although any of you can see those beds are not as distant from each other as they ought to be, according to modern notions of what is requisite for the salubrity of an hospital.

Then there is another important respect in which my wards have been more severely tried than before. There had previously always been an annual cleaning of the wards of our infirmary. Now, this involves considerable inconvenience. The patients had to be transported to another part of the hospital, and some cases were liable to be injured by this transport. Therefore, when the annual cleaning came about, I used to consider whether the patients would get more harm from the want of the cleaning of the wards, or from the transportation. I thought they were more likely to get harm from the transport; and this being year after year my conviction, it is now three years since any cleaning took place in these wards of mine. The year 1872 was the last in which it was practised, except in the case of one individual ward where a sore throat prevailed last summer, which seemed to be of the nature of scarlatina, and on that account the ward was emptied and purified. I have sometimes observed remarks made with regard to the results of treatment in my wards, to the effect that I work under superior hygienic conditions. It is, in truth, exactly the opposite. My wards, in these respects, are more severely tried, I believe, than those of any other surgeon in the kingdom.

Then it is said that greater cleanliness is involved in the antiseptic treatment. This, again, is an entire mistake. If we take cleanliness in any other sense than antiseptic cleanliness, my patients have the dirtiest wounds and sores in the world. I often keep on the dressings for a week at a time, during which the discharges accumulate and undergo chemical alteration, probably from oxidation and the action of the resin of the gauze upon them; and, when the wounds are exposed after such an interval, the altered blood with its various shades of colour conveys often both to the eye and to the nose an idea of anything rather than cleanliness. *Æsthetically* they are dirty, though surgically clean.

There is yet another way in which my wards have been unusually tried—namely that I now perform operations which, without antiseptic means, I should not have considered justifiable, some of them being of a character which used to involve especially the risk of pyæmia, such as cutting down on ununited fractures of the femur, and removal of the ends of the fragments.

Yet, in these circumstances, if I have had one case of pyæmia where I have operated myself, it is the only one I know of; and that was a spurious form of the disease. It occurred in a patient from whom I had removed the mamma, and, at the same time, cleared out all the axillary glands; and putrefaction took place in the axilla, in consequence, as we had reason to believe, of mismanagement of the spray. Of hospital gangrene we have not had one single case during these six years. As regards erysipelas, our experience has been various. As a rule, it is very rare in many wards. I have been two entire years without a single case of it; but, on the other hand, there was a time when it was frequent. This was during a concurrent epidemic of small-pox and erysipelas in Edinburgh two years ago. The erysipelas was of a very virulent type, and some patients in private practice in the city died of erysipelas affecting the puncture of revaccination. At this time, we had several cases of erysipelas admitted into my wards from the town, and several, also, took origin within the hospital. But the constitutional rather than the local cause of these cases was shown in several instances by the disease occurring not in or near the wound, but at some remote part, as in the head after an operation upon the penis. And it was somewhat remarkable that in no case did the disease as it originated in the hospital assume the malignant form which it sometimes exhibited in private practice.

Tætaus also appears to be rendered much less frequent by antiseptic treatment. Far be it from me to say that putrefaction is the only cause of it; we all know it is otherwise; but when I say that, in six years, with an average of sixty severe surgical cases, I have only had two cases of the disease, and those both of them in connection with septic wounds, I show strong grounds for believing that, if we exclude putrefaction, we exclude one—and the most common—exciting cause of tetanus.

One objection that has been urged against my treatment is the inordinate length of time patients remain in hospital. No doubt it is so in some cases; but, as a rule, these are instances in which we expect to cure otherwise incurable cases, such as spinal abscess. But, on the other hand, on comparing Mr. Syme's case-books with my own, during two periods of three years, the unexpected result has lately been arrived at that, in proportion to my number of beds, I have had a larger number of operations than Mr. Syme; showing that, while some patients, kept alive by antiseptic treatment, have remained long in the hospital, this was more than counterbalanced by the rapid cure of others.

I trust, gentlemen, that the facts which I have now had the honour

to bring before you will be considered pretty strong proof of the value of strict antiseptic treatment in promoting the general salubrity of surgical hospitals.

FURTHER OBSERVATIONS ON HARE-LIP AND CLEFT PALATE.

BY SIR WILLIAM FERGUSSON, Bart., F.R.S.,
Surgeon to King's College Hospital, etc.

IN THE BRITISH MEDICAL JOURNAL of March 28th and April 4th, 1874, I ventured to write on these topics, under the impression that, in regard to both, I had something new, and therefore original to state. On hare-lip I trod on ground which to many might seem so trifling and so exhausted that I could scarcely expect attention to what I stated, excepting from those who might have special interest in such cases; or who might, like myself, have devoted more than forty years of careful study to matters in surgery and abnormal development, which, in the estimation of many, have been considered of minor importance.

Within these two years, my experience on such malformations and their treatment has been considerably increased; and, at the risk of being considered prolix, I venture to give the results of that experience in the hope of making additions to our knowledge in this department of professional study.

At this date in surgery, it is not easy to imagine how any novelty in regard to hare-lip could be announced. In the paper above alluded to, I described a practice in the operation which I thought likely to be advantageous in certain examples. In some cases of single fissure, I had learnt from experience that failure of the usual operation was induced by the projection of the intermaxillary bone on that side, and I had long been in the habit of removing such projection previously to bringing the edges of the gap into approximation. This removal was readily accomplished, in the majority of cases, by the scalpel or scissors. Preferring, as I do, to perform the operation in the early months of infancy, the tissues are then so soft that they can be readily cut by these instruments. At an older date, the cutting forceps was sometimes applied to divide the narrow part of the intermaxillary bone where connected with the vomer. For many years in early life, a scalpel can readily be passed between the intermaxillary bones in the mesial line; and it was my custom in many instances to so use the blade as to effect the separation. But even here, in the course of time, I learnt to apply conservative surgery; and, instead of taking away bone, tooth, and mucous membrane, I so managed by cutting and raising the mucous membrane that I could cut away tooth and bone, and leave the membrane as a soft cushion and a more complete covering to the side not interfered with. The object here was to keep a natural surface of mucous membrane, instead of exposing a considerable portion of raw surface. Within these two years, I have frequently acted on these views, and have every reason to be well satisfied with the results. In some instances, I have been content with gouging out the tooth only; but in others, where the prominence has been of considerable bulk, I have clipped away the whole bone, leaving, however, the whole mucous membrane, and probably most of the periosteum. By such a plan, I feel confident that union of the gap in the lip has been rendered more certain. An objection, and seemingly important one, to this plan is, that it costs the milk incisor, and possibly the permanent one. I have long been convinced, however, from experience, that these teeth are rarely of much value. Occasionally, some good teeth are met with in the intermaxillary bone, but so rarely, that their preservation is of small consequence as compared to the result of a well designed and perfect operation. Whilst advocating the sacrifice of teeth, or even of an intermaxillary bone in single hare-lip, where the bone happens to project, I feel equal confidence in recommending free work with the two intermaxillaries when they happen to be very prominent in double hare-lip. In many instances of double hare-lip, as in single, the alveoli are not involved in the fissure; but usually there is the complication of cleft-palate, and the intermaxillary bones are left so isolated, being attached by a slender neck to the vomer, that in subsequent years their value is questionable, even when preserved in a satisfactory operation for the double gap. It does in some instances, even after years have passed, fill up a gap that might otherwise be in front of the mouth; but it has often appeared to me that it would have been better away, so as in due time to permit the closer approximation of the lateral portions of the jaws. Where, however, the intermaxillary bones do not project, so as to endanger the success of an operation on

the lip, I am not disposed to urge their removal; but, where they project so as to interfere with the satisfactory treatment of the lip, I earnestly recommend the removal of the projecting and nearly isolated mass. From time to time, I have met with cases where I have been reluctant to meddle with this projection; and, with a conservative motive, have even been content to do one gap first, and the other in a few weeks afterwards. I cannot say, however, that this plan has given me so much satisfaction as taking away the whole, and effecting junction in the two gaps at once, whether the intermediate portion of skin has been worked into the lip or made to represent the columna only.

It is often a puzzle what to do with the central portion of the lip in front of the intermaxillary bones. It is rare to find it so long and the nostrils so perfect that it can be associated with the lip—particularly to bring its free margin down to the level of the lateral portions of the lip by however small a strip. It more frequently is so short that the surgeon may be well pleased if he can, by paring its extremity into a wedge, incorporate it into the upper portion of the lip. In the majority of cases, he may be well content if he can shape it into a respectable columna; and in some instances it will puzzle his ingenuity even to accomplish this. Some of the most troublesome cases I have met with have been those where the difficulty has been how to dispose of this bit of lip—it might have been called skin—so very short has it been. Some writers on this subject have gone so far as to question the presence of this intermediate portion of lip or skin, as if to show that the gap in the human subject may take place in the mesial line, as in the hare. This, I contend, never happens; but, in some instances, the intermediate portion may be so short as to appear wanting altogether. There are specimens of this kind in the museum of the Royal College of Surgeons of England; but a fissure in the mesial line in the human subject, with the nostrils perfect, has never to my knowledge been seen. It would be to me as unprecedented as to see a fissure in the upper lip under each nostril in a hare. So far as I am aware, no such specimen has ever been seen.

In general, if I have the opportunity of treating a case *de novo*, I try to join the apex of this intermediate portion with the sides of the lip at the first operation, but occasionally union fails. I have tried again months or years afterwards, and usually succeeded. Sometimes I have met with instances where the junction in the mesial line has been effected by others, and I have been in doubt whether a bit of the mesial soft substance has or has not been cut away. I fancy that in some cases a portion has actually been cut away. If anyone who reads these lines should ever think of cutting a portion of the intermediate soft slip away, I earnestly urge him not to do so—at first at any rate. Sometimes, in my own practice, I have left this portion so long and broad as to make it appear far too big for a columna; but that is a fault which can easily be remedied, whilst the surgeon with all his skill may be foiled in closing the opening into the nostrils, left either by the natural shortness of this intermediate portion, or in consequence of its abbreviation by his own hands.

Since I last wrote on the intermaxillary bone in the human subject, illustrative of hare-lip, the most notable case I have met with in practice is to me unique, and, in my opinion, specially worthy of record. In April 1875, I was consulted regarding the case of a young lady, six years old, who had been born with double hare-lip and cleft palate, each of the worst kind. The operation for hare-lip had been performed in early infancy, and union had ultimately been accomplished after several failures, chiefly attributable to the prominence of the intermaxillary bones. To facilitate matters, these had been bent backwards towards the gap in the palate. The whole condition of the upper lip and mouth was most unsatisfactory, both regarding appearance and comfort. There was still a projection in the middle line, caused by the intermaxillary prominence, which was but scantily covered by the sides of the lip and a portion of soft material extending partially from the columna. Being requested to improve if possible, I decided to remove the intermaxillary mass entirely, bring the lateral portions more extensively into apposition, and to raise the columnar portion more into the normal position. These views were most satisfactorily realised. The friends and I were gratified; but, for myself, further matter of interest remained regarding the condition of the intermaxillary bones and the teeth. Prior to the present generation of surgeons, the idea of bending back the projecting central portion had been entertained. Mr. Samuel Cooper described an interesting case of the kind, wherein, by means of a kind of truss, this was accomplished by a slow process of pressure. Some thirty years ago, it was not uncommon to push the projection back by means of rapid force. The slender neck was bent, or rather broken, the mass was carried backwards and held there by the completion of the operation for the clefts in the lip. I performed the operation repeatedly, but was never specially well satisfied with it, nor had I ever an opportunity of examining the parts anatomically

afterwards. Before doing so, the death of the patient was to be implied. Here, however, in the young lady's case above referred to, was an opportunity never presented to me before. So I had the intermaxillary projection macerated with care, and found the slender neck bent upon itself. The bone or bones were thickened somewhat, as if there had been a fracture. The symphysis between the bones had closed by bone, an early period for this, and probably caused by the exalted action subsequent to the bending or breaking action. But the state and position of the teeth chiefly interested me, as I had for the first time ocular proof of what I had long conjectured, and considered a serious objection to this mode of preserving the intermaxillary bones. I doubted the wisdom of thrusting this wedge between the side portions of the jaws, and placing the part so much in the horizontal plane as to make the front surface the under one. Moreover, I fancied that probably the most desired object of this plan, viz., that of preserving the teeth, would so place them that, in the event of their acquiring to even tolerable development, they would grow horizontally backwards instead of downwards, as in the usual direction. Before I removed this intermaxillary process, I could feel the margin of the left front incisor, as if it were coming in this fashion; and, on macerating the specimen, I found such to be the case. Here is a sketch of the specimen, of normal size. It is placed in the line of the alveoli as it was in

Sketch showing Intermaxillary Portion, with Teeth Horizontal.

life. The right, which had not yet come through the gum, besides having its horizontal direction, has its margin where the flat surface should be; and the left, whose edge had protruded, is nearly parallel with the horizontal palate plates of the upper jaw, instead of being at right angles with the roof of the mouth. This specimen I believe to be as unique as were those, now preserved in the museum of the Royal College of Surgeons, when they were first depicted in some of the early editions of my work on *Surgery*, about thirty years ago, and displayed at the College of Surgeons, where I gave lectures on the Progress of Surgery in the Nineteenth Century, in 1864.*

But I fear those matters may appear too minute, and possibly trifling, to those who read them; yet they are of palpable value to the practical surgeon, and this comparatively substantial aspect may possibly prove refreshing to some who feel themselves bound to read up to the day about organisms, anatomies, and atomies which seems so transcendental and subtle as to reach beyond ordinary comprehension and demonstration.

The object of this paper is more with reference to cleft palate than hare-lip. To some it may appear that the latter is a worn out subject, but I believe there are many to whom cleft palate is still an abstruse subject, and for further elucidation I venture to continue the theme which formed the principal feature of the communication in 1874, above referred to. At that date, my experience of the operation for the defect extending to between two and three hundred cases, had led me to the conclusion that operative interference with cleft in the hard palate was rarely followed by satisfactory results. I had resorted to most of the plans familiarly known, likely to prove successful, and was occasionally much pleased, but failures were so frequent that in many instances I made no attempt to close such gaps at all, and was content if I got fair union in the greater extent of the soft velum. The subject had long engaged my attention in every aspect I could think of, and at last I resolved to adopt a plan which in my estimation held out the greatest chance of success. This plan consisted mainly in dividing the hard palate about midway between the margin of the fissure and the alveoli, with a sharp chisel, so as to set a portion of the hard palate on each side free, thereafter paring the edges and uniting them in the middle line by means of stitches. Particulars of the operation were given in the paper in the *BRITISH MEDICAL JOURNAL*, already referred to, and in the concluding remarks I ventured to say that I had touched new ground in surgery. In this, however, I soon found that I was mistaken, for my friend Mr. Hulke, of the Middlesex Hospital, within a few days pointed out to me that Dieffenbach, more than forty years ago, had made a proposition of the kind. The subject was further made public by my friend Mr. Mac Cormac of St. Thomas's Hospital, in a

* See *Lancet*, 1864; also *Lectures on the Progress of Surgery during the Nineteenth Century*. Churchill.

communication to this JOURNAL, of date June 20th, 1874, and I found that I had been in a manner anticipated in what I had considered an original idea. In several of my first trials of this process on the living body, I carried the threads through the holes or slits made by the chisel, but I found that on drawing the noose there was great tendency to bring the palatal mucous surfaces of the flaps into apposition instead of the pared edges; in other words, to throw the two flaps into a vertical position in the roof of the mouth. Here I fancied that I had hit on a remedy for this also, which was to bore one or two holes, according to the size of the flaps, through which I could pass the needles and threads, and so approximate the pared margins without upsetting the horizontal position of the flaps. This plan answered my expectations, but here again I found that the original record of the great German surgeon had anticipated what I had found in practice. Dieffenbach had also suggested these punctures. It seems doubtful whether or not this operation had been done by Dieffenbach; and it is curious that no trace on the subject is to be found in any English surgical writings on cleft palate during the last forty-five years. I myself had not met with any suggestion in regard to division of bone until my attention was called to it by my two friends above referred to. Within the last thirty years much has been said and written by Mason Warren, myself, and others regarding cutting and tearing the soft parts from the hard, and bringing them down in hope of getting union in the middle line, but the proposal with the chisel seems to have been overlooked or ignored by all who have worked at the subject. I shall, however, be well content to have followed in the wake of Dieffenbach, whose proposal to divide the internal rectus of the eyeball for ordinary strabismus gave me the key to my own practice of dividing the levatores palati in ordinary cases of cleft palate.

I shall now proceed to give the results of my experience in regard to the supposed addition to the operation in certain cases of cleft palate, which I described in this JOURNAL of date April 4th, 1874.

(To be continued.)

CLINICAL LECTURE ON WINTER PRURIGO.

By JONATHAN HUTCHINSON, F.R.C.S.,

Senior Surgeon to the London Hospital, and to the Blackfriars Hospital for Skin-Diseases; Surgeon to Moorfields Ophthalmic Hospital.

GENTLEMEN,—I wish to describe to you this evening a certain group of well marked cases in which the skin is made irritable by cold. A man who has gone about through the summer with his skin quite comfortable finds himself, as soon as the first threatenings of winter weather occur, troubled by irritation in various parts, often of a very severe character. Year after year, the same thing happens, until he begins to expect his tormentor, or possibly has learnt how to anticipate and prevent it. This form of prurigo usually affects first and most severely certain special parts: the calves of the legs, the out-sides of the thigh, the forearms, and the outer parts of the upper arms. It usually attacks the trunk last, and but slightly. It is not, in the first instance, attended by any eruption, but only by a general tendency to *cutis anserina*. If, however, the sufferer give way to the temptation to scratch, he will be able to find certain isolated points which itch intolerably; and on these, after use of the nails, little pimples appear. Sometimes I have been told that these points felt like little seeds in the skin, which it was absolutely necessary to dig up with the nail. These are the true prurigo-papules, and possibly are developed in connection with nerve-papillæ. In addition to them, there is often more or less tendency to roughening of the surface by lichen-spots (thickened orifices of hair-sacs). Ultimately, in bad cases, the skin becomes rough and harsh, and there are seen a number of little blood-stained crusts; but in a majority of cases, in comparison with the patient's loudness of complaint, there is surprisingly little to be found. Now and then, patches of eczema are produced, or a porrigo or ecthyma rash may result. Perhaps I shall, however, best convey a good idea of the malady, or rather of the liability, by relating to you some cases; and I will select first a mild one.

W. T. aged 45, is a London collector in good health, but thin and rather bilious. He has all his life suffered from that kind of feeble circu-

lation which allows the extremities to become very cold. He never has chilblains or chaps; but his hands and feet are usually dry, somewhat shrivelled, and very cold. His feet, he says, are often icy. He scarcely ever perspires, and can take vigorous exercise with much pleasure and advantage. In boyhood, he did not ail anything from his skin; and it was, indeed, not until about fifteen years ago that he first began to suffer. He then, in winter weather, found the calves of his legs very irritable, and affected by spots which were aggravated by scratching. Afterwards, his thighs, in their outer and posterior parts, became affected; and then it spread in greater or less degree to the entire surface. From that time to the present, he has suffered with varying degrees of severity every winter. He assures me that in summer he is perfectly well, but he dreads the first advent of cold weather. It is not always the coldest weather which makes him worst; for, if it be cold, dry, and clear, without wind, he does not suffer so much. Wind and draught are his chief enemies, and they make his skin creep and itch all over. He has been obliged to adopt all sorts of precautions to diminish the influence of cold; wears washleather next his skin and woollen over it, and high Wellington boots for the protection of his calves. He sleeps between blankets, fearing lest the cold sheets might induce the prurigo and keep him awake. By these expedients, he keeps himself in a state of tolerable comfort, and has usually very little to show on his skin. When seen in March 1873, we noted that there were a few scattered black blood-crusts, but no papules, and no long excoriations from scratching. The same was the state of things in December 1875. During the intervening summers, he had been perfectly well. I must ask you to keep in mind, as to this patient, who is a good example of the class which affords the subjects of winter-prurigo, that he is thin, chilly, bilious, and has a feeble circulation. With the exception of advising the use of a tar-wash to all affected parts, I was unable to do more than counsel, in the way of precaution, sedulous attention to the class of expedients which he was already in the habit of using. He had previously consulted several specialists, but with no definite result. It was clearly a case for management, rather than for drugs.

The severe and lifelong form of prurigo described by Hebra, and for which he has claimed the name to the exclusion of all others, has the peculiarity of being made worse by cold. It is not impossible but that the severe Vienna winters, and the biting character of the winds to which the Austrian capital is liable, may account for the apparent fact that prurigo assumes there features much more formidable than those which attach to it in London. In another lecture, I shall show that we do not in English practice meet with many cases which fit well with Hebra's descriptions. Our chronic cases either are made better by winter, or, if the reverse, have not begun in childhood: two points which are amongst the more distinctive features of Hebra's disease. In this instance, you will see that the man, now forty-five, began to suffer for the first time in his life at the age of thirty. Nor have his sufferings from the disease ever in the least approached Hebra's description; nor, although his tendency still persists, does there seem reason to apprehend its increase.

The case which I will next read to you corresponds very closely to the Vienna type, except in its minor degree of severity.

Prurigo in an Old Man more or less since Childhood: the Eruption aggravated by Cold.—James Colebrook, aged 66, was under care at the Hospital for Skin-Diseases for a year and a half in 1872-73, on account of prurigo of varying severity. The parts affected were the sides of the neck and insides of the thighs, with a few spots at times on the forearms. The eruption was not copious at any time while under observation. At one time, there was an eczematous patch above the ear. On inquiring as to the duration of his malady, he told us that from early life he had had an irritable skin. In boyhood, he often used to scratch the insides of his thighs till they bled, and also frequently suffered from what he thought was nettle-rash; the latter form of eruption he used to attribute to bites of fleas, gnats, etc. He never could bear flannel next his skin. His prurigo had always been worse in winter than summer, and was worst of all during one winter that he spent in Quebec, where the cold was intense. With regard to time of day, he stated that his itching was generally worst just after getting up in the morning. In respect to treatment, he said he had once derived some benefit while under medical care in Belgium. He had often suspected that he had lice, and had looked for them repeatedly without success; and there seemed no reason for suspecting their presence while he was under care. He said that bugs did not annoy him particularly. It seemed probable that he had transmitted an irritable condition of skin to some of his children, for two of them were said to have had bad "scald-heads" at the age of two or three years. The treatment used for this old man did not have much effect on his very troublesome