OBSERVATIONS ON HARE-LIP AND CLEFT PALATE.

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It may seem recurring to an oft-told story, to refer to hare-lip as giving opportunity of saying anything new or good on such a familiar subject. I fancy that, in my time, I have seen considerable changes for the better in regard to the treatment of such cases, and even now, after the experience of many hundred examples, I think that I can make some observations worthy of consideration. The operation for this malformation was one of the first I ever performed on the living body. It was done some forty-five years ago, and ever since I have taken interest in it, both in my own practice and that of others. I have repeatedly, in public hospital practice, operated on two and three cases in a single day, and I have read most that has been written on the subject throughout my professional life. It may, perhaps, be claiming more than I am entitled to, to say that, prior to the publication of my first edition of *Practical Surgery*, there had been little written regarding the anatomical condition of this malformation. There were few men, if any, alive who could state positively, or could show by specimens, what was the nature of the substance of the intermediate hard material in the midst of the two gaps in the upper alveolar ridge, in a case of double hare-lip. It was not known positively whether it was single or double. So far as I know, it was never even conjectured how it was held in its place; its relations with the vomer were unknown. The number of teeth likely to be developed in it, or their future quality, were little thought of, and the mass itself was found, in most instances, to be specially in the way in any contemplated operation. Until within these few years, there was not a skeleton of such a part in any museum in this country, and, in as far as I know, the specimens presented by myself to the Royal College of Surgeons are still the chief, if not the only, examples of the kind in our anatomical museums. Our knowledge on most such matters is now so precise, that the intermaxillary bones are now spoken of as familiarly as those in lower animals, whereas the actual condition in the human subject had rarely, if ever, been either described or demonstrated. The difference of connection or attachment, in the cases of single and double fissure in the alveolar ridge, seems to have been entirely overlooked; for there was no description which told how, in the double fissure, the intervening mass was held in its place solely by being suspended from the point of the vomer and the rest of the columna of the nose.

The development of the teeth in these cases has also, in my opinion, attracted less attention than in the normal condition of the upper jaw; but it is less my intention to refer to such anatomical and physiological matters than to some points in surgery, which I think specially worthy of notice as part of the result of my long experience in such cases.

First, as to the date or age when operations for hare-lip are most eligible, there is no doubt in my mind that an early period is now mostly preferred. The custom of delaying until after the completion of first dentition has now almost passed into abeyance, and the once prevalent idea that infants were specially liable to fatal convulsions after such operations may be said to have faded away. Experience has shown that they may be performed with safety at any period from a few hours after birth. Even at that dreaded period, first teething, harm is no more likely to happen than at any other time, provided always that the child be in good health. My own favourite date is from three weeks to three months after birth. Healthy-looking children at birth often pine and languish within the first few weeks, especially hare-lip cases, and particularly if the palate be implicated. I think it best to wait, in such instances, to see that health flourishes. A few weeks will give the requisite proof, and then, for many good reasons, I am of opinion that an operation should not be further delayed. I have a strong impression, from my experience, that the older a patient is, the more is the effect of the operation perceptible on the constitution, bodily and mentally; and I am equally convinced that, if it be performed at an age when there can be no subsequent recollection of the circumstances, so much the better for all parties. The parents and others interested in the infant are almost invariably in an unhappy state of mind until the operation is satisfactorily over. Maintaining, as I do, that the younger the

patient is after the first three weeks, the safer and better is the operation, I consider it disloyalty to surgery to delay such a decidedly advantageous proceeding on doctrines which will not bear the smallest scrutiny. I have learnt facts regarding such matters that may appear more akin to romance than reality. I have been asked to see an infant, a few weeks old, with a simple single fissure in the lip, and, on my advice, the operation has been performed shortly afterwards, with the best results. Then it appeared that there was an older child in the family in a similar condition, which had been secluded in the nursery attics for several years. Happily, the experience of this younger family event was the means of freeing the poor child from seclusion; for those who had advised against the operation took heart of grace, and put the senior on a par with the junior, as far as the operation went. I have known an instance of a child being kept in the recesses of the nursery for eight or ten years for a severe deformity of the kind. It was never allowed to play with other children beyond the family; it was never allowed to leave the house without the face being muffled in thick folds of veil; and, for long, the neighbouring nursery maids had the idea that this poor girl, whose face otherwise was unusually handsome, was an example similar to the lady, famous in nursery story, with the pig's face. The opinion previously given, in regard to this case, had been based upon great ignorance of what was going on in surgery during the life-time of the poor sufferer.

But, to come more closely to the purpose of this paper, being of opinion that the intermaxillary portion or portions is or are very frequently the cause of much annoyance to the surgeon, often, indeed, being almost the direct cause of failure in operations, I am desirous of recording my experience on this subject.

In the case of double hare-lip, with double cleft in the alveolar ridge, there may be great projection, or little or none. In the latter case, particularly if the columna and lateral portions of the lip be of good size, there may be no need for meddling with the intermaxillary mass. If, however, the projection be considerable, or what may be called great, and if the columna and side portions of lip be scanty, there ought then, in my opinion, to be no hesitation about taking away the projection at its junction with the vomer. The attempt to push this part back by gradual pressure is troublesome, or well-nigh impossible, in most instances, even if, as has been proposed, its narrow neck be broken. In either instance, it has never been told from experience in what condition, in what direction, the teeth come in the part thus displaced. In either or both instances, I have no doubt in my own mind that the teeth, if they came at all, would so slope backwards as to be of no value either for show or for use. There is, however, indubitable proof that, without thus meddling with the part, there are only two incisors of respectable size, after all, and these are of such indifferent quality, that they had better have been dispensed with at the earliest date. I, therefore, never hesitate to remove the intermaxillary mass when it seems the least in the way of a satisfactory operation. The advantages of doing so seem to me greatly to preponderate, and, if there be cleft hard palate at the same time, there is far greater chance, in after years, of the gap becoming narrower, whilst, in adult life, there will be greater facility for the assistance of the dentist. But, I imagine, there is less hesitation or difficulty in the surgeon's mind in the case of capacious double gap, than when there is only a single one with considerable projection of the intermaxillary margin. It is to such cases that the chief object of these observations is directed. If it be difficult to apply compression on the intermaxillary portion in double cleft, it is still more so when only one side projects; for its base is broader and firmer. The instances where there is no special projection are common, and require no comment, as there is then, as regards this matter, no obstacle to a satisfactory and successful operation; but, when there is a projection, if considerable, it is a more serious obstacle to these results than those inexperienced may imagine. I believe that this condition is a frequent cause of failure in the ordinary operation, particularly if it be done without the truss-compressor on each cheek to push the lateral portions of the lip towards the mesial line. In such a case, the surgeon is naturally anxious to leave the alveolar ridge untouched, and, in accordance with a common practice, when it is desirable to secure union by first intention, when the stitches or needles are withdrawn, strips of plaster are carried from cheek to cheek to hold the union firm. Scarcely a greater mistake can be made, for, the line of union in the lip being generally, under such circumstances, exactly over, or opposite to, the sharp angle of the projection of bone, the young cicatrix is pressed against it, and gradually thins away, until it is fairly split open, when the operation proves a failure. This, I have a strong impression, is an explanation of the failure of many cases that do not seem, in any special way, complicated. I do not mean that straps always conduce to this effect, and that, therefore, they should never be used. On the contrary, I have very frequently seen them of much service. But, if the

single projection alluded to be conspicuous—in which case, there will always be a somewhat sharp, angular margin—it is, in my opinion, best to get rid of it at the time of the operation. In my own practice, I was at one time in the habit of cutting the projection away with sharp small bone-forceps, dividing gum and bone at the same time, and aiming chiefly at getting rid of the projection. This usually involved all the intermaxillary bone on that side, and implied, perhaps, little heed of what damage might be inflicted on the sound side, although, latterly, I always passed the blades into the mesial line between the intermaxillary bones, so as to secure this side from material injury. In the course of my experience, I fancy that I refined on this practice. I found that it was well to detach the portion as high up towards the nostril as could conveniently be reached, and here I discovered that, in all young subjects, there was only cartilage to be divided. This could easily be done with the knife or scissors, and so, for many years, I have used only one or other of these instruments. Usually, I have passed the scalpel through the mucous membrane, under the frænum, up between the bones, and divided the cartilage, periosteum, and gum, to sever the part; and thus the use of cutting bone-forceps has been dispensed with, for, to say the least, such an instrument is coarse-like and clumsy in an operation for hare-lip on an infant only a few weeks old.

Whilst I can offer little objection to this proceeding, I fancy that I have recently fallen on one equally efficacious and void of certain objections which, I think, might be urged against it. Instead of this sweeping wholesale abstraction, I content myself with making an incision, vertical, sloping, or horizontal, with a scalpel through the mucous membrane and periosteum, over the projecting piece of bone; with a few touches of the knife, or a little squeeze with finger and thumb, I so separate these tissues as to permit the entrance of a gouge of a quarter or three-eighths of an inch in breadth, with which I scoop out the body of the milk incisor-tooth in as far as it is formed, taking no heed of the cyst or of that of the permanent one, and even cut out such wall of bone as may be there; usually, at four or eight weeks, only small plates of bone. In this way, the hard projection is removed, and the tissues that remain offer no obstruction to the union of the junction of the lip in front, whilst the operation, as it appears to me, is less destructive, therefore more conservative, in character. There is thus left only the mucous membrane, with possibly some periosteum, which form a soft cushion behind the wound in the lip, and so the remaining intermaxillary bone is not divested of covering so thoroughly as when cutting instruments are passed in the mesial line to take all away on the offending side.

I have now adopted this plan in several cases, and have been much pleased with the effect and result. In one instance, I used a silk stitch to hold the edges of the wound in the mucous membrane together, but I doubt if it be needful, and I have not seen any spurt of blood from the deep part of the wound, such as that which I have often found, in other instances, has required the application of a pointed heated cautery. The wound has healed without attracting special notice. In the case where the stitch was used, the thread came away spontaneously, and, in the end, the gum appeared as if there had been no projection, and, therefore, no such operation.

[To be continued.]

CLINICAL MEMORANDA.

FRACTURE OF THE INDEX FINGER FROM MUSCULAR ACTION.

A SINGULAR accident occurred in the out-patient practice of Charing Cross Hospital to-day (March 16th), namely, fracture of the proximal extremity of the index finger of the left hand, as a result, presumably, of muscular action. A man, 55 years of age, in making a back-handed blow at his retreating son, as far as I can understand, just missed striking him, thereby expending the extreme radial extension of his wrist without meeting with the expected amount of resistance. He immediately experienced great pain and loss of power over the hand, and, on his coming for advice, it was evident what had occurred; the fragment, which was freely movable beneath the skin, was drawn upwards by the extensor carpi radialis major, and powerfully abducted by the lower fibres of the first dorsal interosseous muscle; and, when these muscles were put in action, the deformity was singularly apparent. The line of fracture being considerably beyond the reflection of the synovial membrane, it is not probable that further complication will follow. When one takes into consideration the mode of development of the bone, the accident appears the more remarkable. The treatment was sufficiently obvious.

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THE CROONIAN LECTURES ON FUNCTIONAL DERANGEMENTS OF THE LIVER.

Delivered at the Royal College of Physicians.

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LECTURE I.

Notice of Dr. Croone.—Present Notions as to Functional Derangements of Liver unsatisfactory.—A. FUNCTIONS OF THE LIVER IN HEALTH. *Historical Sketch; Galen's Views; Obsequies of Liver by Bartholin; Modern Views; Functions of Liver threefold.* 1. *Sanguification and Nutrition.* II. *Disintegration of Albuminous Matter.* III. *Secretion of Bile; Composition, Origin, Quantity, and Uses of Bile.*—B. FUNCTIONAL DERANGEMENTS OF LIVER. *Objections to existing Classification; Proposed Classification.* I. *Abnormal Nutrition.* 1. *Corpulence;* 2. *Emaciation.* a. *Deficiency of Bile;* b. *Diabetes;* c. *Other Varieties of Emaciation.* II. *Abnormal Elimination; Symptoms of Retained Bile; Cholestearæmia.*

MR. PRESIDENT, FELLOWS OF THE COLLEGE, AND GENTLEMEN,—It may interest some of you if, by way of preface, I say a few words respecting the founder of the course of lectures which I am honoured by delivering before you. For the particulars, I am indebted to the "Roll" of the College, edited by our learned colleague Dr. Munk.

Dr. William Croone was born in London, and educated at Emanuel College, Cambridge. He became a Fellow of this College on July 29th, 1675, and was Censor in 1679. In 1659, he was elected Professor of Rhetoric at Gresham College, and shortly afterwards he was made Secretary of the Royal Society, which then held its meetings in Gresham College. He resigned his professorship in 1670, on being appointed Lecturer on Anatomy at Surgeons' Hall. He died in 1684, and was buried in the churchyard of St. Mildred's, in the Poultry. He left behind him a plan for two lectureships, which he had designed to found—one course of lectures to be read before the College of Physicians, after a sermon to be preached in the church of St. Mary-le-Bow; the other to be delivered yearly before the Royal Society, upon the nature and laws of muscular motion. His will contained no provision for the endowment of these lectures; but his widow (a daughter of Alderman Lorimer, who subsequently married Sir Edwin Sadleir, Bart.) carried out his intention by devising in her will the King's Head Tavern, on Lambeth Hill, Knight Rider Street, in trust to her executors, to settle four parts out of five upon the College of Physicians, for the purpose of founding the annual lectures, now known as the Croonian Lectures, and the fifth part to found the Croonian Lecture of the Royal Society. A fine portrait of Dr. Croone was presented to the College in 1738 by Dr. Woodford, Regius Professor of Physic at Oxford, and is now suspended in the Censors' room.

The founder of these lectures made no restriction as to their subject, as he did with regard to the lecture before the Royal Society; and it has been customary for each lecturer to select some subject in practical medicine, which his experience has been most calculated to elucidate. The subject which I have chosen is one which it appears to me is well worthy of the attention of this College, and of medical men in general, viz., The Functional Derangements of the Liver. Professional opinion as to what constitutes functional disorder of the liver is vague and unsatisfactory. There is no expression more common among both patients and their doctors than that the "liver is out of order", or that certain symptoms are due to "biliousness", and yet few medical writers have undertaken to define with accuracy what symptoms are referable to a disordered liver. It is to be feared that symptoms are sometimes referred to the liver, with which it has little or no concern; while, on the other hand, there are grounds for suspecting that many symptoms, at first sight apparently referable to other organs, and even grave degenerations of tissue and organic disease, not only of the liver itself, but throughout the body, may be traced back to functional derangements of the liver, although some of these may as yet be imperfectly understood. It is remarkable how systematic writers on Medicine and on Diseases of the Liver in particular entirely ignore the subject of functional disorders of the liver. The remarks which follow must be regarded as a feeble attempt to sketch with the light of recent investigation those symptoms and morbid conditions, which may fairly be put down to a disordered liver.