such as gastrotomy. If primary union is found to have taken place throughout the whole or greater part of the wound, similar dressings are again applied; but if free suppuration has occurred, I abandon dry and infrequent dressings altogether, and use one of several other kinds, particularly adapted to the rapid and continuous and thorough removal of purulent products. In cases with what I regard as "inevitable suppuration"—most sequestrotomies, for example—after the first boracic acid dressing, I am fond of applying pieces of coarse scouring flannel, moistened with carbolic lotion (1 in 40), changed two or three times during the twenty-four hours, and continued until wound surfaces have cleaned and are covered with healthy granulations. I know no material which sucks up discharges with greater avidity.

I have used dry boracic dressings in major surgical operations of all kinds, and primary union has followed in the vast majority of cases. I have opened the abdominal cavity scores of times, the cranial cavity in many instances, and the cavities of joints on numerous occasions, and have never seen more than the roughest trace of suppuration in any of the wounds.

I have had hip-joint amputations soundly cicatrised, and patients sitting up on the twelfth day. Failure to secure primary union in breast excisions comes as a bitter disappointment. I purposely avoid detailing cases in this paper, because I believe that no useful practical end would be served thereby.

My own experience of surgical dressings began at the General Hospital at a time when Listerism had attained what was considered its highest perfection, when operations were performed in a cloud of carbolic steam, and patient, and operator, and assistants practically swam about the theatre in floods of antiseptic fluids. None amongst my earliest teachers had a more thorough conception of what Listerism could do, none followed the precepts of his enthusiastic leader more energetically, no disciple of the germ theory was more conscientious, than the late William Preston Goodall. In his practice I gained my first experience of perfect primary unions after major operations: and without saying my present results are better than what I saw then, I am sure they are as good, and are secured with less labour to the surgeon, with less expense to the hospital, and with less suffering to the patients.

In conclusion, I would add my belief that no small measure of my success is due to the introduction *into* the wound of the non-irritating, non-poisonous, and reliably antiseptic, dry, and absorbing powdered boracic acid.

A CONSECUTIVE SERIES OF OSTEOTOMIES.¹

By A. W. MAYO ROBSON, F.R.C.S.,

Honorary Surgeon to the Leeds General Infirmary, and Lecturer on Practical Surgery at the Yorkshire College.

THE following list, which has been compiled for me by my house-surgeon, Mr. Berkeley G. Moynihan, M.B., is a consecutive series of osteotomies for genu valgum and bow-leg which have been performed by me during the past three years, with two or three exceptions, in the Leeds General Infirmary.

Full antiseptic details, including the carbolic spray, were carried out. In the cases of genu valgum Macewen's osteotome was employed, the popliteal surface of the femur being first divided, and afterwards the anterior border; the incision on the inner side of the thigh being no larger than just to admit the osteotome. No suture or drainage-tube was ever employed. In straightening the limb, instead of bending the leg inwards to begin with, it was found very much easier to break the portion of the femur undivided by pressing the leg outwards, after which it was easily straightened. In order to secure a straight limb, the leg was always pushed well inwards, even beyond the position it was intended to occupy, and retained there by means of a long splint with a very thick pad at its lower extremity, up to the time of applying the plaster-of-Paris.

In the cases of bow-leg—with two exceptions, in which the saw was used—Macewen's chisel was always employed to remove a wedge out of the tibia, the fibula being then broken without division.

The following is a list of cases:—

TABLE I.—Cases of Genu Valgum.

Name.	Age.	Degree of Deformity.	Result and Remarks.
J. A. ²	16	Between malleoli, 20 inches	Plaster applied 11th day. D 7th day.
H. B.	7	—	Plaster applied 5th day. Temperature normal.
W. B.	17	—	Plaster applied 13th day. Temperature normal.
J. C.	8	—	Plaster applied 8th day. Temperature normal.
J. H. ²	15	Between malleoli, 15 inches	Plaster applied 11th day. Each leg once D.
E. M. ²	8	—	Plaster applied 8th day.
A. P. ²	8	—	" " 9th "
A. S. ²	8	—	" " 10th " Ogston's operation had been performed a year previously.
S. S. ²	15	Between malleoli, 24½ inches	Plaster applied 10th day.
A. A. ²	14	" " 6½ "	" " 9th "
M. W. ²	9	" " 6½ "	" " 13th "
G. B. ²	9	" " 6½ "	" " 8th "
P. B. ²	7	—	" " 11th " Also osteotomy of left tibia.
E. D.	16	—	Plaster applied 11th day.
T. B. ²	19	—	O January 7th. D January 11th, 20th, 22nd (pus 3 ss) and 26th. Small piece of necrosed bone came away. Ultimate result good.
E. H.	16	—	Plaster applied 12th day.
L. B. ²	11	Between malleoli, 6 inches	" " 9th "
J. G. ²	12	" " 8½ "	" " 9th "
W. H. ²	16	" " 9 "	" " 8th "
R. H.	9	" " "	" " 10th "
C. S.	4	" " "	" " 9th "
G. W.	4	" " "	" " 12th "
E. W.	7	" " "	" " 9th "
M. B. ²	15	" " 10½ "	" " 13th "
E. D.	10	" " 3½ "	" " 14th "
A. D. ²	5	" " 8 "	" " 11th "
J. H.	16	" " 6 "	" " 15th "
M. H.	17	" " 3 "	" " 16th " D 7th day.
E. H.	10	—	" " 14th "
F. J. ²	3	Between malleoli, 7 inches	" " 20th " D 8th day.
B. S. ²	23	" " 8 "	" " 26th "
P. S. ²	9	" " 6½ "	" " 12th "
W. T.	10	" " 4 "	" " 11th "
C. V.	14	" " 7½ "	" " 11th " Genu varum opposite leg.
E. W. ²	14	" " 8 "	Plaster applied 23rd day. D 19th day.
E. W.	7	" " 5 "	Plaster applied 16th day. D 8th day.
A. B.	38	" " 18 "	Plaster applied 21st day. Genu valgum opposite leg.
M. A.	17	" " 17 "	Plaster applied 14th day. Left leg less deformed, and corrected by instruments.
J. W. ²	7	" " 5 "	Plaster applied 8th day.
W. L. ²	14	" " 4½ "	" " 7th "
J. A. ¹	12	" " 9½ "	" " 7th "
W. F. ²	16	" " 10 "	" " 11th "
E. F. ²	15	One leg at right angles to thigh	" " 16th "

TABLE II.—Cases of Bow-leg.

Name.	Age.	Remarks.
J. D. ²	7	Right tibia. Plaster 7th day. Left tibia. Plaster 11th day.
F. M. ²	—	Three-quarters of an inch of bone removed from each tibia. Both healed perfectly on 14th day when put up in plaster. Saluber lotion employed, 20 grains to pint.
W. T. ²	11	Wedge from left tibia. Plaster 15th day.
W. T. ²	—	Osteotomy of both tibia. " 12th " on each.
P. B. ²	7	Wedge from tibia. " 10th "
A. H.	6	" " 10 weeks. Suppuration and several dressings. Ultimate result good. Saw employed to divide bones.
E. M. ²	3	Wedge from tibia. Plaster; R. 6th day, L. 7th day.
W. T. ²	11	Right leg. In the infirmary six months. Sinuses formed; the ends of the bone had to be refreshed. Saw employed to divide bone. Ultimate result good.
L. J. ²	3	7 inches between mid points of tibia. Plaster 15th day.
J. M. ²	7	Bowed tibia. Plaster 16th day.
F. B. ¹	14	Extreme bowing of tibia. Plaster applied 32nd day. D 2nd day.

Note.—² After name of patient means both legs operated on. D means dressed. Result and temperature, when not otherwise stated, were good.

In the preceding 84 osteotomies performed on 54 patients, it will be noticed that recovery ensued in every case, and that only

¹ Read in the Section of Surgery at the Annual Meeting of the British Medical Association, held in Glasgow, August, 1888.

9 out of the 84 operations needed a second dressing; the dressing first applied being one of salicylic or "salufer" wool held in position by a gauze bandage.

Out of 63 divisions of the femur for genu valgum, in only 1 was any pus seen, and in that case, a small piece of necrosed bone, about the size of a sixpence, came away, but the patient ultimately did well.

Of the tibial cases, two suppurated and required a number of dressings, and in one of these the ends of the bone had to be refreshed. In these two cases the saw was used instead of the chisel. Except in the three cases which suppurated, the temperature was normal. The ultimate results, so far as the straightness of the limbs is concerned, have been very satisfactory; but it was found that unless instruments were ordered there was usually a tendency to a recurrence of the deformity when the patients returned to their old mode of life; hence, after the first few cases, instruments were always ordered to be worn from about the eighth week, that is from the time of removing the plaster-of-Paris dressing, which was usually applied during the second week, when the cases were treated as out-patients. The ages of the patients varied from 4 years to 40, but the greater number were young adults. Syrup of phosphate of iron was generally given for some time after the operation, and if possible the patient was sent to a convalescent home or into the country.

The presence of the considerable numbers of deformed limbs seen in most of our large towns, for instance Glasgow and Leeds, is a standing reproach to the public authorities and to preventive medicine. I would suggest that more attention ought to be paid to the dwellings of the poor, overcrowding should be prevented, back to back houses should not be allowed, efficient sanitary arrangements should be compulsory, and no chamber should be permitted to be used as a dwelling room that would not allow of the free entrance of light and fresh air.

I cannot help thinking, that ignorance has more to answer for than negligence, in the greater number of these cases, and that if parents were instructed in the art of correctly feeding their progeny, and were educated to be ashamed of seeing their children grow up deformed (when by a little attention in the incipient stages, deformity might be prevented), a great step would be taken in the right direction.

Fortunately, however, as the foregoing cases show, it is now possible, thanks to Dr. Macewen and to the antiseptic system of treating wounds, to correct these deformities by division of the bones, just as easily and efficiently as subcutaneous tenotomy can correct cases of talipes.

THE FIBROMATOUS PROSTATE.

By REGINALD HARRISON, F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary, and Lecturer on Clinical Surgery in the Victoria University.

THE term fibromatous prostate seems to me to represent better than any other that condition of the part which most frequently brings it under the attention of the surgeon. Ordinary hypertrophy, where the relative proportions of the constituents are preserved, may be said to be the acquired disposition of the prostate in a considerable proportion of elderly males, to whose comfort we may infer it contributes. In the examination of men of sixty years of age or thereabouts, many of us must have been frequently struck, not only with the size the part has attained, but also by the immunity of the individual from symptoms of urinary incompetency. But in these persons, though the area of the prostate is increased as determined by the touch, there is usually no evidence that the part has undergone structural substitution. Nor is it at all necessary or consequential that such a hypertrophic alteration in bulk should give place to a new order of things, and that disturbed function must ensue. It seems to me, from a good many years' clinical observation in reference to this point, that no inconsiderable proportion of persons who have large prostates live about as long and as comfortably as others who are not so provided. Is the accession of urinary symptoms in persons so circumstanced to be attributed to what might be called the accidents of living, or to the development of tolerably well-defined changes in the hypertrophied part itself? Without referring to points which I have already discussed at length,¹ I may say that my

observations lead me to believe that it is only when the hypertrophied prostate becomes the fibromatous prostate that it is capable of arousing those symptoms of chronic irritation and obstruction with which we are familiar in persons of advancing years. The liability to these and sundry complications arising out of them is largely determined by the elements entering into the composition of the part involved. That a muscular prostate is capable of adapting itself to circumstances where a fibrous one is not, is, I think, a statement most of us would at once be inclined to admit. Reviewing what I have noticed of the symptoms which are assigned to senile prostatic enlargement, I cannot recall an instance where there was not evidence when looked for, not of structural increment alone, but of fibrous predominance. In some of these careful examination after death has shown us that fibrous tissue has largely invaded the muscular apparatus of the prostate. This substitution or proliferation is in practice observed in a variety of ways, which may be briefly illustrated.

The slightest forms of fibromatous prostate are often met with in elderly men in connection with sudden attacks of retention of urine, which conventionality assigns to indulgence in alcohol or sexual excess, often without sufficient evidence thereof. Exposure to wet or cold, such as sitting on a damp seat, is, I believe, a far more frequent cause. In this way some swelling of the part occurs, and retention of urine ensues. A few days' careful catheterism and warmth to the perineum usually put matters to rights again. Examination of the prostate with the finger, from the rectum, shows by the presence of indurations that it has undergone other alterations than those which could be included under the term hypertrophy. Taking another class of cases, I refer to those where elderly persons suffer from more or less irritability of the bladder, with excessive mucous exudation. Such individuals are often tormented by day and night to a degree which neither Nature nor the catheter can appease. Rectal examination shows not only that these men have, like a great many others, large prostates, but that they also have hard, knotty ones, which offer considerable resistance to the finger. In the last place let me illustrate from that class of cases where the prostate, by its fibrous excrescences, simulates stone. Here not only have we intense vesical irritation and inflammation due to the growth having encroached upon the interior of the bladder, but we have a secretion of mucus far exceeding anything that is usually seen in connection with stone in the bladder. Again, the catheter and the finger show that we have a still more advanced form of fibrous degeneration to contend with.

The outcome of these remarks, so far as I have observed, is that a large prostate may, functionally, mean very little. When, however, there is evidence that structural alteration of the kind indicated has taken place in it, the liability to the accession of urine symptoms is greatly increased. Further, in these changes we shall probably find an explanation not only for the development of symptoms which the commoner form of prostatic hypertrophy does not afford, but also, I believe, for certain alterations which have been observed in the physiological action of drugs upon the part.

In practice I have found that the structural condition of the prostate in the elderly often furnishes the best means for prognosticating events, so far as the urinary apparatus is concerned, just as a physical examination of the heart will enable the physician to forecast the future of the circulatory system.

These observations, bearing upon the pathology of the enlarged prostate, will probably find full expression in connection with the views I have advanced in my recent Lettsomian Lectures, as to the muscular power of the prostate in retaining and storing urine.

NOTES OF A CASE OF ABSCESS IN THE GROIN CONTAINING THE VERMIFORM APPENDIX.

By W. D. SPANTON, F.R.C.S. Ed.,

Surgeon to the North Staffordshire Infirmary.

AN unmarried lady, aged 62, consulted me in October, 1888, for an abscess of the right groin, which was so painful as to call for relief. She stated that her general health had been good, and that two years before, in carrying a heavy basket, she felt something give way in the right groin. It caused pain at the time, and a small swelling appeared shortly afterwards, but as it occasioned only slight inconvenience, no further notice was taken

¹ Lettsomian Lectures, 1888.