ing; we have had no instance in which deep-seated suppuration has occurred in an operation wound made through unbroken integument. If we have had any pus at all in such cases it has been from the surfaces exposed between stitches or at situations where drainage tubes have been inserted, where what I have termed antiseptic suppuration has shown itself occasionally, and even this in very slight degree. Such being the case, I feel not only permitted but bound to bring this material under the notice of my professional brethren.

As to the composition of this so-called double salt, it is for the present uncertain. This much is already established: that the cyanide of mercury is in very much smaller proportion to the cyanide of zinc than Watts's *Chemistry* would lead us to expect the double salt would give. But what the precise composition of the salt is we do not yet know. I am having it investigated by the Pharmaceutical Society, who have kindly undertaken the work.

There is another use for this material besides the charging of dressings. The powder moistened with a weak solution of corrosive sublimate may be rubbed into hairy parts, when it will convert the hairs into an antiseptic dressing. Not long ago a medical friend of mine brought his wife to me with no less than seven sebaceous cysts in the scalp, requesting me to remove them. Having washed the hair with 1 to 20 carbolic acid solution, I simply passed a comb over each tumour in the line where I was about to transfix, without shaving at all; and after taking out the cysts, rubbed some of the moistened powder into the hair in the vicinity. I then applied a dressing of cyanide gauze, and I was glad to learn that all the seven wounds had healed without disturbance.

We have now in the hospital a case of psoas abscess, shown to be of spinal origin, not only by the history of the case and the symptoms, but by the discharge of a portion of bone with the pus. That case is pursuing a course which, allow me to say, psoas abscesses will pursue in the great majority of cases, if the surgeon uses a trustworthy antiseptic, and takes the same pains with dressing to the last as at the outset; that is, he will find his trouble rewarded by the complete cure of these formerly incurable cases. I say this because I grieve to think that psoas and lumbar abscesses still seem to be regarded as hopeless affairs by many surgeons. In this man's case the temperature has never been affected in the least; he has put on flesh rapidly; the discharge, after the purulent and curdy matter that existed originally in the abscess was got rid of, has been of serous character, and is in small and diminishing quantity. But the opening made for the discharge is in the vicinity of the pubes, and the pubic hairs used, under such circumstances, to be a constant source of anxiety to us unless frequently shaved away. Here we rub in at each dressing a little of the moistened cyanide, and convert the hairs into an antiseptic application.

I will not at present enter into the details of the preparation of this material; these will be supplied in a note on a future occasion.¹

The sketch which I have given you of this investigation, though it has, I fear, wearied you, conveys but a small idea of the toil it has involved. There are those who still believe that the use of antiseptic substances in surgical practice is always useless, if not injurious. The germ theory of septic diseases is indeed now happily established incontrovertibly. All now admit that septic mischief in our wounds depends upon the development of micro-organisms in them derived from without. But the gentlemen to whom I refer are, more or less logically, disposed to trust everything to the antiseptic powers of the human tissues.

I believe I happened to be the first to direct attention to the antiseptic agency of living structures, and there is perhaps no one who attaches greater importance to it than I do. Without it surgery in former days would have been absolutely impossible. Still I know too well from experience that it cannot always be trusted, and that the use of antiseptic adjuncts is in the highest degree important. And I have the satisfaction of knowing that there is among you a constantly increasing number who, when they have operated on an unbroken skin, with a fair field around for the application of their dressings, if they see septic inflammation occurring in the wound with its attendant dangers, know that it is their fault or the fault of the antiseptic appliances at their disposal. To those among you who are impressed with this conviction I offer the dressing which I have described as the most satisfactory that I have hitherto met with; and I venture to hope that you will regard it as a not unwelcome addition to your resources.

¹ This note will appear in our next issue.

AMPUTATION AT THE HIP-JOINT.

By THOMAS MYLES, F.R.C.S.I.,

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I HAVE recently been practising on the dead body a new operation for amputation at the hip-joint, though I have not yet had an opportunity of trying it on the living.

The dangers of this operation are three—shock, hæmorrhage, and infection of the wound from its proximity to the anus. The first-named will exist probably in spite of every improvement; the two latter I think are obviated by this new method of operating, which I will now briefly describe.

The femoral artery is carefully felt for below Poupart's ligament; one inch below Poupart's ligament and half an inch outside the artery a stout nickel or steel skewer is thrust straight through from before backwards, and emerges on the posterior aspect a little above the gluteal fold. This skewer passes just inside the neck of the bone in the angle between neck and shaft of femur. A piece of india-rubber like that used in boy's catapult is passed on the inside of the thigh, and twisted in a figure

FIG. 1.—A, artery; F, femur; X, space between bone and artery into which pin is thrust from before backwards; T, elastic or india-rubber band passed around limb and ends of pin on inner side.

of 8 over the projecting ends of the skewer. It can be tied or, preferably, clamped with a bit of soft metal. By this means the femoral artery is completely controlled above the origin of the profunda. A long straight transfixion knife is now passed in the same direction as the skewer, but entering the skin at a slightly lower level, and emerging at a slightly lower level behind. A straight vertical incision, about two inches long, is now made with the knife, which is finally carried inwards, making a tapering flap from the tissues on the inner side of the limb.

During this part of the operation very little hæmorrhage is likely to occur, as the femoral in front and the sciatic artery behind are compressed by the elastic band. The limb is now forcibly abducted, and the capsule, stretched over the protruding head, comes into view, a nick with the knife allows the head to escape, and the blade is now carried first above and then outside the great trochanter, keeping close to the bone; and, finally, a second flap, similar to the first, is cut from the tissues on the outside of the limb.

This operation can, of course, be modified by tying the femoral and other visible vessels after the first incision; or, when the head is freed, a second pin, an elastic ligature, may be made to encircle the outer flap before it is completely divided. The accompanying rough diagram explains the method. The advantages of this are:—(1) extreme rapidity; (2) complete control of hæmorrhage; (3) the wound is vertical, therefore allows for drainage; cleanly cut, therefore ensures apposition and prompt union; away from the anus, and, therefore, not liable to infection. I trust that other surgeons will at least try the method, which, I believe, will be found most satisfactory.