For my case, I procured two ordinary bradawls. I selected them about the fourteenth of an inch in diameter. As it happened, we had a *post mortem* examination in the hospital a day or two before. I then had the advantage, fortunately, of going through the operation. I then found the bradawls of this diameter too short for the purpose; although I was astonished at the ease with which they were pushed through the patella.¹ No longer bradawls of that diameter being procurable, the difficulty was met by filing down a larger size, and these answered very well. I, however, had also one shorter and stouter, with which I pierced the harder external portion of the bone.

Secondly, it is a matter of very slight moment, which fragment is pierced first, if they be nearly equal in size; but when, as in my case, and in one of Sir Joseph Lister's, there is great disparity in the size, it seems to me a rule absolute that the smaller portion, whether upper or lower, should be the fragment on which the operation should be first performed. By such action we are enabled to select the strongest point for the insertion of the bradawl or drill, and thus make the puncture in the larger portion, where it is less necessary to select the strongest point, adapt itself to the smaller.

When the two portions were threaded, I seized each end of the wire with pliers; and pulling this straight, allowed the wire to move freely backwards and forwards; I was thus certain there was no twist of the wire. The pliers, too, gave me a much firmer hold in twisting, so that the two fragments were well home, and in close apposition before the twist. One and a half turns were made.

I notice that, in some of the cases similarly treated at Leeds, a transverse incision was made. This, I take it, is not advisable; the scar, being transverse, is in the bend of the joint, and I think, therefore, likely to be injured in use; there is ample room for all the manipulation in the longitudinal incision.

Sir Joseph Lister mentions, in the case where he had a very small fragment to deal with, that large quantities of osseous material were subsequently thrown out. A comparison of the two patellæ in this case shows the same condition, and the fractured bone is now considerably the larger.

January, 1884.—This patient has, during the winter, been playing football, and considers one leg just as good as the other.

THE RAPID CURE OF DUPUYTREN'S CONTRACTION BY EXCISION.

By H. A. REEVES, F.R.C.S.E.,

Surgeon to the Royal Orthopædic Hospital, Senior Assistant-Surgeon and Teacher of Practical Surgery at the London Hospital.

THE following case is worthy of record, not simply because it proves the possibility of speedily remedying a disease of long standing, and which has hitherto been considered slow of cure, or intractable and even irremediable, but also because it is the second case of this deformity occurring in females which has come under my observation during the past five months. Though only three months have elapsed since the operation, the case may be considered complete on account of the method of operating, which removed the cause of the distortion, so that no fear of relapse need be apprehended, as the linear cutaneous cicatrix is unlikely to retract to any noteworthy extent. There is a slight longitudinal depression along the site of the excised band, but the finger is perfectly straight and thoroughly serviceable.

Before narrating the case, some remarks of Mr. Noble Smith in a recent number of the JOURNAL require notice. He says, in his paper on Dupuytren's Contraction, "Modern writers have stated that contraction of the palmar fascia is only found in men. This statement is incorrect, etc." Of course it is; and just as incorrect as Mr. Smith's statement that modern writers say that the deformity only occurs in men. If Mr. Smith will refer to the BRITISH MEDICAL JOURNAL, 1881, vol. ii, p. 1049, he will see that I was the first to show that Dupuytren's contraction does occur, and not very uncommonly, in women; and, since then, I have drawn further attention to the subject at p. 354 of my book on *Bodily Deformities*. Shortly after my paper, Mr. F. A. Southam, of Manchester, corroborated my statements, and others did likewise.

Mrs. P., aged 45, is a relative of a student at the London Hospital, who was present at the operation. She first noticed a thickening in the palm and contraction of her right ring-finger at the age of 32. She thought it might have been produced through falling from, and being dragged some distance by, a horse, while holding the reins. Shortly after-

wards, she worked much with a sewing-machine, which was as a new toy to her. Being fond of music, she practised a great deal on a digitorium. The contraction increased, and, when seen by me, it presented the condition shown in the accompanying figure.

The right hand figure is from a photograph of the case a month after operation, and the perfect correction of the deformity, which continues to be maintained, is well shown.

Assisted by Mr. P.—Dr. J. Oliver administering an anæsthetic—I made an incision through the skin down to the band, and along its entire length. The skin was then separated from the band, which was thoroughly isolated, except at its ends, and was divided at its upper end. I then tried to straighten the finger, which, however, only became straight after the use of a little force, which was accompanied by two loudish snaps, due to the rupture of some deep fibres. The band was then freely excised, and, after removing Esmarch's bandage, as there was no hæmorrhage, I accurately adjusted the skin-edges with fish-gut sutures, and put the hand in a long back-splint for the forearm and hand, with the fingers fully extended. The bandages had to be relaxed in twenty-four hours, having purposely been applied somewhat firmly, in order to keep up full extension. The wound healed by first intention; and, within three weeks, my patient could play the piano, write letters, etc. I saw her a short time since, and find that the finger is quite straight, and that the use of it is so very like the normal as to be termed perfect. I should state that this is the patient's view of the condition as well as mine.

Mr. Hardie, of Manchester, has recently revived Goyrand's operation with encouraging results; but I think the plan I adopted and intend to repeat, of excising the offending band, and removing the cause of the contraction, is the proper proceeding. Certainly, the result in the case, narrated is most satisfactory; and, now-a-days, we know that cleanliness is all that is necessary in a healthy patient to insure good union of a wound, so that the former risks of the treatment by open division are no longer feared.

Before this case was operated on, I was strongly in favour of subcutaneous division; but seeing how slow, and sometimes uncertain, this plan is, and knowing the liability to recontraction when the band is left, I have no hesitation in stating my belief that excision of the band will be the operation of the future when dealing surgically with Dupuytren's contraction.

I must, in accuracy, state that we attempted to use the spray; but those present will bear me out in the observation that our backs were drenched instead of the hand, so that the carbolic spray did not have a fair chance; but this seemed to be of no consequence to the wound.

TRAUMATIC URETHRAL STRICTURE CURED BY EXCISION.

By A. W. MAYO ROBSON, F.R.C.S. Eng.,
Surgeon to the Leeds General Infirmary.

It is taught in all the text-books that urethral stricture can be relieved, but is incurable; the following example proves an exception, and I am inclined to believe that the treatment followed out in the present case may be pursued in so many others, that a new rule may be formulated as follows. All narrow strictures of the urethra may be cured by excision, if situated anterior to a point half an inch in front of the membranous urethra; easily if behind the scrotum; without much difficulty, if covered by the scrotum or even if penile.

Whilst formulating such a rule, I would have it clearly understood that I would not advise or practise excision of the stricture unless it did not yield easily to the ordinary forms of treatment, or rapidly relapsed into its old condition. The following notes of one of my hos-

¹ Much more easily than in the actual operation. The patient had died of malignant disease, and the bones, it struck me, were softened.