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The automatic balance of nerve-function is here superseded by emotional hypergenetic agency.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

bandage is put over all, wide enough and tight enough to effect all that is required. The time for removing the sponge and under-covering of linen or cotton may vary from twenty-four to forty-eight hours (never longer), and the removal must be effected so carefully as not to cause any dragging on the flaps. If the linen or cotton be found to adhere to any point of the wound, I prefer leaving it where it is, quite dry, to bathing or tearing it off, and a snip with the scissors is all that is needed for this. The linen is replaced by a clean bit, if all be found favourable, and the sponge is washed, wrung dry, and put on again, and left for two or three days, or even more, in order to make sure that the union is quite firm. The patient is kept in bed, and not allowed to move freely until the wound is healed. For three or four days, very meagre diet is allowed, and no stimulants in ordinary cases.

Ligatures, even of waxed silk, do not generally produce irritation, as will be shown in the following case, which I give in support of what I have said.

Three weeks ago, assisted by Dr. McWatt, I amputated the left breast for cancer. The patient was very stout and the gland large and embedded in fat, a considerable amount of which was removed after the tumour, because of infiltration and in order to admit of adjustment of the flaps. Seven waxed silk ligatures were applied, the edges were brought together with carbolised gut, and the wound was dressed in the way described above. On the second morning, while removing the dressing for the first time, and just as I was finishing, the patient suddenly started aside, and thus caused the forcible separation of the linen from the axillary angle of the wound to which it was adhering. About a teaspoonful of blood followed, and I feared that mischief might be the result of this irritation. Next day, when I called, I found she had had a rigor after I left, and, on removing the dressing, I observed a faint blush over the inner half of the wound. I reapplied the dressing, and, in anticipation of erysipelas, prescribed twenty grains of sulpho-carbolate of soda every six hours. Although there was a faint blush over part of the wound, Dr. McWatt, who was present when I removed the dressing, thought it looked like healing by first intention; and everything about the case, at this stage, certainly afforded more reason for saying that it *had* done so than was found in that reported by Mr. Maunder at the same period after operation. Two days later, the linen cloth next the wound was damp, and, on removing the dressing and carefully examining the cicatrix, I found it healed and firm, save for about the third of an inch. To prevent reopening, I supported the flaps on each side of this unclosed spot with strips of adhesive plaster. A little thin pus continued to pass for a few days, but gave no trouble. Five ligatures have come away through the firmly closed edges without a drop of pus accompanying or following any of these, and the remaining two are clean and dry, though gentle traction is applied to each daily. The patient's pulse never rose above 90, and she has never had the slightest pain, except when she gave the start when I was removing the first dressing.

This is not a selected case, but I give it simply because it is the last I have had. I may further remark that, in minor amputations, I invariably place a bit of sponge right over the stump, and have hitherto found it of much service.

CURE OF AN "ULCERATED LEG" OF FULLY THIRTEEN YEARS' STANDING.

By JOHN COCHRANE, L.R.C.P.Ed., and L.R.C.S.Ed.,
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THE following case, the details of which I now present, is a somewhat interesting one. When I commenced practice here (Colmonell), in April last, I was called to see a male pauper who had suffered for a long time from an ulcerated leg. On proceeding to the patient's house, I discovered the following state of matters. The leg affected was the right one; and about four inches above the ankle, on the outside of the limb, there was an ulcer, measuring five inches in length and three inches in breadth. The smell from it was something most horrible, and, on examining it more closely, I found the wound gangrenous. The limb, from the knee down to the ankle, was very much swollen and the skin dark-coloured in appearance. The foot also was much swollen and the ankle oedematous. The ulcer also discharged continually much watery fluid. Its edges were exceedingly hard and the surface of a slaty-blue colour. Its depth was fully an inch, and conjoined with these signs was much pain in the affected limb. The pain at times was so severe as to prevent the man from getting sleep at night. The history of the case, obtained from the man and his wife, was as follows. Fully thirteen years ago, the limb was attacked with an inflammatory form of

disease; the symptoms, as described to me, warranting the supposition that it was erysipelas, the result of an injury to the leg. Since then, numerous little ulcers had appeared at different parts of the limb, and had disappeared under treatment, such as it was. Then a large ulcer formed on the anterior aspect of the limb, and, healing at one spot, spread over the limb till it settled in the part which was now affected. At the same time, the leg began to swell and become dropsical. For some years, the man continued to work at his employment, which was a laborious one; and then, when he found the leg becoming worse, he applied for relief from the parochial board. When I saw him for the first time, his leg was as hard as a stone from the knee to the ankle. He said that this hardness had been present for a considerable period, and the limb now was almost three times the circumference of the neighbouring leg and much heavier. There were a few varicose dilatations of the veins near the knee; but what struck me most was this same *hardness* of the tissues and the blackened appearance of the skin. The skin also, from the knee downwards, was affected with psoriasis. This latter, no doubt, was due to the continual irritation from the nasty discharges coming from the ulcerated surface, and from the venous obstruction, which also undoubtedly was the cause of the oedema of the ankle and foot. Possibly, also, the condition of the blood was at fault, owing to the neglect which had been shown to the treatment of the ulcer.

The man had never been put under suitable treatment, and all sorts of absurd applications had been made to the ulcer on the recommendation of friends. At one time continual poulticing was used, which, he said, however, never failed to remove the pain for a time. Then my predecessor here, the late Mr. Wilson, who acted on the homoeopathic system, prescribed some drops, which, of course, did no good either to relieve pain or help the curing of the sore leg. At one time, also, the man was sent to Glasgow Infirmary at the expense of the parish, on the suggestion of a member of the board and with the concurrence of the parish doctor. There he was told by one of the surgeons that it was a hopeless case; and, seeing that there was little prospect of a cure, he left the infirmary and returned here again, to be informed by the parish doctor "that there was no chance of effecting a cure", and that, even if it were possible, it would be dangerous to attempt it. Such is the history of the above case, and I believe the man's statements to be true; inasmuch as he enjoys the character of being a truthful and honest workman, and most of the inhabitants of the district know well how he has suffered so long.

I diagnosed the case to be one of what is called "diffuse hypertrophy of the skin and subcutaneous connective tissue", or "pachydermia". The ulcer was merely a concomitant.

The Treatment I adopted, and it has been so far successful as to reduce the size of the leg, cure the ulcer, remove the dropsical swelling of the foot and ankle, and improve the condition of the skin, lasted over a considerable length of time, nearly five months. First of all, I determined to attack the ulcer and bring it into a healthy condition. I used at the commencement, as a dressing, a diluted solution of permanganate of potash applied on lint, which at first was changed twice in the day. After a few trials of this, I resolved to apply a solution of carbolic acid, in the proportion of about two drachms of the acid to eight ounces of water, along with a little glycerine. This soon told on the sore, as it soon commenced to granulate and new skin to form gradually. Very hot weather setting in, I discontinued the watery solution of carbolic acid, and used instead an oily solution of the acid mixed with glycerine, and this did remarkably well. Occasionally, slight venous oozing appeared at the surface of the ulcer and around its edges; but this was counteracted by the application of a solution of zinc sulphate. Soon the wound began to fill up, the hard edges to disappear, and, after a protracted period of over several months' duration, the ulcer entirely healed over. But from the very commencement, I adopted the measure of bandaging the limb from the foot up to the knee, and this was done daily, and often twice in the day, with few exceptions. The man was also kept as much as possible in the recumbent position, with the foot slightly elevated and the limb laid on a pillow. I also gave him internally iodide of potassium in five-grain doses, combined with bichloride of mercury, one-twelfth of a grain, in compound decoction of sarsaparilla, and the compound tinctures of cinchona and of cardamoms. This he continued to take from the first, and occasionally mild symptoms of iodism were produced, but the dose was easily stopped. This dose of the above drugs he took thrice daily, and at the same time occasional doses of saline purgatives were given to keep the bowels regular. When the ulcer healed, I used, for the psoriasis, the inunction over the affected skin of, first, carbolic acid in solution with oil and glycerine. Then I afterwards tried benzoated oxide of zinc ointment, the nitrate of mercury ointment diluted with lard, etc., and latterly used nothing, but simply bandaged the leg. The leg is now almost as well as its neigh-