The association of chorea with valvular disease of the heart does not support the embolic theory, or, to say the least, does not maintain it; for the latter, as a rule, does not precede the former, but originates in direct ratio with the persistency of the choreic movements, inasmuch as chorea, acute rheumatism, and valvular disease of the heart are directly associated in the same habit of body and nervous temperament. So far in this respect might it be inferred that emboli were productive of chorea, but one cannot push this point of the argument farther. I ask the question, Is it possible that the initiative nerve-change or irritability over any given cerebral area, can be maintained after the absolute causative agent has been removed? or, on the other hand, is it possible that the lesion which gave rise to the abnormally active impulse has so impressed the nerve-matter as to induce in it a property of hebetude which acts in correlation with subjective, attendant, and perverted mental processes? We know that a choreic patient will, when occupied, perform many movements quite co-ordinately which it is impossible for her to do whilst under observation.

The automatic balance of nerve-function is here superseded by emotional hypergenetic agency. Such a condition as this is the outcome not infrequently of what is often termed nervous mimicry, and there can be no doubt that such is frequently the case without what is usually understood as gross pathological change. If pathology do not serve us (and as yet this is perfectly true that it does not) in clearing up by demonstrative proof many vexed questions in reference to the cause of nervous disease. There are, on the other hand, many objective factors at work evidenced in the shape of clinical features, or signs, or symptoms, which, if carefully considered, weighed, and compared, will lead us to a correct and truthful issue.

In the cases of well marked embolic plugging which have come under my observation, the results have been, as before remarked, so unlike chorea, that I am inclined to think the theory untenable; and, judging from my own pathological data, such condition is absolutely negative; and the fact that the middle cerebral artery was found plugged by Dr. Moxon in a case of hemichorea followed by hemiplegia does not by any means invalidate this conclusion; in fact, it rather goes to prove that chorea was followed (by association) with valvular disease of the heart, which gave rise to the embolon that plugged the Sylvian vessel, and that this plugging gave rise to the hemiplegia.

ON THE DRESSING OF WOUNDS.

By EDMUND OWEN, F.R.C.S.,

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MR. RICHARD DAVY's clinical remarks on the dressing of wounds, which appeared in the *JOURNAL* of December 30th, 1876, are as bold as they are well timed. Mr. Davy comes forward as a champion of simplicity and æsthetics in surgical dressing; and, at the present day, when surgeons of the so-called antiseptic school are prone to attribute their success to some special virtue in carbolic acid, or in the way in which they employ it, Mr. Davy's trenchant remarks are of the greatest value.

By their side, I would like to place a few extracts taken from the lectures of a surgeon and teacher of vast and ripe experience. Thus we read in Spence's *Lectures on Surgery* (vol. i, p. 140, 2nd edition):—"Some of the statements advanced in favour of the antiseptic system so ignore the success obtained by simple dressing and treatment of wounds, or assert such an amount of infallibility as to the curative powers of the special method, as to require notice." Such statements, the author considers, arise from want of experience in, or misrepresentation of, the simple method of treating wounds. Further on, he says: "Novelty is not always progress, and unfortunately many novelties in surgery at the present day seem to consist in departure from simplicity of treatment."

The so-called antiseptic method of treatment is held by some of its practitioners to be all but infallible. Indeed, if such an one hear of a case treated "antiseptically" where the issue was unhappy, he is apt to say that there must have been a flaw somewhere in the intricate process. On the other hand, the patient recovers; there the treatment was carried out in its entirety.

Mr. Davy gives us thirty-two cases of important operations without a death, and without any special antiseptic treatment having been adopted. No disciple of any school, however modern, can show better results.

I will now venture to point out how it is that Mr. Davy has been so successful in his hospital practice. Like practitioners of the so-called antiseptic method, Mr. Davy pays the most careful attention to his patients after operations; he does not leave them (as is often the case in hospital practice) too much to the care of house-surgeons, dressers,

and nurses. I speak now with all respect for house-surgeons, but it cannot be denied that they are not always competent to take entire charge of a patient during the critical phases which present themselves in the first few days after an operation. In my experience, there is something for the surgeon to suggest, or to see carried out, each time he sees his patient in the first week, no matter how often he comes. Now, this is just where the antiseptic surgeon, in my opinion, effects so much. He is continually seeing his patient. Nothing is left to an untrained assistant or to chance. His dresser is a picked man and is specially instructed. Nothing is neglected; for everything is done in order and under the surgeon's personal and watchful supervision. The time and labour which he gives to his patient meet their due reward.

Ambroise Paré, whom Mr. Davy quotes with much effect, used to say of his patient in simple faith: "I dressed him; God cured him." But I apprehend that Paré's watchful care did more for his patients than did his "balsam of boyled whelpes and wormes".

Without presuming to adduce statistics from the work of five or six short years of hospital practice, I would, nevertheless, venture to make a few remarks upon the dressing of wounds. I dislike poultices; sometimes they are applied so hot as to distress the patient considerably. At other times, they are little more than warm. They are always disagreeable and unwholesome. Often the wound is allowed to become chilled whilst a fresh poultice is to be applied. Moist warmth can, when necessary, be obtained in many better ways.

Sores, however foul, may be cleansed and kept absolutely sweet by the liberal use of sulphurous acid lotion, which is of far more value than the fashionable carbolic acid lotion. For the treatment of fresh wounds, nothing is better than dry lint: I have left it on a wound after a herniotomy for three weeks, and, at the end of that time, have found the wound represented by a healthy cicatrix.

As Mr. Davy reminds us, the wound is but a single element in the case, and I apprehend that, if a patient be carefully watched and subjected to well considered hygienic influences, Nature will repair it, unless the interference on the part of the surgeon be too officious.

THE USE OF SPONGE-PADS IN EXCISION OF TUMOURS.

By W. WATSON CAMPBELL, M.D., F.R.C.P.E., Dunse.

IN the *BRITISH MEDICAL JOURNAL* of October 21st, 1876, I observe a note on a case of amputation of the breast, in which it is stated that the wound was healed in seventy-two hours after operation. There is a suspicious reference to continued high pulse and a drop or two of pus, which makes me wish I heard more of this case; for it occurs to me that these are sufficient to give rise to a fear that the result may not have proved what Mr. Maunder expected. Mr. Maunder speaks of pads, and I have sometimes wondered that what are usually employed as such, viz., lint, tow, towels, etc., have not long ere this been superseded by something better—sponges. Short as the time of healing in this case is reported to be, it does not strike me as extraordinary, but merely what might be obtained in a great majority of cases were sponges used as pads. I have been for years in the habit of using sponge-pads in the excision of tumours, and the rule has been union by first intention. There may be one or two points in the method I adopt that are worthy of attention; and, even if these be not original, I hope I shall be excused for bringing them before the profession.

After excising a tumour, I pare the edges, if necessary, and do not hesitate to remove anything—such as fat—which might interfere with accurate apposition of the flaps and the margins of the wound. Before closing the wound, I wait until every drop of blood has ceased to flow; for I believe that even slight capillary oozing is sufficient to prevent primary healing, by keeping the internal and opposing surfaces separate. Having carefully applied the sutures, I press a sponge firmly over the place from which the tumour has been removed, so as to force out between the stitches any blood which may have escaped into the cavity during the sewing. I then lay a bit of dry soft linen or bleached cotton-cloth over the place, and over this apply a dry clean sponge of sufficient size to produce, when bound down, such an amount of pressure as will serve to keep the internal surfaces close together and prevent capillary hæmorrhage. The advantage of linen or cotton over lint is, that neither has fibres like those of lint, which cause it to stick into the edges of the wound, and give rise to trouble to the surgeon and uneasiness to the patient when it is removed. The sponge is light, soft, and elastic, and readily adapts itself to such irregularities as there may be in the cavity from which the tumour has been removed. A