ABSTRACTS FROM CURRENT MEDICAL LITERATURE.

SURGERY.

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Retropharyngeal Abscess.—Archambault (Albany Medical Annals, February, 1900) records a case in which recovery took place eight days after operation by intrapharyngeal route. The patient was a female, aged 17 months. Four weeks after an attack of measles, difficulty in swallowing set in. The pharynx was full of secretion as from rhinitis. Swelling and redness then appeared to the left of the median line, and an abscess was diagnosed. Eight days after dysphagia commenced the abscess was opened by an incision directed downwards and obliquely inwards. The finger introduced into the incision was pressed downwards, "bruising" the cut edges and tearing them so that no cul-de-sac might form. The happy result was, in the author's opinion, due to this little detail.

Modern Surgical Treatment of Hæmorrhoids. Gustavus M. Blech (St. Louis Medical Gazette, February, 1900).—Germms are, in Blech's opinion, the primary factors in the production of hæmorrhoids. Incipient piles are cured by the following antiseptic procedure:—Irrigate with hot 2 per cent solution of antinosine, after which a tampon of cotton saturated with glycozone is left in for several hours daily. Don't dilate the anus in such cases. Should there be a mass of hæmorrhoidal tissue, he uses the ligature. The operation is preceded for a few days by mild laxatives. Bath and shave on morning of operation. Two ounces of 10 per cent hydrozone solution, thrown into rectum and allowed to remain one minute. The rectum is next irrigated with 2 per cent solution of antinosine. The field being aseptic, dilate to expose tumours. These are transfixed and ligatured with silk, after which two-thirds of the mass are cut away. Irrigate with antinosine as before, and follow with douche of normal saline solution. Dust with nosophen and apply a pad and bandage over the anus. If there be a single tumour of large size, ligate temporarily, cut away, and sew wound-edges in axis of rectum.

A New Method of Treatment of Carcinoma Æsophagi. W. Zweig, of Berlin (Albany Medical Annals, February, 1900).—This is Rosenheim's method (see Therapie der Gegenwart, February, 1899), and depends on the fact that the dysphagia is due not so much to stenosis as to spasm, which is brought on by irritation following the attempt to swallow food. The treatment is lavage above the seat of the stricture, using 150 grm. of water and not more, so as to obviate dilatation of the oesophagus. Having thus washed away fragments of food, the lavage is followed by 50 grm. olive oil poured in as the soft stomach-tube is being withdrawn. If pain be very severe, a 4 per cent solution of eucaine acts well, instead of the oil. After two or three minutes the patient can cautiously eat solid food, which glides down without much difficulty. The treatment can be repeated two or three times a day. Its value is three-fold—(1) moral effect, (2) holds cachexia in check, (3) delays the necessity for gastrostomy.

Appendicitis with Suppuration, Limited by Intestinal Paresis. Westbrook (Brooklyn Medical Journal, February, 1900).—This case was reported to the Brooklyn Surgical Society in October, 1899. The patient was a married woman, aged 42, and was operated upon in June, 1899.
Between seven and three months previously she had had several attacks of appendicitis. Her last attack occurred four days before operation, with sudden onset of acute pain, which was at first generalised, and later became confined to the right iliac fossa; vomiting during first and second days. She was thoroughly dosed with morphia. On admission, her temperature was 101.5°; pulse, 104; respiration, 28. There was restriction of abdominal respiratory movements, with generalised moderate distension, rigidity of right rectus, and general abdominal tenderness, worst in the right iliac fossa. An elongated tumour extended downwards from the iliac crest in the outer half of the right iliac fossa. When the peritoneum was opened, very consistent pus gushed out. As the pus came away the intestines fell into the cavity of the abscess, showing absence of true adhesions, and merely a lining of greyish lymph. The appendix, which was gangrenous and perforated, was removed. Dr. Westbrook was of opinion that the paresis, due to the full administration of morphia, allowed the intestines to lie quiet and block in the abscess-cavity. The early use of cathartics might have scattered the infection broadcast.

Radical Cure of Strangulated Inguinal and Femoral Hernia. Haynes (Journal of American Medical Association, 10th February, 1900).—After the gut has been treated according to the requirements of the case, the measures in connection with radical operation are as follows:—

1. Inguinal.—Carefully isolate sac from spermatic cord. Free neck of sac and parietal peritoneum about the internal ring, to do which satisfactorily the internal oblique and transversalis muscles and the transversalis fascia must be divided outward above Poupart's ligament to the junction of its outer and middle thirds. Pull the sac well down, ligate its neck as high up as possible, and cut the sac away. All the veins of the cord, save one or two, are next removed, along with excess of loose tissue (thickened cremaster, fascia, and areolar tissue). The cord is next drawn outwards with a hook to outer extremity of incision in the muscles, after which the incision is sutured from without inwards behind the cord. The suture fixes the above-mentioned muscles, their conjoined tendon, the transversalis fascia and the outer edge of the rectus (when possible), to Poupart's ligament. The internal ring and posterior wall of inguinal canal having been now formed, the cord is laid down and covered over by suturing external oblique aponeurosis.

2. In femoral operation, sac is removed after ligating its neck as high as possible. The crural arch and Poupart's ligament are then sutured firmly to the pectineal fascia close to the ilio-pectineal line, from without inwards. The difficulty is to prevent the outermost suture from producing compression of femoral vein; this vessel always remains as a weak spot alongside the obliterated ring and canal.

Both operations are finished by subcutaneous suture. All sutures are of chromic gut.

The author thinks that retaining the sac as a pad leaves a wedge which will tend to reopen the canal.

He differs from Halsted in forming an oblique canal for the cord, and Bassini's operation he improves by the reconstruction of the internal ring far out, by diminishing the thickness of the cord, and by substituting absorbable for non-absorbable ligatures and sutures.

Evolution and Diagnosis of Cancerous Tumours of the Kidney. Guyon (Annales des Maladies des Organes Génito-Urinaires, January, 1900).—An analysis and comparison of three cases is here given:—

1. Male, aged 70, with large varicocele on the right side, an enormous tumour in the corresponding flank, and a history of occasional haematuria during the last fifteen years. The form of the clots in the urine along with the varicocele suggested a renal origin, which was further confirmed by the presence of the tumour in the renal region. His health was good, and he only sought admission to the hospital on account of the pain accompanying the passage of the clots down the ureter. No operative treatment was carried out.
2. The second case was that of a man, aged 51. He was pale and emaciated, and had a history of haematuric attacks during the preceding nine months. Except on one occasion, when symptoms were referred to the bladder, his pain has always been in region of right kidney. Renal palpation negative. Cystoscope showed, three months before admission, normal bladder, blood issuing from right ureter. While the eliminative power of the right kidney was much diminished, that of the left was normal, and authorised removal of the right if necessary. This was done by Albarran, and a tumour the size of an egg was found situated on the upper end of the organ. Recovery was perfect.

3. Woman, aged 35. History of occasional haematuria dated back to five months. Anemia marked. Palpation of renal regions was negative on left, but on right side the kidney was found to be slightly enlarged and mobile, and its anterior surface hard and a little irregular. Ill-defined pain had been present in right side for several months. Catheterisation of ureters showed both kidneys normal, so far as excretion of urine was concerned. The right kidney was removed. It was enlarged and a tumour was seated on its upper extremity. Recovery.

Guyon draws attention to the slow evolution of cancer in the kidney, as compared with other organs, and considers the rapid progress in Cases 2 and 3 as distinctly rare. Nephrectomy is only allowable in tumours of moderate size. Haematuria unassociated with other symptoms, and with a healthy bladder, should lead to suspicion of a tumour being present. Compare the analysis of urines from both kidneys, and only abandon the idea of a small tumour when you have found another explanation of the hematuria. If in doubt, explore. Negative result of palpation is of little value.

**Metatarsalgia.**—Péraire and Mally contribute an interesting article on this affection in the *Revue de Chirurgie*, April, 1899.

The paper is based on the observation of seven cases, and is freely illustrated by means of radiographs. The authors classify the condition in three categories:

1. The benign form, which is cured without surgical intervention.
2. An intermediate, which is characterised by acute paroxysms, brought on by the slightest fatigue or injury.
3. A grave form, in which there is continuous pain exaggerated by walking and fatigue.

Predisposing causes—arthritis, heredity, neurasthenia, epilepsy, &c.

The exciting causes are trauma, constriction by tight boots, prolonged standing and walking.

The anatomical condition, as seen by the use of the Röntgen rays, is one of subluxation downwards and inwards of the metatarso-phalangeal articulations. The treatment adopted by the authors consists in excision of the head of the metatarsal bone or bones affected. This is effected through a dorsal incision, and the operation is carried out under local anaesthesia with cocaine. Microscopic examination of the pieces of bone removed show them to be the seat of condensing osteitis. Results, immediate and remote, are successful, one of their patients subsequently being able to dance without fatigue.

The authors consider the pain of metatarsalgia to be due to the abnormal contact of the articular surfaces with the plantar tissues.

Giannettasio has a paper on the same subject in the *Revue de Chirurgie*, February, 1900.

His conclusions agree with those of Péraire and Mally.

He reports very fully one case of a girl, aged 15 years. His article is illustrated with radiographs and with drawings of the microscopic appearances of the bone removed.

**Iliac Colostomy by Double Ligature.** Gangolphe (Revue de Chirurgie, February, 1900) gives the details of a method of performing colostomy in the left iliac region, founded on an experience of sixteen cases. The usual incision having been made in the abdominal wall, the sigmoid
loop of gut is brought out by the left index finger. The portion brought out generally measures 5 to 6 cm. The mesocolon is pierced by a pressure-forceps at a distance of 3 to 4 mm. from its attachment to the gut. A stout silk ligature is seized at its middle by the forceps, and by them drawn through the mesocolon. The silk loop is then cut, and the two ligatures thus formed are interlocked and tied firmly round the upper and lower corresponding portions of the loop of intestine; the ends of the ligatures are left long to aid in their subsequent removal. The serous coat of the gut, about a finger's breadth above the ligatures, is sutured to the general peritoneum at the edges of the abdominal wound, which is then closed as far as possible. The strangulated loop of bowel is surrounded by iodoform gauze. In forty-eight hours the dressing is removed, and the strangulated piece of bowel is freely opened by the thermo-cautery. The broken-down tissue is irrigated with boiled water, and, finally, the silk ligatures are cut away. The results are stated to be satisfactory, the patient wearing a pad fixed by a belt.

Fractures of the Clavicle.—An apparatus for the treatment of fractures of the clavicle is described at the conclusion of a lengthy paper on the subject by Gratschoff (Revue de Chirurgie, February, 1900). It consists of three principal parts:

1. A shoulder-piece, bandaged to the shoulder of the affected side.
2. A solid rod of iron, of which one end is attached to the shoulder-piece at the place corresponding to the point of the acromion; the other end is attached to a bandage which fixes it at a point on the front of the chest about 4 cm. below the nipple of the healthy side.
3. A bandage with four tails joined at right angles. This junction has attached to it the lower end of the iron rod, and lies at the point on the chest-wall above mentioned. The four tails are so disposed on and around the body as to keep their junction a fixed point.

The advantages of the apparatus are—case of application, simple construction, and comfort in wearing. Two or three weeks suffice for cure.

Books, Pamphlets, &c., Received.

Physiology, a Manual for Students and Practitioners, by Howard D. Collins, M.D., and Wm. H. Rockwell, Jr., M.D. Edited by Bern. B. Gallaudet, M.D. With 153 Engravings. London: Henry Kimpton. 1900.

Catalogue of the Anatomical and Pathological Preparations of Dr. William Hunter in the Hunterian Museum, University of Glasgow. Catalogue prepared by John H. Teacher, M.A., M.B., C.M. Glasgow: James Maclehose & Sons. 1900. (2 vols.)

Nordrach at Home, or Hygienic Treatment of Consumption adapted to English Home Life, by Jos. J. S. Lucas, B.A., M.R.C.S., L.R.C.P. Bristol: J. W. Arrowsmith. 1900. (1s.)

Catechism Series: Surgical Anatomy and Operations. Parts I and II. Edinburgh: E. & S. Livingstone. (Each 1s.)

Midwifery Notes for the Use of Students, by T. A Glover, M.D. Edinburgh: E. & S. Livingstone.