

cent., or more at London Hospitals during pre-Listerian days. Had we been permitted to amputate more often, at least three or four cases might have been saved, and our death-rate reduced to 2 or 2½ per cent., which is the present rate at the Edinburgh Royal Infirmary. It may appear some slight set off against the higher mortality, that over thirty-two limbs have been saved which would have been amputated if our ratio of amputations to conservative operations had been the same as in Edinburgh.

Précis of operation on joints in the Kashmir Mission Hospital, 1890 to 1899, inclusive.

		Cured.	Improved.	Not Improved.	Left hospital.	Died.
EXCISION of	Shoulder	3	...	...	...	...
	Elbow	26	1	1	1	1
	Wrist	4	1	...	...	...
	Hip	4	1	...	1	2
	Knee	13	2	...	...	1
	Ankle	5	3	...	...	...
	Smaller joints	4	...	...	...	...
ARTHRECTOMY of	L. jaw, condyles of	6	...	...	...	...
	Elbow	8	...	...	...	...
	Hip	1	...	...	...	...
	Knee	15	1	...	1	2
ARTHROTOMY of	Ankle	2	...	...	...	...
	Sterno-clavicular	1	...	...	...	...
	Shoulder	2	1	...	...	...
	Elbow	23	1	...	3	...
ASPIRATION or injections of larger joints	Wrist	3	2	...	1	...
	Hip	19	3	3	1	...
	Knee	9	6	3	1	2
	Ankle	10	2	...	1	...
	TENOTOMY, ETC., for Ankylosis of	...	...	...	...	...
	L. jaw	11	3	...	...	...
Shoulder	12	6	1	...	...
Elbow	27	8	...	...	...
Wrist	2	...	...	...	...
Hip	17	8	1	...	...
Knee	106	43	1	...	...
Ankle	5	1	...	...	...
UNCLASSIFIED	...	12	4	1	...	...
Totals	...	392	116	13	11	8

About half the cases were under the care of Dr. E. F. Neve.

AN OPERATION FOR PILES.

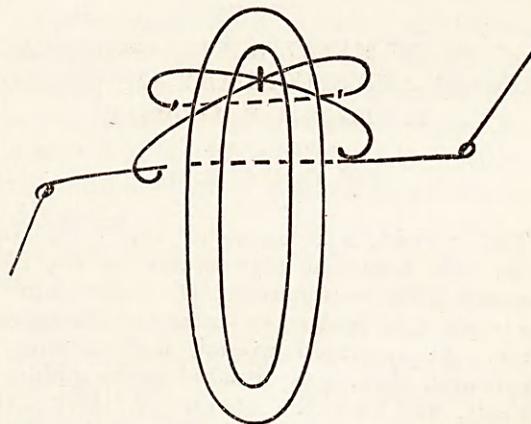
By W. H. HENDERSON, F.R.C.S.I.,

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In the *British Medical Journal*, November 26th, 1898, Mr. Thelwall Thomas published an account of an operation for piles which I have tried and found so satisfactory that I have since been in the habit of performing it on

all my cases. The results are excellent, and it has the advantage of being easily and quickly performed. The patient complains of very little pain and recovery is rapid. A full description of the operation will be found in the *Journal* referred to above. I propose here to give a short description of the process. The patient having been prepared in the usual way for rectal operations, is placed at the edge of the table in the lithotomy position and the crutch applied. The rectum is dilated, and the pile with the redundant tissue having been brought into view is seized with a pair of forceps. The parts are then clamped, always in the long axis of the gut. Mr. Thomas, in a foot-note, recommends Doyen's broad ligament clamp (small size). This I have not tried. I use a small-sized hæmorrhoidal clamp which answers the purpose admirably. The pile is removed, leaving a good margin of tissue protruding from the surface of the clamp, which is now treated in the following manner:— A fine piece of catgut about a foot in length is taken, and threaded at each end with a domestic needle. One needle is passed through the edges of the wound at the upper part, until the middle of the catgut is reached, when a reef knot is tied. The needles are then passed to the opposite sides, re-entered and again tied as before. This is repeated until the entire length of the wound is closed. Mr. Thomas' simple illustration will help to make matters clear.



The clamp is removed when a wound with the edges in accurate opposition is left, which heals by first intention. All bleeding is effectively controlled. In none of my cases has a bleeding vessel ever given trouble. The tying of an artery is rarely called for.

No action of the bowels must be allowed for four days. On the fifth day a dose of liquorice powder is given. The introduction of an enema tube is to be avoided. It is claimed for this operation that the wound is treated on sound surgical principles. The use of the hot iron to the surface of a removed pile leaves on the separation of the eschar an ulcerating surface. The method of ligaturing piles and allowing the

ligature to ulcerate through, and the pile to drop off is one which would not for a moment find favour in ordinary surgical practice. Mr. Thomas' method is sound in principle, and the excellent results which follow it are, in my opinion, strong arguments in favour of its adoption. There are occasions when Whitehouse's operation may be necessary, but the operation which I have just described is an excellent substitute in a large majority of cases. An operation resembling Mr. Thomas' to some extent is described at page 673 of Treves' Surgery, Vol. II. Mr. Coates, of Salisbury, uses a special clamp with which he fixes the pile to be operated upon. Interrupted sutures are passed beneath the clamp, which is removed, the pile excised and the sutures tied. Mr. Coates remarks "that this substitutes for the contused wound produced by the ligature, a cleanly incised cut neatly adjusted by sutures."

Mr. Thomas, referring to the operations of the ligature of piles, cauterizing piles, injecting irritants and painting them with caustics, remarks "that they are contrary to the spirit of modern surgery. Who is there amongst us who would resort to such methods for the encouragement of healing or the control of hæmorrhage in other parts of the body?" Such operations are certainly rightly condemned, and might justly be relegated to the category of the tapping of ovarian cysts, and the indiscriminate cutting for stones.

A CASE OF FATAL SEPTIC GANGRENE: PRIMARY AND SECONDARY AMPUTATION.

By VICTOR E. H. LINDESAY,

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THE patient, a rifleman of the 1/4th Gurkhas, was admitted to hospital on the 29th January 1900, complaining of severe pain in the right foot, with tenderness of the leg and thigh. A punctured wound, with a ring of discoloured skin, was situated in the middle of the sole, and from the opening a thick dark brown discharge escaped. The whole of the foot was swollen and congested, and the femoral glands were inflamed. The temperature on admission was 103.2°, the pulse was feeble and rapid (120 beats to the minute), and the man was sallow in appearance, with the anxious expression usual in cases of severe septicæmia. He gave a history of having trodden in bare feet upon a large thorn whilst cutting firewood on the hillside six days before admission. His age, according to his medical history sheet, was only 28, but he was probably nearer 38.

The presence of incipient double cataract suggested diabetes, but the urine remained absolutely free from sugar and albumen throughout his illness. As he steadily refused

amputation of the foot, treatment at first consisted of an attempt to remove the gangrenous tissue from the sole of the foot with free drainage and antiseptic applications every hour, but by the 2nd February (5th day after admission) the gangrene had reached the level of the internal malleolus, though tactile sensation remained unaffected in all the toes, and the dorsum of the foot was warm. The patient was at last persuaded that his only chance of recovery lay in immediate amputation, and with the assistance of Lt. Kemp, I.M.S., I removed the limb three inches below the knee on the 2nd February. The man's temperature at the time of the operation was 101.2, pulse 130. For the next two or three days all went well. The temperature remained almost normal, having previously been of an irregular remittent type. The pulse became stronger and the general appearance of the patient became more hopeful. But when dressing the stump on the 5th February I noticed that on the postero-internal surface of the limb the skin was of a bluish colour in the neighbourhood of the operation wound, and this appearance became more marked daily, while the temperature and pulse gradually resumed their previous warnings of constitutional danger. On the 8th (sixth day after the first operation) the condition became very grave. Pressure behind the stump below the knee gave the characteristic crackling of decomposition gases in the tissues, and a very offensive sanious discharge escaped through the internal drainage tube. The internal saphenous vein was prominent beneath the skin as a dark red line and the femoral glands were full of pus. The pulse was 144 and the temperature 102.5°, and although the patient was almost moribund, I decided to risk a further operation as a last chance, intending to excise the inflamed saphenous vein for several inches, together with the affected glands, after amputation through the middle of the thigh. The modified circular amputation was rapidly performed, the flaps adjusted over a long drainage tube protruding at either end of the stump, and dressings of boracic wool were applied.

The man's condition, however, was so grave that it was obviously useless to proceed further, and the pulse stopped twenty minutes afterwards, in spite of the injection of $\frac{1}{10}$ gr. strychnine and other stimulant measures.

Gangrene does not often occur in the reports of the Native Army Hospitals, and presumably this case would not have ended so disastrously had the man come to hospital before gangrene had set in, and had he not refused amputation till septic phlebitis had ensued. The onset of gangrene was possibly favoured by the exposure to cold at the time of the accident, the vitality of the man's foot being lowered by his standing in melting snow when he was collecting firewood.