to if the case be mild, because they are conspicuous; or if the child be very young, because they are likely to tax its strength, and this I have known them to do. Straight wooden splints are used by some; and I have tried them, but without satisfaction, because they take their bearings upon the knee and ankle, which, if these joints be normal, is objectionable; while, as regards both irons and wooden splints, the most valuable time—namely, the many hours during which the child is asleep, and therefore no weight is upon the bones, and no muscular effort can bias treatment—is lost, as irons and splints cannot be worn in bed; and splints, if worn, are either kicked off or pushed by the child into an useless position.

This state of bent tibiae is generally observed in fine children soon after they begin to walk, and is believed to be caused by the child's legs having to carry a weight heavier than they are able to support. I believe this to be an intensifying, but not the primary cause. I hold, in fact, that, like talipes varus and talipes equino-varus, of which this may be considered the mildest modification, it is congenital, and due to the position which the child's legs and feet occupy *in utero*; the most favourable exciting cause being that of a large child lying in a uterus containing but little liquor amnii, so that the lower extremities are obliged to conform to the rounded containing cavity.

All obstetricians must have observed how newly born infants' limbs, when extended, rebound into the bent position they occupied in the uterus; and that often involves the appearance I have mentioned, and even talipes varus and equino-varus. It is well known also that a good nurse, by daily manipulations, can cure even pronounced talipes. What we need, therefore, for treatment, and early treatment, is an elastic power acting directly upon the bone affected, leaving free the knee and ankle joints, which can be worn when the child is awake and active, and particularly during the long hours of rest. These small light steel spring splints, which I have devised, and which a clever mechanist, Mr. Bryant of Lower Park Row, Bristol, made in accordance with my instructions, are designed to act in the same manner as manipulation. If we place the fingers of one hand on the upper extremity of the tibia, and of the other hand on the lower extremity, and both thumbs on the outer surface of the limb, the bone can, with gentle firm pressure, be soon made to assume almost the straight line, as at an early age it is cartilaginous. These splints consist of a spring shaft well curved outwards, having the lower extremity cupped to cover the malleolus of the fibula, and to the upper extremity fixed a transverse band of malleable iron to partially embrace the limb below the knee. In applying them, the centre of the shaft and the lower portion are first bandaged in position; then the upper part is pressed to the limb, the soft band moulded to the surface, and the bandaging completed. I have lately had straps affixed to the extremities of several, and these keep the splints in place without bandages. It is requisite that the splints be not strong, or they cause pain; but, if they be mild and well fitted, I find that mothers and nurses readily apply them, and see their operation; and children do not get them out of place, and wear them willingly both when asleep and when awake; and, so far as I have had time to observe, the results are most encouraging. I have adapted the same principle in these splints for bent radius and ulna in boys, the result of walking-stick fractures which had occurred some months before I saw them; also for keeping a toe straight after division of its flexor tendon for contraction.

NOTES ON A CASE OF DEAFNESS FOLLOWING CONCUSSION OF THE BRAIN.*

By RICHARD ELLIS, F.R.C.S. Ed.,

Senior Surgeon to the Newcastle-on-Tyne Throat and Ear Hospital.

THE patient, aged 28, the second officer of a steamer, on going on board his vessel in the harbour of Leith, at night, and where the light was bad, fell off the gangway, between the vessel and the wharf, into the water, a distance of about twelve feet. In falling, he struck his head against the sponsoom of the vessel, and he was in the water for some minutes. When taken out, he was insensible, and remained so for twelve hours. Upon recovery of consciousness, he remembered nothing of the fall; he was told he had vomited much, and bled freely from the mouth, nose, and left ear. Meantime, as his general symptoms were promising, he was allowed to proceed quietly in his vessel to South Shields. On arrival at this port, he found he was totally deaf in the left ear, for which he applied to Mr. Rajaonah, the house-surgeon at the Ingham Infirmary, who sent him up to the Newcastle Throat and Ear Hospital, where he came under my care a week after

* Read in the Section of Otolary at the Annual Meeting of the British Medical Association in Worcester, August 1882.

the accident, presenting the following symptoms. There was a lacerated wound on the upper portion of the mastoid process; the pinna was also lacerated; these wounds were in a healing condition. He could not hear the watch on contact; he said that, on closure of his good ear, he could not hear the noise of the railway-train on his journey up. The tuning-fork was heard very faintly and indistinctly. On using the otoscope, no impulse was heard from the Eustachian tube. The tympanum was dull in colour, particularly in its lower segment; the cone or pyramid of light was not seen. The diagnosis was intratympanic hæmorrhage, blocking the Eustachian tube; and laceration of the lower segment of the tympanum, which was possibly fastened down by a coagulum of blood, thus preventing vibration.

Treatment.—The meatus was filled with a warm solution of bichloride of soda, in distilled water, with glycerine. This was renewed, and the steeping continued, for about twenty minutes. The syringe was now very gently used, which brought away a small thin coagulum, about half the size of the little finger nail, and he expressed a sense of relief; but still the hearing, although much improved, was defective. The Eustachian catheter was now passed, through which a weak alkaline solution was passed by means of a syringe; finally, he was Politizerised, with the result of there and then completely restoring his hearing. I recommended him to take, for a week or so, a mixture containing five grain doses of the iodide of potassium.

PARALLEL HISTORIES OF TWO CASES OF BLEEDING MYOMA.*

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

IT is now just ten years since I introduced the operation of the removal of the uterine appendages for the arrest of hæmorrhage; and though at first my results were so unsatisfactory as to lead almost to a desertion of the practice, within the last six years the results, both primary and secondary, have been so brilliant, that I have every reason to regard this proceeding as the most satisfactory addition to gynecology which has been made during the present generation.

The idea seems to have occurred simultaneously to Professor Hegar and to myself; and the performance of the operations in order of date gives only a few days' priority to Professor Hegar. But, for the relief of pain, I had performed the operation seven months before Professor Hegar. At first I was contented to remove the ovaries, but I soon found that the results were not speedily and completely satisfactory unless the tubes were removed. Increased experience in this class of cases has satisfied me that it is with the tubes that we have chiefly to do, and that the function of menstruation has little or no dependence on the ovaries. If the tubes are removed and the ovaries left, menstruation may be entirely suspended. Thus it will be seen that the principles upon which is based the operation introduced and practised by myself differ very much from those of Hegar and Battery.

I have already published several series of cases of removal of the uterine appendages for the arrest of intractable uterine hæmorrhage, in which I have shown that both the primary and the secondary results are more satisfactory than those of lithotrity in the male, so far as these are known.

I have now to give the histories of two most curiously parallel cases of bleeding uterine myoma; the contrast afforded by these being a singularly powerful argument in favour of the operation I advocate.

The first case is that of a young woman, aged 28. I admitted her to the Hospital for Women on May 15th, 1879, on account of profuse menorrhagia. She was in a condition of the most extreme anæmia, due to the presence of a small myoma in the fundus. Every therapeutic measure had failed to make the least impression on the hæmorrhage, and I therefore attempted to remove the myoma by dividing the cervix and opening the capsule. This was done on August 12th, and a mass as large as a hen's egg was removed. She hung between life and death for weeks, and was eight months in recovering strength sufficiently to get about. In a report published in the *Lancet*, I remarked that I was of opinion that, in such a case, the removal of the appendages was a much safer proceeding than enucleation of the tumour, and that it had given much better results. There can be no question that enucleation is a most terribly fatal operation; and even when it does not kill, it is not necessarily successful, as will be seen in the second part of the history of this case.

I saw her from time to time after she left the hospital, and she became strong enough to resume occupation in July 1880. She became engaged to be married about this time, and everything promised well

* Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association in Worcester, August 1882.

for her future life, for her menstruation was normal, and her uterus quite as it should have been. But in December 1880 she came to me on account of increasing menstruation; and I found that the fundus was enlarged, and in all probability the seat of another myomatous growth. In April 1881, matters were much worse, and I then proposed to her the more complete operation for the cure of her disease—removal of the uterine appendages. She was quite prepared for anything, but the consent of her intended husband had to be secured for the proceeding; and here a difficulty was encountered. In spite of my assurance that with a myoma she had little or no chance of being a mother, and that with the increasing hæmorrhage she had little chance of surviving her marriage more than a few months, my advice was rejected, and she was taken to London for the opinion of a distinguished surgeon there. I am informed that his advice was that nothing should be done, as the tumour was small, and would probably never trouble her, and that she might be married. She married in June, and died of hæmorrhage in August.

In the same period exactly which limits the history of this case, I had another under my care, sent to me by Dr. Law Webb of Ironbridge. She was thirty-two years of age, and had suffered from profuse menstruation for about twelve months, when I first saw her in February 1879. I found the cause of the hæmorrhage to be, as in the first case, a small myoma. I enucleated it also, and she made a very tedious recovery. Up to January 1881, she remained perfectly well; but she came back to me in August last with all the old symptoms, and I found another myoma. On August 25th, 1881, I removed the appendages, and she made a speedy recovery. On January 30th, 1882, she came to see me, looking very well, expressing herself as being much stronger; and she told me that there had been no return of menstruation. The last interview I had with her, in June last, was to discuss the question of her marriage. The tumour had become greatly reduced in size; and as she was entering into the married state with full knowledge, in the case of both parties, that she could never be a mother, I could see no objections to the step, and it is about to be taken.*

The lessons from these two cases are: first, that hæmorrhage due to a myoma may be fatal; second, that enucleation of a tumour is often not a successful operation in its secondary results; and this fact, together with its enormously high primary mortality, is quite enough to condemn it.

The series of cases I have already published prove conclusively: 1. That the primary mortality of removal of the uterine appendages for bleeding myoma is very small, and is limited to those cases already so reduced by loss of blood as to be practically unable to withstand any surgical proceeding; 2. That the secondary results of the operation are extremely satisfactory, and are permanent, the arrest of the hæmorrhage being followed by the shrinking of the tumour, and in many cases by its complete disappearance.

The objections to the operation, so far as I have seen them, are only two. (a) It deprives a woman of her sexual powers. This is proved on all hands to be incorrect; but even if it were true, nothing could be more immoral than to refuse to relieve a suffering woman on such a plea. (b) It is argued that it completely destroys the possibility of maternity; but the answer to this is, that the chances of a woman suffering from uterine myoma becoming a mother are infinitely small, and if she should become pregnant, she runs a most serious risk of her life.

Dr. SUTTON (Pittsburg, U.S.A.), in response to a call from the Chairman, said that, coming as he did from the country where ovariectomy had its birth, and where Battey had more recently re-introduced the operation for removal of the ovaries, he knew well the difficulties which surrounded the introduction and advocacy of a new operation. He had, during his stay in this country, had the opportunity of seeing Mr. Tait's operations; and although he did not, of course, know what the ultimate result might be, he was able to say that patients recovered from the operation perfectly. He should go back and tell his countrymen that he considered Mr. Tait's operation was worthy of their acceptance, and he recommended them to give it a full and fair trial.

* She has now been married some months, and is in perfect health. The tumour is about one-third of the size it was at the time of the operation (December 20th, 1882).

KING'S COLLEGE, LONDON.—The Right Hon. Sir John Mowbray, Bart., M.P., D.C.L., has consented to preside at the annual dinner of associates and students, to be held in the College Dining Hall, on January 17th, 1883. Gentlemen wishing to be present are requested to communicate with the Honorary Secretary of the Committee, Mr. H. Courtenay Luck, at the College.

ON MEDICAL LIFE-HISTORIES.*

By F. A. MAHOMED, M.D.,

Physician to the London Fever Hospital; Assistant-Physician to Guy's Hospital.

GREAT as our advances have been during the last half century, I suppose that all of us will agree that our knowledge of medicine at the present time is painfully deficient. I say advisedly of medicine, for our advances in surgery have been far more satisfactory. Here we are dealing with more tangible things; surgical diseases are on the surface or within reach; we can see them, handle them, remove them. The physician only obtains outward and visible signs, from which by an elaborate mental process, founded on past experience, he deduces his diagnosis of an inward invisible disease.

Now I would ask you to glance for a moment at the present position of medical science. Our diseases may be roughly divided into three great groups:

1. Acute diseases, with organic changes (including the specific fevers).
2. Chronic diseases, with organic changes.
3. Functional diseases, without organic changes, but often preceding or forewarning of them.

Our knowledge of disease has been obtained almost entirely from hospital experience; from that we have learnt much.

1. With regard to acute diseases, we can recognise their nature, we know their usual course, we can estimate to some extent their severity, we know their special dangers, and we have more or less well ascertained rules to apply which enable us to guide a patient through them with the least possible risk.

Concerning the specific fevers, we know how most of them are propagated, though we still know next to nothing of their ultimate cause. There are three diseases which are more or less specific—by that I mean propagated by germs—of which much less is known, *i.e.*, diphtheria, acute pneumonia, and ulcerative endocarditis; the first two of these are being at present investigated by the Collective Investigation Committee. These specific diseases we now class together as preventable, because we recognise their means of propagation, and can therefore, to a large extent, stop their spread among the population. When we have discovered their cause, we shall still more rightly call them preventable.

Another class of acute diseases—such as pleurisy, peritonitis, meningitis, pericarditis, and enteritis—usually occur as an extension of disease from other parts, as the results of injury or of some known blood-poison, such as pyæmia, rheumatic fever, uræmia, or some specific fever; they are rarely primary diseases, more commonly they are complications. They are, occasionally the manifestations of some obscure and unknown blood-poison (such as sewer-gas), and from this point of view require much further study; but this aspect of the disease can only be studied in the patient's home, and not in the hospitals to which they are removed; it is therefore a very proper object for collective work.

With regard to other acute diseases—such as bronchitis, nephritis, gastro-intestinal catarrh—we have yet much to learn about their causes, and why they should attack some individuals more frequently than others. Many of them are manifestations of what are called "general" or "constitutional" disorders, such as rheumatism and gout. Of the real pathology of these diseases we know next to nothing; most of them appear to be due to disordered function, though they frequently produce chronic organic changes; we have a good deal of loose unformulated knowledge concerning them, but our facts require to be carefully collected, collated, and laid before us in definite shape. How various, and often contradictory, are the opinions held about the pathology and treatment of such a common thing as gout. No more valuable work could be undertaken than that of defining our knowledge on these subjects. Our committee has already commenced on one of them, and we may hope in time to take up others.

2. We next come to the great class of chronic organic diseases. The advance of our knowledge concerning them has been enormous; but to what has it brought us? We now have the means of diagnosing most cases of advanced organic disease. That is to say, if our patient has a greatly cirrhotic liver, an advanced disease of his kidney, an extensive disease of his lung, a generally irrecoverable disease of his brain or spinal cord, it is our privilege to inform him of the fact. We may perhaps advise him how to live, that he may prolong his life to the utmost; but, if he asks us to cure his disease, we have to tell him that that is now impossible. But these chronic organic diseases do not come in a day; the health of such a patient must have been for long impaired; the disease must have been preceded by characteristic minor

* Read at a meeting of the Birmingham and Midland Counties Branch.