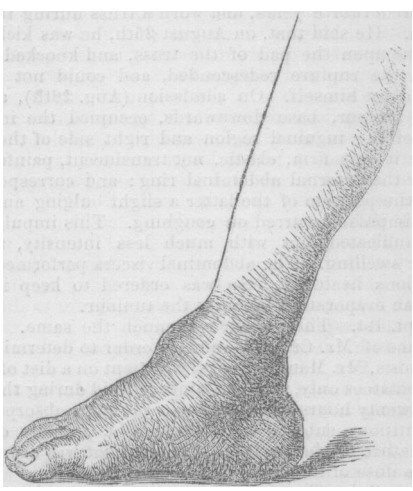
Case I. On Aug. 10th, 1856, being at Richmond, I was asked by Dr. Julius to see a case of disease about the ankle, of the articular nature of which he was doubtful. The history of the case was as follows. A young woman, aged 18, about three years and a half before, severely sprained her right foot, and was laid up for more than a fortnight. She could move about with difficulty; but in a little time the ankle again became more and more painful, until, about eight months after the injury, it was impossible to put any weight on the foot. The limb was much swollen. She lost her appetite, and slept but little. Blisters, splints, irritating ointments, etc., were used, but apparently with no benefit. In about six months, an abscess opened a little above the ankle-joint, near the front of the inner malleolus; after a further interval, another opened lower down, over the dorsum of the foot. She was recommended amputation; but willing to try other means first, she removed from home to Richmond, and came under Dr. Julius's care. During the last six months several London surgeons had seen the case, which was set down as one of old and inveterate joint-disease; and amputation was recommended; but there were some circumstances which rendered Dr. Julius doubtful, and at last he asked me to see the patient.

I found a strumous looking, but robust girl, about 18, whose health did not appear to be affected by suffering or exhaustion. The right foot and ankle were a good deal swollen in front, and there were three mouths of sinuses, one to the outer side of the lower end of the tibia, the other two near each other on the dorsum of the foot. The shape of the swelling was not very defined; it was greatest over the front of the joint, was broadly fusiform, running up the leg and down the foot towards the toes, and it fluctuated obscurely from one part to the other. Although the boundaries of the tumefaction were by no means defined, and although the whole limb was swollen, there was an evident distinction between the character of this condition in front and behind the joint. In the former situation, it might be discovered that, below the sodden and infiltrated skin, the anatomical parts were really swollen; while, behind the joint, manipulation showed that the swelling so manifest to the eye was mere puffiness of the skin and subcutaneous cellular tissue. The deep parts were not affected. This freedom from enlargement was most significant behind the malleoli; in which situation there is always considerable and deep enlargement in ankle-joint disease. The joint could be moved within certain limits and in a certain direction without pain; thus, passively bending the foot upwards was painless, but any attempt to extend it (to point the toe) so as to put the anterior tendons on the stretch, could not be borne. I diagnosed the absence of joint-disease, asserting that the case was one of suppuration in the anterior tendinous sheaths; and, with the concurrence of Dr. Julius, I proposed laying open the sinuses and tracing the course of the suppuration upwards and downwards. The proposal was accepted, and I agreed to perform the necessary operation on the following Saturday.

On Aug. 16, chloroform having been administered, I passed a grooved probe into the sinuses, and opened them entirely, being careful to leave no passage, however small, unexposed. One vessel was tied, the wound was stuffed with lint, and a bandage applied. Dr. Julius continued to attend to the case. In a fortnight the patient could walk a little. On Sept. 23, the wound having entirely healed, she left Richmond walking quite well, perfectly cured.

Case II. George Russell, aged 7, was brought to me at the Charing Cross Hospital, April 3rd, 1861, with a swollen ankle. He was a highly strumous child, with thin skin and transparent complexion, and reddish or chestnut-coloured hair. He had an old scar, and an enlarged lymphatic gland in the neck; and a red scar, with a still weeping sinus, at the elbow. The left ankle had been swollen for the last three months and a half; the enlargement and the lameness both increasing.

Examination of the swollen part showed that the enlargement was situated in front of the ankle-joint; it fluctuated but very obscurely, in a direction upward and downward, in which directions the tumefaction gradually decreased, leaving the part above firm and normal, while, below, the dorsum of the foot was puffy and



sodden. Below and behind, although the subcutaneous tissues were somewhat puffed, there was no actual swelling; indeed, the absence of any real enlargement in these situations caused me to diagnose suppuration in the anterior tendinous sheaths, and that the joint was quite free from disease. I opened the sheath by a longitudinal incision about an inch long, and ordered a poultice for a day or two; and cod-liver oil and quinine, in mixture, to be taken three times a day. On the third day, pressure was applied to the parts round the wound. The swelling was diminishing, and the patient seemed in a fair way of recovery.

May 6th. The foot and leg were swollen and red. Erysipelas had come on: the attack turned out a very bad one, the inflammation spreading up the thigh and over the abdomen. For several days the boy was in considerable danger, and for nearly a month all local treatment had to be suspended.

June 3rd. Local treatment of the original disease was resumed. The wound had nearly closed; but it did not seem advisable to make a fresh opening. A thick pad was placed over the seat of swelling, and bound on very tightly with a bandage renewed twice a week. Under this management, the tumefaction and the discharge visibly decreased. On July 10th, he was dismissed cured.

Suppurations of tendinous sheaths about the wrist are less frequent in a pure and simple form; either because the disease spreads very easily and quickly to the neighbouring large and ramified synovial structure of the carpus, or because the small spongy bones of that part assume diseased action more readily than the larger bones of the tarsus. However this may be, I have seen fewer such instances at this joint. The generality of those I have treated offer nothing except mere locality different from the cases already quoted. One is interesting.

Case iii. Miss —— had a swelling at the back of the hand, which had been treated for eighteen months by rest, poultices, blisters, etc., without apparent benefit. On March 26th of the present year, she was brought to me. The whole back of the hand was puffed; but the chief swelling was on the outer side. The roots of all the outer fingers were swollen, but chiefly that of the index; even the outer side of the palm was a little puffy. At first sight, and without manual examination, it appeared that the whole areolar tissue of the hand was inflamed; but a more careful manipulation of the part showed that along the metacarpal bone of the index was a bag containing fluid. The position of the sac showed it to be the sheath of the index tendon; the long continuance of the disease showed that the fluid was probably pus. At a part where the skin seemed thinnest, and where was an apparent tendency to point, a fine exploratory trocar and cannula was inserted, and the contents of the sac seen to be pus. It was very important to this young lady to avoid a long scar running along the back of the hand. I determined to try the effect of pressure, passed a rather larger cannula into the sac, emptied it, and strapped a thick hard pad with resin plaister very forcibly upon the swelling.

April 20th. The pressure had been renewed every week. The swelling was much less; but the wound would not heal; it kept weeping a thin pus, showing that the walls of the sac still secreted. I injected the sac with iodine, one drachm of the tincture to three of water; and reapplied pressure.

April 30th. The discharge was less, but had not quite stopped. The injection was repeated. Only a very little could be made to enter; the lower part of the sac being apparently impervious.

May 15th. The wound had been healed for nearly a week. The back of the hand was a little clumsy and thickened, but that was daily diminishing. The wound left a small, red, but rather ugly scar, which, if it do not shortly disappear, may be excised, and a narrow linear cicatrix be substituted.

These cases are selected, as showing the success that may attend three different modes of treatment, if proper cases for each be chosen. When the inflammation is severe, as with the boy Russell, injection is too hazardous a remedy; pressure may succeed more easily in such instance; whereas, if the constitution be not greatly depraved, and if the locality render a scar of no importance, opening up the sheath is the most rapid and best mode of cure.

## IS INHERITED SYPHILIS PROTECTIVE AGAINST SUBSEQUENT CONTAGION?

By C. F. Maunder, F.R.C.S., Assistant-Surgeon, London Hospital.

Of late years many successful attempts have been made to unravel the mysteries of syphilis; and the above question put by Mr. Hutchinson (to whom the profession is already indebted for the elucidation of facts connected with syphilis), in the British Medical Journal of Sept. 21st, embraces another of the interesting points in relation to syphilis, with which that incomprehensible disease is surrounded. Perhaps, of all the maladies to which flesh is heir, and which come more immediately under the eye of the surgeon, not one has been so unfathomable, and yet in its early stages is so straightforward in its course, as syphilis. In the time of Hunter, both chancres and gonorrhœa were regarded as equally liable to engender constitutional disease; but, thanks to Ricord, not only have chancres and gonorrhœa been proved to be quite independent of each other both in origin and consequences, but chancres are known under two forms, the *indurated* or *infecting*, the *soft* or *non-infecting;* each variety, with its sequelæ, pursuing a course in a sure and determinate manner. It is the knowledge of this latter fact that enables the practitioner to foretell, from the nature of the chancre before him (except under rare conditions), whether or not his patient will become the subject of constitutional and syphilitic infection.

The point at issue cannot be readily solved by positive proof—at least, in this country, where the liberty of the subject is held to be so sacred that the law will not open the door to science, and allow the practitioner, if so disposed, to trace the disease, of which his heredito-syphilitic patient is the subject, to its source, namely, the woman from whom it was contracted. Again, so long a period has now elapsed, that the practitioner who treated the parent for the original chancre may either not live to see the tainted offspring at an age when that offspring is liable to contract venereal diseases; or, should he live, the opportunity may not present itself. Also, the heredito-syphilitic patient, the subject of chancre, may fall into the hands of a practitioner who does not deem it necessary to recognise the variety of chancre which he is called upon to treat, and who, therefore, alters its character by local treatment, and probably administers mercury, which drug has the power not only of diminishing the severity of constitutional symptoms, but also of postponing their appearance often for many weeks. At this period, perhaps, the patient consults a practitioner who takes a scientific as well as a monetary interest in his case; but, after one or two visits, the local sore is healed, he loses sight of his patient, and is no longer permitted to watch the progress of disease; or, if the heredito-syphilitic subject present himself with an apparently soft chancre, which runs its course as usual, and no constitutional symptoms follow after the lapse of some months, such a case is only a proof that soft chancre is purely a local disease, but is not a proof that a patient so tainted cannot contract an indurated and infecting chancre.

Knowing, however, that, except in rare instances and after the lapse of many years (when all the original tissues of the body have probably been renewed), a person cannot contract an indurated chancre for the second time, I am quite disposed to believe that an heredito-syphilitic subject would, in like manner, be free from the danger of a second inoculation. But, to prove this point, the chancre contracted by the heredito-syphilitic subject must either be traced to its source, or to its effects produced upon a third and healthy subject. Unless one or both of these propositions be complied with, opinion can be founded on conjecture alone.