NOTE.—Since writing the above, I have noticed, in the *JOURNAL* of February 7th, a letter from Dr. F. Simms on the internal use of permanganate of potash. In regard to the statement that this drug, "administered in tablets of the strength of one grain, gives rise at once to ulceration of the parts it comes in contact with," I have had no experience of any such effects; nor have I ever found any symptoms of gastric or intestinal irritation produced even after three to six grains have been taken daily for weeks. But I have never used the drug in tablets, but in pills. That the latter, if properly made, should pass unchanged through the length of the intestinal canal, must be, it seems to me, a very rare occurrence.

Kaolin ointment, it may be mentioned, is the best excipient for making the pills; and saccharine ingredients should be carefully avoided, as being liable to cause decomposition, and even spontaneous combustion. Possibly this may be the secret of the caustic action produced by the tablets.

AN OPERATION FOR DISPLACED SEMILUNAR CARTILAGE.

By THOMAS ANNANDALE, F.R.S.E.,

Regius Professor of Clinical Surgery, University of Edinburgh.

THE pathology of the condition called by that wise old surgeon Hey, of Leeds, "internal derangement of the knee-joint," by Sir Astley Cooper, "partial luxation of the thigh-bone from the semilunar cartilages," and which is now by some authors termed dislocation or displacement of the semilunar cartilages, has not yet been thoroughly worked out, as few opportunities occur for the dissection of a joint so affected. It is, however, a clinical fact that one of the semilunar cartilages, usually the internal one, does occasionally become loosened from its attachments; and, in consequence, this body is liable to be displaced either forwards or backwards, and so to interfere with the proper movements of the knee-joint.

Two classes of this displacement are met with; one in which the condition takes place suddenly, as a result of a twist or wrench of the knee; and the other in which the displacement is not so sudden, but appears to depend upon a gradual stretching of the attachments of the cartilage, owing to some effusion into the joints, or owing to some continued strain upon the joint, as is illustrated in connection with certain occupations.

When the displacement has once occurred in either case, it is liable to occur again; but from my experience, I judge that in cases, the result of a sudden rupture of the ligamentous attachments, which are promptly and carefully treated, the displacement is less likely to recur than in the more chronic ones.

If the condition be not permanently relieved, the displacement of the cartilage takes place more or less frequently in different cases; and sometimes in connection with the slightest movements of the joint.

The symptoms of this accident, as is well known, also vary in degree in different cases. The movements of the joints may be merely stiffened in one direction, or the joint itself may be firmly locked, and remain so until manipulation returns the displaced cartilage. Two patients have come to me from considerable distances suffering from this condition, and in both the knee-joint had been firmly locked in a flexed position for many hours. Manipulation easily replaced the cartilage, and the movements of the joint were at once re-established.

In all cases of this affection, some effusion into the joint follows the displacement.

The ordinary treatment of a displaced semilunar cartilage is to reduce it by flexion, extension, and manipulation; to apply a splint of elastic bandage, in order to keep the joint at rest, and prevent the displacement from recurring; and, if effusion be present, to employ the usual remedies to promote its absorption. When the accident is recent, I would strongly urge the importance of keeping the affected joint absolutely at rest for two or three weeks, so as to promote the union of the ruptured attachments.

This affection may become so troublesome, owing to the constant recurrence of the displacement, that a patient's occupation and comfort are seriously interfered with; and I relate the following example of such a condition in order to illustrate a new method of procedure which I successfully adopted in connection with it. The excellent result obtained in this case encourages me to express the opinion that this, or some similar proceeding, may now become an established

means of treatment, when the more simple methods fail to give relief, and to obtain for the patient an useful limb.

CASE.—Thomas M., aged 30, miner, was sent to me from the north of England, on November 1st, 1883, with the following history. About ten months before his admission, he was working in a kneeling position, when he felt something give way in his right knee. He suffered sharp pains, but continued at his work for a few hours. Great swelling of the joint followed, and the pain became much aggravated, so that he could not return to his work, and he had not since worked at his occupation. The condition was treated by rest, blistering, the application of iodine, and various liniments, with the result of reducing the swelling; but the pain still continued, and the movements of the joint were interfered with by something "slipping" in the knee.

On admission, the joint was slightly swollen, and there was a small amount of effusion into its cavity. The patient complained of acute pain in certain movements of the joint, which frequently became locked in the flexed position. He was able, by a little manipulation, to unlock the joint, but the frequency of this symptom made him quite unfit to follow his employment as a miner. On careful examination of the joint, there was a well marked hollow over the anterior border and position of the internal semilunar cartilage. This hollow was most marked when the knee was flexed. Having decided that the case was one of displaced semilunar cartilage, and one not likely to be cured by any ordinary treatment, I, on November 16th, performed this operation. An incision was made along the upper and inner border of the tibia, parallel with the anterior margin of the internal semilunar cartilage, and the few superficial vessels having been secured, the joint was opened. It was then seen that this semilunar cartilage was completely separated from its anterior attachments, and was displaced backwards about half an inch. The anterior edge of this cartilage was now seized by a pair of artery-clutch forceps, and it was drawn forwards into its natural position, and held there until three stitches of chromic catgut were passed through it and through the fascia and periosteum covering the margin of the tibia. The forceps were then withdrawn, the cartilage remaining securely stitched in position. The wound in the synovial membrane and soft textures having been closed with catgut stitches, a splint and plaster of Paris bandage were applied, so as to keep the joint at rest. The progress of the patient, after the operation, was perfect, the temperature never rising above 99° Fahr. Seven weeks after the operation, the splint and bandages were removed, and gentle movements of the joint practised.

On January 25th, 1884, the patient was dismissed cured, the movements of the joint being good, and the limb steadily gaining strength. In April of the same year, the patient returned to show the result. He was then seen and examined by many of our distinguished guests at the tercentenary, who all expressed the opinion that the result was everything that could be desired. He had perfect movement in the joint, and had never had the slightest stiffness or locking of the joint since he commenced to go about after the operation.

HOW TO PREVENT SEPTICÆMIA IN CASES OF MORBIDLY ADHERENT PLACENTA.

By KEITH NORMAN MACDONALD, F.R.C.P. Edin.,
L.R.C.P. Lond., Cupar, Fife.

WITH the exception of *post partum* hæmorrhage, adherent placenta is one of the most troublesome after-consequences of the lying-in state. It is, moreover, much dreaded by many practitioners, owing to the probability of septic matter finding its way into the circulation; but that an ordinary case need not give rise to any extraordinary alarm, the following history well illustrates.

Mrs. S., aged 38, six years married, and mother of one child, five years having elapsed since her last confinement, which was a forceps case, with partial placental adhesion, was taken in labour at midnight of December 29th, 1884. The pains were moderate and regular; and I was sent for at 7 A.M. in the morning. The case was apparently natural; the second stage was rather prolonged, owing to the head resting for more than an hour on the perineum, but was completed at nine o'clock, two hours after my arrival at the house, there being nothing unusual about it, except that the child, a female, appeared feeble, and the cord was unusually small.

During twenty minutes she retched several times, though firm compression was applied externally: she said that she had done so during the entire period of her pregnancy, and also had a "pain in her side." After this interval, I tried to remove the placenta,

but found that it was adherent to the fundus of the uterus, and, as far as I could make out, all round. After a further delay of half an hour, I reintroduced my right hand, carbolicised, made firm traction on the cord, and tried to peel it off, but it was of no use. The contractions of the uterus prevented my getting hold of the edge of the placenta, and, as I could remove nothing but clots of blood, I dug my fingers into its substance, and removed two small pieces, as much as I could do with safety, certainly not more than one-third of it; and after repeated attempts at extraction, I determined, very unwillingly, to let the case alone for a time, and to renew my attempts under chloroform if necessary, leaving the cord attached for future guidance. Before leaving, I applied a firm binder with pad, gave her some whiskey and ergot, and left her, for a time, none the worse for her rough handling.

Feeling that it would be very unsatisfactory to leave her in this condition, I resolved, after a few hours' further rest, to remove the coagula of blood that had collected in the uterus, if I could do nothing more; and, accordingly, at 7 P.M. the same evening, with the assistance of my friend Dr. Whitelaw, she was put under the influence of chloroform, when I again introduced my hand, carbolicised, into the uterus, and removed a quantity of clots, but could make no impression upon the still firmly adherent placenta. I did, therefore, consider further interference unjustifiable; therefore, after removing other two small pieces of the placenta, with the cord, I bound her well up, gave an opiate, ergot, and brandy; and left her for the night, after syringing the uterus and vagina well with a weak solution of Condyl's fluid.

December 30th. She passed a fairly good night, retched once, and expelled a small coagulum of blood. The lochia were normal; the secretion of milk was established; pulse 94, and weak; temperature 99° Fahr. There was no tenderness over the abdomen, which felt fuller than usual. A solution of carbolic acid (1 in 40) was now substituted for the Condyl's fluid, and five grains of quinine were ordered every four hours. This was a very important step in the treatment, as will afterwards be seen; and I have no doubt whatever that the early use of an antiseptic lotion, and the free administration of such a powerful febrifuge as quinine, prevented the propagation of septic germs in the system.

On the morning of the 31st, after passing another good night, and nursing her baby in the meantime, she had a severe rigor at 10 A.M., when the pulse rose to 130, and the temperature to 105° Fahr. This was, in all probability, the beginning of blood-poisoning; but the assiduous application of the lotion and the continued administration of quinine evidently rendered the septic agent abortive, as all the symptoms subsided towards evening, and no tenderness on pressure over the abdomen was felt; and, as far as her feelings were concerned, she felt fairly well, though the secretion of milk was considerably diminished in quantity.

On the morning of January 1st, 1885, she had another rigor at 9 A.M.; and the pulse again rose to 130, and the temperature to 104° Fahr. The milk was almost suppressed. After this, the child was not again put to the breast. The lochia were slightly offensive, but normal in quantity. The rigor began to subside towards midday; but the pulse and temperature continued high, but without any increase in the evening. Still there was no abdominal tenderness.

On the morning of January 2nd, the lochia seemed more offensive. A small portion, about three fingers' breadth, of the placenta had come away. There were more rigors. Pulse still 120; temperature 103°. She said that she felt much better, and wondered at my close attention to her.

On the 3rd, the pulse came down to 96, and the temperature to 100°; the lochia were slightly increased, but there were no more portions of placenta. However, on the morning of the 4th, another piece, much the same as the last, came away, and from that date she continued steadily to improve without a bad symptom. The lochia continued a little longer than usual, but, in other respects, presented no features calling for remark. To err on the side of safety, she was kept in bed for eighteen days, after which she immediately resumed her household duties.

REMARKS.—The most noteworthy point in the above case was the early stage at which the quinine was administered. Had I waited until there was a considerable rise of temperature with abdominal symptoms, I should probably have been too late. As it is well known that this important remedy possesses the power of destroying minute organisms outside the body, it is but a reasonable influence that it should also destroy, at all events, certain micro-organisms forming, or about to form, within the body. It was with this latter intention that I resorted to it at such an early stage, and the result shows that I was justified in doing so. The removal of the clots ten hours after the confinement I also consider an important item, perhaps the

most important of all; for, if they had not been cast off, septic matter could scarcely have failed to enter the system.

I cannot account for the remainder of the placenta. Probably it did soften and come away with the lochia; but, if so, it was in a very unostentatious manner, as I am at a loss to understand how it gave so little trouble.

CHRONIC SUPPURATION IN THE ANTRUM.

By MORTON SMALE, M.R.C.S., L.D.S.,

Dental Surgeon to Westminster Hospital, and Dean of the Dental Hospital of London.

DURING 1884, three cases of antral suppuration came under my care. They were treated somewhat differently from the method described in most text-books, and with so good a result, that I think an account of the cases might be of interest. They are, in most surgeons' hands, admittedly difficult to cure, and treatment generally extends over a considerable period.

The usual treatment is to open the antral cavity freely, if possible, through the alveolus of the bicuspid or molar teeth, and teach the patient to wash out the cavity by the forcible contraction of the buccinator and orbicularis oris on a dilute disinfectant held in the mouth. I have treated many cases in this way, but always with very unsatisfactory results. I resolved, therefore, to be a little more heroic in my treatment, and instead of the dilute disinfectant, to use a powerful one. Having removed all offending teeth, with none of which the disease appeared to be connected, the cavity was freely opened through the socket of one of the teeth, and freely syringed with a ten per cent. solution of carbolic acid. The cavity was plugged with lint soaked in a twenty-five per cent. solution of carbolic acid. This was allowed to remain twenty-four hours, the opening into the mouth being closed by a plate in two cases, and by a plug of cotton-wool soaked in gum mastic in spirit in the third. This was renewed for several days after syringing the cavity with a ten per cent. solution of carbolic acid, until all fetor (which was of the characteristic kind found in these cases) had disappeared.

From that time for about a month, the cavity was syringed every other day with a ten per cent. solution of carbolic acid, but there was no return of the fetor. The pus, in the first instance, was full of bacteria, and had for months, in each case, been a source of great discomfort and anxiety to the patients. They looked anæmic, and were losing flesh. All appetite had gone, and they were afraid to go into society. Each case had to be treated with slight differences, but the above treatment is sufficiently accurate to apply to all. I append some notes of one of the cases.

The patient was Miss M., aged 40. Her history was good. There was no specific taint. She was very anæmic, and much thinner than previously; had no appetite, and was always feeling sick; she had a disgusting taste in her mouth at all times, and occasionally a discharge from the nostril. There was a collection of fetid discharge at the back of the throat every morning. She had noticed it for quite six months, and had been treated medically, but with no good result. The breath was very offensive. There was no ozæna. The face had been slightly swollen several times, just under the eye. There was very little pain, except when the swelling was coming. I removed several roots of teeth, and opened the cavity through the second bicuspid socket, making the opening as large as possible. A large quantity of very fetid pus was discharged. I syringed the cavity freely with a ten per cent. solution of carbolic acid, and plugged it with lint soaked in twenty-five per cent. solution of the same. On April 7th, I removed the plug, syringed, and applied a fresh plug. There was very little pus, but still fetor. On April 8th, there was slight improvement. The treatment was continued. On April 12th she was much better; no fetor. The plug was removed permanently. The cavity was syringed with ten per cent. solution of carbolic acid. The syringing was continued every other day for a month. By May 20th, it had healed; there was no discharge, and the patient looked and felt better. On February 6th, 1885, I saw Miss M.; she was then quite well.

SPLENIC MURMUR IN INTERMITTENT FEVER.—In a patient suffering from intermittent fever with considerable enlargement of the spleen, Dr. Maissuriaz discovered, on auscultation, a loud murmur, synchronous with the beats of the heart, and most distinct just below the costal cartilages on the left side. This phenomenon is only observed when the spleen is hypertrophied, and the author compares it with the murmur heard over the thyroid gland in cases of exophthalmic goitre.