bably be less than that which accompanies a large irreducible scrotal hernia.

The extra-opening into the abdominal cavity is not attended by much more danger, if the operation be performed with strict antiseptic precautions; and the risks attendant upon it are, I think, not greater than those which accompany the leaving of the bowel unreduced in the sac, or the attempt to forcibly reduce it by dividing or tearing through old adhesions, when exceptionally dense and firm.

NOTE ON CHOLECYSTOTOMY.

Read before the Pathological and Clinical Section of the Birmingham and Midland Counties Branch.

By LAWSON TAIT, F. R. C. S.,

Surgeon to the Birmingham and Midland Hospital for Women.

THE performance of this operation has now been so frequently successful in various parts of the world, that I think we may take it as an established addition to surgical procedure. I have been written to by many practitioners, asking for a list of the cases which I have performed, and I therefore desire to publish them, in order to save the necessity in future of furnishing each of my correspondents with manuscript references.

[Here Mr. Tait gives a Table, the particulars of which, with the exception of the case related below, are contained in Mr. J. W. Taylor's Table, published at page 221 of the JOURNAL of January 31st.]

The only addition to the literature of the subject, which requires present notice, is a recent paper by Dr. G. McF. Gaston of Atlanta, Georgia, which has been sent to me by its author. It was printed in Gaillard's *Medical Journal* for October, 1884; and the editor proposes that the proceeding advocated by Dr. Gaston should, in future, be known as Gaston's operation. Briefly, it consists of making a communication between the gall-bladder and the duodenum. The paper in which the proposal is made is so indefinite, and contains such singular views of the anatomy and physiology of the organs concerned, that it is quite possible I do not understand the full merits of the proceeding. Dr. Gaston's operations were limited to five dogs, upon two of whom the results were eminently unsatisfactory; and it is perfectly certain that the proceedings, which he recommends for dogs, could not possibly be applied to the human being. I can see no advantage in the establishment of a circular canal passing through the duodenum and the gall-bladder; and I think that, in all probability, the ring so formed would be a very convenient trap for knuckles of intestine.

The operation of Marion Sims restores the gall-bladder to its normal function, whilst that of Gaston certainly never could. In the event of the recurrence of the disease, whether it be suppurative or the formation of gall-stones in the bladder, a small incision will enable us to reach the bladder on the second occasion without opening the peritoneum; but the whole trouble would have to be gone over again, from the first step to the last, with additional complications, if Gaston's operation had been performed; and, from my experience of artificially made fistulous openings, I do not think the chances would be very great in favour of the artificial communication remaining long open between the gall-bladder and the duodenum. Another difficulty would be that the contraction might, in process of time, form a stricture of the duodenum, so that I cannot, in face of all these considerations, see my way to give Dr. Gaston the credit for his suggestion which he evidently thinks I ought to award him.

In addition to this proposal of Dr. Gaston, I have had a large number of suggestions communicated to me from various sources, all of which I have carefully considered without having seen my way to recommend any of them as an addition to the original proposal of Marion Sims, the only practical addition to which consists in crushing the stones outside the duct by means of forceps, as already published in this JOURNAL, May 8th, 1884. The case there narrated has had a perfectly successful result, for Mr. Forty, of Wotton-under-Edge, under whose observation the patient is, tells me that the fistula has been completely closed for nearly five months, and that she is in perfect health.

I have now to add a fourteenth case of the operation for gall-stone, in which this plan of crushing the stone outside the duct had to be employed, the fragments being removed by the ordinary apertures in the bladder—a sort of combined lithotomy and lithotripsy, by which one of the chief difficulties of the operation was easily and successfully overcome.

I saw Mrs. W., aged 50, in consultation with Mr. Littlewood, of Walsall, on January 6th. The patient was then haggard in expres-

sion, her face denoting protracted suffering. She had been in bed for many months, suffering from constant pain in the region of the liver, with symptoms of gastric disturbance and general *malaise*. She had been practically an invalid for five years. Mr. Littlewood had discovered a tumour below the liver; it was firm and elastic, and could be moved, latterly, in almost any direction, and to some considerable distance over to the left of the middle line; it varied from time to time in size, and sometimes could not be discovered at all. She suffered from violent exacerbations of pain, which Mr. Littlewood regarded as due to the spasmodic contraction of a distended gall-bladder, the duct of which was blocked by a calculus. I entirely agreed with his view, and we both advised the patient to submit to a surgical operation, and to our advice she yielded a ready consent.

On January 13th, I made an incision, about three inches long, over the notch of the liver, and came at once upon a distended gall-bladder. This I emptied through an aspirator needle, and made an incision into the bladder at its base. I found in the neck of the bladder a large rough calculus, which was easily removed; but, beyond this, in a saccular expansion of the cystic duct, I could just touch another calculus, upon which I could not get my forceps to act from within the bladder. Keeping the forefinger of my left hand inside the gall-bladder as a guide, I passed my forceps into the peritoneal cavity, and grasped the calculus through the walls of the duct, gave it a smart squeeze, and easily broke it into small pieces, all of which I carefully removed with a scoop. I then stitched the wound of the gall-bladder to the wound of the abdominal walls in the ordinary way, and put a gum drainage-tube into the gall-bladder.

On January 16th, bile began to flow freely through the wound, but it has now entirely ceased, as the wound is quite closed. The drainage-tube was removed on the 18th, and the stitches were taken out on the 21st. The patient got up on the 29th, and returned home on February 5th.

SEVENTY CASES OF DUPUYTREN'S CONTRACTION OF THE PALMAR FASCIA.¹

By NOBLE SMITH, F.R.C.S. Ed.,

Surgeon to the All Saints' Children's Hospital, and Surgeon to the Orthopaedic Department of the Farringdon Dispensary.

THE contraction of the fingers in these cases is now well known to be due, as Baron Dupuytren first pointed out, to induration, thickening and contraction of the palmar fascia, the tendons and other structures remaining in a perfectly normal condition.

The truth of this view of the pathology of these cases has been abundantly proved by dissection in the dead, and by examination and operation in the living. A simple way to demonstrate the fact that the resistant cords which may be present are not tendons, is to place a finger upon the palm, while the patient brings the flexors into action by closing his hand against some resistance. If the cord were a tendon, such action would increase its tenseness, whereas the band of fascia will be thus relaxed.

Without entering into further details of description of this affection, which are well known, I propose to discuss several points which appear to me to be of chief interest, and upon which my researches enable me, I believe, to throw some new light.

Through the courtesy of Dr. Rayner, medical officer to the Marylebone Workhouse; Dr. Yarrow, of the City Road Workhouse; and of Dr. Dunlop, of the St. Pancras Workhouse, I have been enabled to examine 700 elderly inmates of those institutions, among whom I have found 70 cases of Dupuytren's contraction (in 15 of which, however, the fingers were not bent). The points to which I have chiefly directed my attention, are,

1. The supposed immunity of females from the affection;
2. The cause of the malady;
3. Its treatment.

Modern writers have stated that contraction of the palmar fascia is only found in men. This statement is incorrect, for, out of 444 women examined, I found 11 cases of well-marked Dupuytren's contraction, and 15 cases of indurated, thickened, and contracted fascia alone.

I may here remark that, amongst the individuals examined, I found many cases of various kinds of deformed and contracted fingers; some from gout, some from rheumatism; also some of those congenital cases in which the joints and the tissues in the immediate neighbourhood of the joints are at fault. These congenital cases have occasionally been set down wrongly as Dupuytren's contraction, and I

¹ Read before the Medical and Chirurgical Society, March 25th, 1884.