

CASE XII.

A. J. H. Shrapnel bullet wound over right frontal bone. Depressed fracture; trephine necessary when depressed bone removed with piece of bullet. Dura uninjured. Temperature on admission 102°. On discharge, five days later, temperature was normal and the wound almost healed.

CASE XIII.

G. A. N. Compound fracture of left humerus, received October 26th. Musculo-spiral nerve exposed and partly divided. The whole track and wounds of entry and exit were very foul and stinking, with redness and oedema of the whole upper arm, when the case was received on board on the 29th. The wounds were enlarged, drained, and irrigated four-hourly with hypochlorite. No spread of sepsis occurred and redness and oedema rapidly subsided, as did the offensive odour. When discharged, four days later, the wound was lined with healthy granulations and there was only a trifling discharge of pus.

CASE XIV.

G. T. Compound fracture of jaw and shell wound of right arm. The fragment of shell had entered at the tip of the right shoulder and emerged above the external condyle of the humerus. All the wounds were horribly offensive. They were irrigated with hypochlorite under anaesthesia, and many loose fragments of jaw and detached teeth were removed. Four-hourly irrigation with hypochlorite was adopted, and the patient was given a chloramine mouth wash. On discharge, four days later, the patient's mouth was remarkably clean, but the external jaw wound was still discharging though relatively clean in appearance. Sloughs had all separated. The arm wounds were clean and lined by healthy granulations.

CASE XV.

W. C. When received on board the right foot was gangrenous as regards the soft tissues up to the base of the metatarsals; its appearance was black with an intense zone of inflammation of the higher part of the foot. The left foot was gangrenous to the base of the proximal phalanges, with similar signs of intense inflammation. The odour was appalling. Hypochlorite baths were used and at once removed the odour. In two or three days the dead soft tissues had softened and could be quite easily removed. The wounds took on a healthy aspect, and the granulations were red and clean.

CONCLUSIONS.

The advantages we have observed in the employment of the sodium hypochlorite solution in the treatment of septic wounds may be briefly stated as follows:

1. The simplicity and cheapness of preparation of the antiseptic.
2. Being non-toxic and non-irritating to the tissues when properly prepared according to Dakin's formula, the hypochlorite solution may be safely used in large quantities over long periods of time without ill effects.
3. The deodorant action of the solution is remarkable. The fetor from gangrenous tissues usually disappears in twenty-four hours.
4. The rapidity with which sloughs separate and clean granulation tissue is formed in a wound under its influence.
5. The infrequency of redressing required by cases treated as described with hypochlorite, compared with the constant change of dressings required in large wounds with other forms of antiseptic.

6. The fact that injections of the hypochlorite solution into the rubber tubes used in the dressings may with safety be entrusted to very imperfectly trained orderlies without fear of ill results, once the case has been adequately dealt with by the surgeon.

The facts referred to under (5) and (6) are very important considerations in war surgery, as cases frequently arrive in large numbers at varying intervals.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TYPHOID PERFORATION: OPERATION: RECOVERY.

THE following case of perforation in a man suffering from unsuspected typhoid (no doubt modified by inoculation) is, I think, of interest as emphasizing the importance at the present time of a strict investigation into all cases of pyrexia, even when unaccompanied by other marked symptoms. It is also worth recording from a surgical point of view, since recovery took place in spite of the fact that operative measures were unfortunately not taken until some eighteen hours after the accident.

Pte. C. was admitted to the Reading War Hospital on

September 17th, 1915, having been wounded in Gallipoli on August 24th. On admission he had a small healed entrance wound in the buttock and an irregular open wound, about an inch in diameter, on the inner aspect of the thigh, where the bullet had emerged. He appeared in good health. He stated that he had been inoculated against typhoid in November and December of the previous year (two inoculations).

On September 28th it was noted that there had been some pyrexia since he had been in hospital, the temperature ranging from 100° to rather over 101°, though frequently down in the morning to normal. The man said that he felt perfectly well except that now and again he suffered from headache. His bowels had on several occasions been somewhat relaxed. No abnormal physical signs could be detected in chest or abdomen, and the tongue was clean. The pulse had varied with the temperature from 90 to 112. The wound had nearly healed.

On arrival at the hospital on the morning of October 1st I was informed that the patient had complained the previous afternoon of sudden severe pain in his stomach, and now appeared to have serious abdominal mischief. I found him with a temperature of 103.4°, a pulse of 136, and all the signs of an acute abdomen.

He was at once taken to the theatre and laparotomy performed. There was general peritonitis, with a quantity of free pus; the lower part of the ileum was covered with masses of lymph, and a perforation a quarter of an inch across, evidently the result of typhoid ulceration, was present in this portion of the bowel. I closed the hole with some difficulty, on account of the condition of the gut, and drained by means of a large tube passed down into the pelvis. The usual after-treatment for general peritonitis was adopted, and the patient made an excellent recovery, the only trouble being some suppuration in each breast where he had received subcutaneous saline infusion. He had fairly typical typhoid stools for about ten days after the operation, but by October 19th the temperature was normal. There was a short relapse from October 31st to November 11th. The patient is now (December) nearly well.

Bacteriological examination of the stools shortly after the operation showed the presence of a non-lactose fermenting bacillus, typhoid or paratyphoid (the exact identity not determined). On November 7th it was found that the blood agglutinated *B. typhosus* up to 1 in 500 dilution, but had no effect on *B. paratyphosus* A or B.

Reading. W. BERNARD SECRETAN, M.B., F.R.C.S.

A SECOND CASE OF COMPLETE INVERSION OF UTERUS.

MRS. R., aged 30, was confined early in September. She looked very delicate and fragile, and the pains were weak from inertia of the uterus. A little chloroform was given, and the delivery was very easily effected by forceps. The placenta caused no trouble, and the uterus contracted normally. All went on well for fourteen days. The nurse then assisted the patient to stool, when on pressure a pain was felt, and "something seemed to come down." On my arrival I found the fundus uteri well outside the vulva and still being extruded; there was no bleeding. An hour later Dr. MacLagan gave chloroform, and reduction was accomplished after some patient work in ten minutes or less. As in my previous case (BRITISH MEDICAL JOURNAL, 1910, vol. i, p. 260), the method by direct pressure on the fundus was not successful and was not long persevered with, whereas the other method was very readily effective. I reduced the bulk of the tumour into the vagina followed by the right hand, grasped the neck of the mass with the finger tips surrounding, and worked at it exactly as one would reduce a hernia. The patient made a good recovery. I venture to record this case on account of its very great rarity, and, after my experience, would suggest to any one who may be unfortunate enough to encounter this formidable accident that the method I have attempted to describe will most readily be successful.

C. L. FRASER, F.R.C.P., F.R.C.S.Ed.
Berwick-upon-Tweed.

DR. CHARLES RICHET, professor of physiology in the University of Paris, who is now serving in Russia, has been elected an honorary member of the University of Moscow.

War, by G. J. Guthrie, F.R.S., etc., President Royal College of Surgeons 1833, 1841, 1854, etc., covering the wars of the period 1808 to 1855. The treatment of wounds by chlorides of lime, soda, and zinc, haemorrhage, sloughing, sepsis, gangrene, and every other accident or illness of the battlefield will be found there, as well as the same old grumblies at the War Office.—I am, etc.,

LIONEL F. WEST, M.R.C.S., L.R.C.P.

Birmingham, Jan. 14th.

SHERBURN HOSPITAL.

SIR.—Dr. Meachen is no doubt right in saying that there is an ancient hospital at Sherburn in Durham, and I accept his assertion that he is the physician-in-charge as conclusive evidence of its existence. I knew of his hospital, which is said by Dugdale to have been founded by Hugo de Pateaco, which I take to be the Latinized form of Hugh Pudsey, Bishop of Durham. It does not follow, however, that there was no leper house at Shireburn in Yorkshire, and Dr. Meachen admits that there was a hospital there, though he says it was not a leper house. He accuses me of spelling the name wrong, and says that my Shireburn in Yorkshire ought to have been Sherburn in Durham; but in the seventeenth century, when Dugdale wrote, people spelt according to their own fancy, and acknowledged no obligation to spell the same name always in the same way; and sometimes one, sometimes another, of these variants has been accepted and adopted. The place now called Sherborne in this county of Dorset was spelt by Dugdale Shireburne. I think, therefore, we may conclude that, while Dr. Meachen is right, I am not wrong; in fact, he is right, and I am right, and all is right as right can be.

Allow me in conclusion to thank you for your very handsome and interesting review of my lectures.—I am, etc.,

Parkstone, Dorset, Jan. 15th.

CHAS. A. MERCIER.

THE TONSILS.

SIR.—In the correspondence under this title it is accepted that, when there is any question of removing the tonsils, these glands should be removed *in toto*. The two points which are giving rise to discussion appear to be the following: (1) Is there any risk in carrying out complete enucleation of the tonsils in singers? (2) Should this enucleation be carried out by dissection or with the guillotine?

I have never had any complaint from a singer after this operation, for the very good reason that I have never ventured to perform it on a trained artist. With students of singing—those who are just “learning to sing,” and in whom the operation is indicated—I have never seen any but satisfactory results, the improvement and development of the voice being sometimes very noticeable. But many other observers have had experiences which should put us on guard. Hudson Makuen thinks it is safer, in the case of singers, to leave the tonsil capsule, and possibly some portions of the tonsil.¹ Bryan D. Sheedy examined a series of one hundred throats, three to ten months after operation by the modern method of enucleation; about 5 per cent. of the patients complained of difficulty in using certain words, and had nasal intonation six months after operation. Four of the whole number had practically lost their singing voice.² It is, to say the least, unwise for any one with the necessarily limited experience of his individual practice with this operation amongst professional singers to stigmatize this possible risk as a “popular fallacy.”

As to the method of operating: Enucleation of the tonsils by dissection, as I have seen it carried out by its chief exponent, is a neat and thorough operation, leaving the throat in a satisfactory condition. As evidence that I have no prejudice against it, I may point out that as long ago as 1901 I called attention to the inadequacy of the guillotine in certain cases of submerged and adherent tonsils, and recommended in such instances removal by dissection.³ Later on I learnt to use the guillotine to effect excision of the tonsil with its capsule by

using a tractor to draw both gland and capsule well through the ring of the guillotine. Specimens illustrating the completeness of this method were shown before the meeting of the British Medical Association in London in 1910, and are figured in my textbook. About the same time, as Dr. W. Hill has pointed out, Whillis and Pybus in this country and Sluder in America demonstrated that, instead of using traction, the tonsil and its entire capsule could be impressed through the guillotine ring by manipulation with the forefinger or by crowding the mass against the alveolar eminence of the lower jaw. No special “tonsillectomy guillotine” is required for this, as Dr. Syme appears to think. In my own clinic all tonsils are enucleated with the form of guillotine which was slightly modified by Mr. Charles Heath at the Throat Hospital more than twelve years ago. Until he left for the front, these enucleations at King’s College Hospital were carried out rapidly, completely, and safely by my colleague, Mr. C. W. M. Hope, who formerly practised and advocated the dissection method. Many others have likewise discarded the method of dissection since learning that an equally good, if not better, operation can be executed with the guillotine. It is the method which is employed in many throat clinics in London and largely in America.

The correspondence columns are not the best place for studying and comparing the advantages and drawbacks of the two methods of enucleation. This can be done much better in our operating theatres and by demonstrations of patients and specimens before our medical societies. It is sufficient here to protest against Dr. W. S. Syme’s statement, in regard to the removal of the tonsil complete in its capsule, that “to do this in every case some method of dissection is necessary.” Enucleation of the tonsils by dissection is certainly not the only way. It has still to be shown that it is the safer, speedier, easier, or better way.—I am, etc.,

London, W., Jan. 17th.

STCLAIR THOMSON.

SIR.—All who have contributed to the discussion in your columns regarding the surgery of the tonsil are agreed as to the superiority of enucleation over the older methods, but there is some difference of opinion as to the technique of the operation. The following guiding principles may, therefore, be worthy of consideration. (1) In children the procedure introduced by Whillis and Pybus, that is, enucleation by means of the reversed guillotine, or, as I prefer to call it, the “new guillotine operation,” gives uniformly good results. (2) In adults, and especially in those who have suffered from quinsy, firm adhesions bind the tonsil to its bed and render the above operation impossible. The ideal method for such cases consists in dissection with scissors and snare under local anaesthesia.—I am, etc.,

DOUGLAS GUTHRIE,
Lieutenant, R.A.M.C.

. We cannot continue this correspondence.

Universities and Colleges.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A QUARTERLY Council was held on January 13th, when Sir W. Watson Cheyne, President, was in the chair.

Earlier Closure of the Library.

The Library will be closed at 6.30 p.m., instead of at 7 p.m., during the next three months. The Common Room will be closed during the war.

Contribution to British Red Cross Fund.

The Council recommended that the College should contribute 50 guineas to the funds of the Joint Committee of the British Red Cross Society and the Order of St. John.

Court of Examiners.

Mr. H. J. Waring was re-elected to the Court of Examiners.

Removal of a Member.

A member’s name was removed, and a notice to this effect was sent to the Registrar of the General Medical Council.

Hunterian Oration for 1917.

Sir George Henry Makins was appointed to deliver the Oration for 1917.

¹ *Trans. American Laryngol. Assoc.*, xxxiii, 1911, p. 222.

² *Trans. Amer. Med. Assoc.*, Section of Laryngology, lxiv, 1913, p. 180.

³ *Trans. Medical Society*, London, xxiv, 1901, p. 302.

years practised in London; he went to South Africa in 1854, and received an appointment in the Convict Department then mainly engaged in road making. Subsequently he practised for many years at George. He retired in 1880, and lived afterwards at Capetown. All Dr. Lawrence's four sons entered the medical profession. Dr. T. G. Lawrence, first in practice in George, went to Johannesburg in its early days and died in the Eighties. The remaining sons, Drs. Alfred, Norman (Major R.A.M.C.), and Arthur Lawrence, are still in the Cape Province. Two of Dr. Lawrence's grandsons are doctors—Dr. Ruthven Lawrence of Claremont, at present serving with the South African General Hospital in England, and Dr. Cyril Wilson, late Surgeon, R.N., more recently in practice in South Africa, and now serving with the Royal Army Medical Corps. The *South African Medical Record* describes Dr. Lawrence as a man of fine presence, who until lately retained all his vigour; only three years ago he underwent suprapubic lithotomy, and walked about, as though nothing had happened, within a fortnight. Dr. Lawrence was well read, as he never neglected general learning. His social qualities were high, and he charmed his friends by his conversational powers.

THE HON. WALTER HUMPHRIES MONTAGUE, M.D., of Winnipeg, died of apoplexy on November 15th. He was born at Adelaide, Ontario, in November, 1858, and was the son of a farmer. His career was remarkable; he began as an errand boy in a country store. He took a teacher's certificate at Woodstock College, and afterwards entered the Toronto School of Medicine, going from there to Victoria University, Cobourg, where he obtained his degree. He was admitted to the College of Surgeons and Physicians of Ontario, and to the Royal College of Physicians of Edinburgh. For several years Dr. Montague practised at Dunnville, Ontario. In 1883 he was an unsuccessful candidate for the Ontario legislature, and was first elected to the House of Commons in 1887. The election was voided, but he was re-elected the same year; that election was also voided by the Supreme Court of Canada. In 1889 he was an unsuccessful candidate at a by-election, which also was declared void, and in 1890 he was again elected. He was re-elected in 1891 and 1896, but was defeated in 1900. In December, 1894, Dr. Montague entered the Bowell administration without portfolio, and in 1895 became Minister of Agriculture, which office he retained under the Tupper Government until July, 1896. In 1908 Dr. Montague removed to Manitoba, and in 1913 was appointed Minister of Public Works. He retained that office until the resignation of the Roblin Government some months ago. Dr. Montague leaves a widow, two daughters, and two sons—Captain R. J. Montague, who is Staff Captain for General Ketchen, and Captain F. Montague, A.D.C. to General Turner.

The Services.

EXCHANGES DESIRED.

A CAPTAIN R.A.M.C.(T.F.) Field Ambulance, at present in England, wishes to exchange with an officer doing duty in a hospital or casualty clearing station. Address No. 350, BRITISH MEDICAL JOURNAL Office, 429, Strand, W.C.

Captain (T.F.), at present serving in Mounted Brigade Field Ambulance at home, wishes to exchange with officer in Field Ambulance or Casualty Clearing Station abroad or about to proceed abroad.—Address, No. 349, BRITISH MEDICAL JOURNAL Office, 429, Strand, W.C.

THE late Dr. J. W. N. Mackay, of Elgin, left personal estate of the total value of £13,269.

THE Police Commissioner of New York has taken action for the prevention of unnecessary noises, and has issued an order enjoining a strict enforcement of the regulations.

UNDER the presidency of Professor Sanarelli a national league for the hygienic well-being of soldiers in the field has been formed at Rome. Its object is to supply whatever is needed to make life in the trenches and fighting line generally more comfortable for the men, to improve their physical condition, and increase their power of resistance to disease. Branches of the league will be formed in different cities for the special purpose of arranging for the transmission of gifts for the troops.

Medical News.

THE *Journal de Médecine de Bordeaux* states that at the opening of the academic year 1914-15 there were still some students too young for military service, but the successive calling up of the 1915 and 1916 classes quickly thinned their already depleted ranks. At present Saint André, the principal clinical hospital, has only two residents; both are doctors of medicine, and one is a woman. Eleven externs are doing duty as residents. The other hospital workers (*stagiaires*) comprise a few young men medically unfit for military service with some women students and a sprinkling of foreigners. In the early months of the war there was a marked decrease in the number of ordinary patients. The total number for the third quarter of 1914 was 1,351. In 1915 the figures became almost normal; the number of patients in the third quarter was 1,883, higher by 532 than that for the corresponding period in 1914. A noteworthy point is the change in the nationality of the patients. Whereas before the war the wards were filled with Portuguese, Greeks, Dutchmen, Danes, and Norwegians, lying side by side with Moroccans come to Bordeaux to work on the quays, now their place has been taken by French men and women and by Belgian refugees. The scheme for uniting the four teaching hospitals—Saint André, the Children's Hospital, that of Le Tondu and the Pellegrin Hospice—into one vast general hospital, which was on the point of being carried into effect, has had to be held in abeyance till the end of the war.

IN some notes on insecticides published in the *Journal of Tropical Medicine and Hygiene*, Drs. Castellani and Jackson state that for use against lice on a large scale the best powder is naphthaline. It has a lower destructive action than kerosene oil, guaiacol, iodoform, or anise preparations, but has a less unpleasant odour than the first three named, and is much cheaper than the last. Of liquid insecticides kerosene appears to be the best. Where price is not a matter of consequence menthol powder is to be preferred to naphthaline; it not only repels lice and fleas, but mosquitos also. For bugs kerosene oil is the best insecticide, and next to it guaiacol and pyrethrum powder.

LAST February the *Field* published a very remarkable special supplement, written by Dr. Arthur Tacquin, Physician-in-Ordinary to the King of the Belgians, giving an account, with striking illustrations, of some of the deeds of the Germans in Belgium. The editor of the *Field* now announces that a special shilling number of that paper will be published on January 29th, giving a further account of the crimes of the German army. Among other matters it will deal with the murder of women and children, and the murder and wounding of civilians in France, with corroborative evidence from German sources; the use of civilians as screens, with German admissions that this had been done; and with the killing or mutilating of wounded, again with German admissions. The long preliminary table of contents, of which we have given only a brief outline, includes also outrages on the Red Cross and the poisoning of wells, and ends with the significant words, "more to follow."

THE China Inland Mission has issued a report by Dr. G. Whitfield Guinness (London: Morgan and Scott. 1915. Price 3d. net), of the medical work done in Kaifeng, the capital of Honan, under its auspices. The death (from typhus fever contracted in the course of his work) of Dr. Sidney Carr in 1914 made the running of the hospital there very difficult, but Dr. Guinness has since been joined by Drs. Jessie McDonald and D. M. Gibson. Medical training is carried on, and although Kaifeng Mission Hospital is not a medical school with power to grant a doctor's degree, the curriculum is a practical one and turns out men who are able to do a large number of operations with skill. These hospital assistants are divided into three classes: Student assistants, ward nurses, and ward coolies. The women's work is now under the charge of Dr. Jessie McDonald, who is a graduate of Toronto. In 1904, when the work was begun, there were 1,476 outpatients' attendances; in 1913 the number had risen to 15,021, and there had been a further increase in 1914. The number of in-patients in 1913 was over 600; and the 1,600 operations included 505 for entropion, 175 for fistula in ano, 372 for various abscesses, 157 tooth extractions, and a few serious operative procedures. Local anaesthesia was used in 950 cases, no anaesthetic at all in 567, and chloroform in 133.