disagreeable, and expensive. It would be impossible to apply it in the majority of cases.

In some recent text-books on therapeutics and materia medica, sulphur-ointment is also recognised as the treatment for scabies. In consequence of this, I have been induced to bring the treatment of scabies before the Section, in order to give a practical hint on a line of treatment which recommends itself on the grounds of efficiency, economy, and rapidity of cure. It is not by any means a new method, but it does not appear to me to be sufficiently known or appreciated. It is the treatment by sulphide of calcium. This name is also applied to a powder, the pills of which, in small doses, are very useful in the treatment of boils. The preparation used is in a liquid form, and from its colour, is known in the army and in the Poor-law service as golden lotion. It may be made from the following formula: Flower of sulphur, 100 parts; quicklime, 200 parts; water, 1,000 parts. Boil the whole for some time, stirring occasionally until the substances become incorporated, allow the liquid to cool, and decant into hermetically sealed bottles. It should not be made in a metal vessel; and as in the process of making the smell is not agreeable, care should be taken in this respect.

There is a great difference in the preparations in the market. The best preparations I have met with, I have obtained from Richardson and Son, Leicester; Clarke, Bleasdale, Bell, and Tollington, of York.

The method of application is as follows. The patient is first put into a warm bath; he is then painted with a brush dipped in the solution, and placed in bed, either in blankets or in a flannel night-gown made for the purpose. After a short time, owing to the deposit of the sulphur, the patient's body is almost of the colour of a guinea. The beneficial effects are speedily manifested; the itching ceases, and, as a rule, in simple cases, after another warm bath, the patient may be discharged cured.

In long standing neglected cases, the duration of treatment would be longer, as the scales and crusts produced by itching and neglect have to fall off. Scabies underlies many of the forms of skin-disease seen in Poor-law practice, and this is a practical point to bear in mind. I have used the sulphide of calcium since 1869, when I first entered the Poor-law Medical Service. I have since treated some thousands of cases, using the sulphide alone. My experience enables me to testify the accuracy of Dr. Bourguignon's statement that it is a specific for scabies. It has the following merits: it is a clean application—different in this respect from the sulphur-ointment; it is easy of application, and will penetrate—here again it has an advantage over the sulphur-ointment; it is cheap and speedy in its action; one or two applications will, as a rule, be sufficient; it does not require the destruction of any clothing, nor the complicated process described by Dr. Liveing in Quain's *Dictionary of Medicine*. At the end of the short article from which I have quoted, Dr. Liveing briefly alludes to this method, and says: "This lotion is effective, but it is apt to irritate the skin, and is not so generally useful as the sulphur-ointment." In a small number of cases, the use of this remedy causes roughness of the skin. Its over-use or abuse produces troublesome irritation of the skin. This may be at once remedied: the patient should be ordered a bath of soda and water, when all ill effects will speedily disappear.

The sulphur-ointment should be expunged from our text-books as an obsolete form of treatment. The sulphide of calcium should take its place. I believe it is used in the army in England and on the Continent, and generally throughout the Poor-law Medical Service, so that my testimony is not singular as to its value.

CLEATOR MOOR.—Dr. Eaton records with satisfaction a diminution in the mortality from zymotic causes during 1882, as compared with the previous year, and he thinks that a further decrease may be looked for when the prevalent notion that these diseases are inevitable has been dispelled. Commencing on the fatality from scarlatina, the health-officer observes that all the cases can be accounted for by the opportunities of personal contact between the affected and healthy, a state of things which seems to have been brought about by the inherent carelessness of parents. This disorder caused 7 deaths out of a total of 18 recorded from zymotic causes. The general death-rate represented 14.52 per 1,000, against 13.9 recorded in 1881, an unsatisfactory feature being the increase in the number of deaths of children under five years of age, which numbered 75 against 63 recorded in 1881. There was also a considerable increase in the fatality from chest-complaints, and wasting diseases of infants claimed an unusually large number of victims.

OSTEOTOMY OF THE HIP.

Read in the Section of Surgery.

By C. B. KEETLEY, F.R.C.S.,

Surgeon to the West London Hospital, and to the Surgical Aid Society.

My paper deals with ten¹ osteotomies of the hip, performed on nine patients.

No.	Date.	Name.	Age.	Above or Below the Trochanters.
1	February 1st, 1881	Alice B.	25	above.
2	April 10th, 1881	William M.	14	above.
3	October, 1881	Alice B.	15	above.
4	February 28th, 1882	Joseph S.	15	below.
5	April 4th, 1882	Elizabeth A.	24	above.
6	June 6th, 1882	Alfred J.	9	below.
7	December 12th, 1882	Alice H.	16	above.
8	April 10th, 1882	Joseph S. (again)	16	below.
9	—	Kate C.	6	below.
10	September 13th, 1883	Edith N.	18	above.

Six were done above the trochanter, and four below it. Nine were for ankylosis, one was for an irreducible dislocation. All were done in the West London Hospital, with the chisel and mallet, and under strict Listerian modes of operating and dressing. The dressings were changed, in all the cases but two, at most once or not at all. In the two exceptions, drainage-tubes were used, as I now think, needlessly. Once recurrent hæmorrhage necessitated a renewal of the dressings within three hours. All did well. The constitutional disturbance was surprisingly small.

Each patient was kept in bed six weeks, and allowed to discard crutches and sticks in a few weeks more.

An iodoform pad was usually placed next the wound, then a quantity of packing. Then the ordinary dressing with jaconet was applied, over all, an India-rubber bandage, covering the whole dressing completely.

The effect of the operation may be gathered by contrasting these two diagrams with the figure in the splint (further down in this paper) and from the following statement of facts.

Cases 1, 2, and 5 have now no apparent shortening whatever, and wear symmetrical pairs of boots. Case 7 wears about half an inch of cork sole. Case 3 wears a cork sole, 2 inches at the heel, and $\frac{3}{4}$ inch at the sole. The deformity in her case was originally very great. Case 4, which originally required a cork sole of 7 $\frac{1}{2}$ inches, is now made level by one of 2 $\frac{1}{2}$ inches.

In most of these patients, walking more than a mile used to cause fatigue and pain in the back. All but Case 9 can now walk vigorously. This Case 9 is very exceptional. She, a bright little girl of six years old, had never even stood in her life. She can now walk.

Being almost all young women and youths, they are vastly improved in spirits as well as in health; and, finding themselves no longer cripples, but merely marked by a slight limp, life has now new charms and hopes for them.

With reference to supratrochanteric osteotomy, I wish to draw your attention to certain points of importance, nowhere in surgical literature, to my mind, satisfactorily treated: 1. The place of incision; 2, the size of the osteotome; 3, the direction; 4, the position of the patient during operation; 5, the method of snapping the early divided bone in two; 6, the way to bring the limb down; 7, the mode of preserving, and even of increasing, the gain as regards position.

Trisect a line joining the anterior superior angle of the great trochanter, and the anterior superior spine of the ilium. Take a point at least half an inch below the junction of its middle and inner thirds. Enter a sharp-pointed steel director at this point, and pass it down to the bone you are about to divide. It will have to go downwards and inwards, but chiefly backwards; how much each way, you must judge by taking carefully the bearings of the great trochanter to the condyles of the femur, by noticing also the fatness or leanness of the patient. Send your knife² along the director (the use of which was first suggested to me by Mr. Willett), and make an incision large enough to admit one finger. Pass in your

¹ I have added a tenth, operated on since the paper was read. This has been done now exactly a month. The wound is healed, and the hip in excellent position; but the patient is still in the double splint.

² In my last case, I only used the knife to incise the skin, and then cut down to the bone with a small pair of ordinary surgical scissors, keeping the point of one blade in the groove of the director. This plan reduced the hæmorrhage almost to nothing. This may seem a trifling consideration; but in these "operations of expediency" one should spare no pains to prevent any, even the slightest, complication, and especially to avoid what may necessitate a change of dressings.

finger and feel, with the pulp; the inner edge of the anterior border of the great trochanter. Do not tear the deep parts in the

effort to feel more. Take out your finger, and pass in the chisel. The chisel should be large, heavy, and decidedly wedge-shaped in section.

Now for a most important point—the plane in which to place the chisel-blade. This should always make a slight, but not very large, angle with the longitudinal plane of the shaft of the femur.

Drawings A, B, C, D, E, are from the four specimens in the Museum of the Royal College of Surgeons. C and D are respectively front and back views of the same specimen. It will be noticed that only one, A, presents

anything like the appearance of the diagram placed in text-books to illustrate "subcutaneous" division of the neck of the femur. In the last mentioned diagram, a narrow saw is always placed in position, forming an angle of 45° with the axis of the femur. A saw so placed with respect to specimens B and E would either get into the

pelvis, or, more probably, cause the operator great embarrassment and waste of time.

A represents a section; B, C, and E, are views from the front; D is a view from behind of the same specimen as that shown in C.

All the drawings illustrate very well the necessity of getting well inside the great trochanter. All show the desirability of placing the chisel in a plane slightly oblique with respect to a plane drawn antero-posteriorly through the axis of the femur.

The bony points which it is necessary to examine and compare the positions of, in trying to discover the nature, position, and size of the bone forming the ankylosis are—1, the condyles of the femur; 2, the top of the great trochanter; 3, the anterior superior spine of the ilium; 4, the tuberosity of the ischium. Nos. 1 and 2 are sufficient to tell you where the femur is, and how it lies; Nos. 3 and 4 give the same information about the pelvis. The patients are often far too fat for much to be made out by direct palpation of the hip.

In the actual course of an osteotomy, as Dr. McEwen points out, the chisel conveys important information, much as a probe does. Make use of this to guide you in cutting the bone sufficiently.

The patient should lie supine on a sand pillow. In finally snapping the bone, rotate it a little as you forcibly bring it down. Put the limb in good position at once. It is absolutely necessary not to be afraid of employing force; this should be the ample force of a strong man exerting himself, but well within his strength.

F.

I have generally tenotomised the adductors, but not very extensively. It is quite clear that a complete tenotomy of all the adductors would leave nothing to resist the strain of manipulation, except the skin and the femoral vessels. Where there are deep cicatrices on the inner side of the hip, and always in infra-trochanteric osteotomy on a thin patient, you must remember the vessels.

For my first cases, I employed double extension in the after-treatment. The second weight was used to pull outwards from the upper part of the thigh. It was a source of comfort and relieved pain. But the best results have attended the use of this splint. As the annexed diagrams indicate, it is an ordinary double splint or trough, such as that invented by De Morgan, and modified by various surgeons, but entirely simple, and free from elastic bands, pulleys, springs, etc. The patient lies in it, with the foot of the side operated on strapped down to the crosspiece of the splint. Little blocks of wood, not unlike an octavo book in size and shape, are placed between the crosspiece of the splint and the sole of the foot of the sound side, and the patient is told to keep the knee of this leg straight. In this way, and without any other bandaging, the angle

of abduction or adduction of the hip operated on can be regulated so nicely, that a little abduction can be made to exactly compensate for an inch or so of real shortening. Of course, pads and padding are used with the splint. Extension is not always required; when

G.

H.

it is, apply a weight to the middle of the foot-piece (see the arrow in the diagram), and raise the bed-foot on blocks.

In conclusion, I beg of you to excuse the somewhat authoritative way in which I have laid down as law what is, after all, merely opinion open to discussion. I have chosen to do so only with a view to conciseness, and in order to spare your time.

CASES OF ABDOMINAL SURGERY.

By T. J. WALKER, M.D.,

Surgeon to the Peterborough Infirmary.¹

THE following ten cases have occurred consecutively in my private and public practice during the past fifteen months, and, although of little value as compared with the long series of cases recorded by the leaders in abdominal surgery, I think they are worthy of the notice of the profession, as marking the strides made in recent years in this department of our art, and as illustrating some points of very great practical importance. Into the details of the cases I shall not enter, but shall briefly allude to the points of interest where they exist in any of the series.

CASE I. H. W., labourer's wife, aged 33. July 10th, 1882. Ovarian tumour. Ovariectomy. Lister's antiseptics. Cured.

CASE II. W. K., seedsman, etc., aged 57. July 31st, 1882. Epithelioma of gullet and trachea. Gastrostomy, incomplete. Lister's antiseptics. Died.

CASE III. M. W., railway labourer's wife, aged 40. August 17th, 1882. Strangulated femoral hernia. Herniotomy. Lister's antiseptics. Three days. Cured.

CASE IV. E. K., railway signalman's wife, aged 37. September 20th, 1882. Soft fibro-myoma of uterus. Extirpation of uterus and its appendages. Lister's antiseptics; drainage-tube. Cured.

CASE V. H. W., wife of coal agent, aged 37. March 5th, 1883. Ovarian tumour. Ovariectomy. Lister's antiseptics; drainage-tube. Cured.

CASE VI. H. W., wheelwright's wife, aged 54. June 15th, 1883. Ovarian tumour. Ovariectomy. Lister's antiseptics; drainage-tube. Cured.

CASE VII. Mrs. W., independent, aged 63. June 24th, 1883. Strangulated femoral hernia. Herniotomy. Cured.

CASE VIII. J. S., waiter's wife, aged 44. July 9th, 1883. Infil-

trated irreducible hernia and peritoneal fistula. Extirpation of sac and reduction of contents. Drainage-tube. Cured.

CASE IX. M. P., labourer's wife, aged 47. September 12th, 1883. Ovarian tumour. Ovariectomy. Lister's antiseptics. Cured.

CASE X. E. C., factor's child, aged 13. September 13th, 1883. Ovarian tumour. Ovariectomy. Lister's antiseptics. Cured.

Case I, ovariectomy, calls for no special comment, excepting that I may mention that this was the first case of the class in which I determined to carry out strictly the rule of limiting the number of my assistants to that actually necessary, and of excluding spectators, who might be the unconscious vehicles of septic or other germs. I may also say that I take very special precautions to prevent the possibility of myself being the source of infection, and that I request my consultants to adopt similar measures. By Lister's antiseptics, I mean operating under carbolic spray; the use of carbolic solutions as practised by Lister; the dressing with carbolic gauzes. I do not, however, use protective to any wound; do not apply a layer of wet gauze next to the incision, nor do I cover the dressing with waterproof tissue, but with strips of plaster, as practised by Sir Spencer Wells. The pedicle, in all these cases, was treated by ligature, cut short, and dropped into the abdomen. In most of the operations ether was the antiseptic used, and was generally administered by Dr. W. E. Paley. The patient, Mrs. W., recovered without a bad symptom, her temperature never reaching 100° after the first day, and her convalescence being rapid and uninterrupted.

Case II, incomplete gastrostomy, is one of greater interest. The patient applied at the infirmary in May, 1882, with dysphagia. Laryngoscopic examination showed the larynx and vocal cords quite healthy, and the diagnosis was for some time uncertain; but, the voice and breathing becoming affected, and the indurated gland parting in the neck, cancer was diagnosed. Dysphagia became greater, and the arguments for and against gastrostomy were put before the patient, and he declined the operation until, having had, for some time, no food but that administered *per anum*, he begged me to give him the chance afforded by the operation of prolonging his life. Although the patient's condition had become very unfavourable, at his earnest solicitation, the first stage was performed, on July 31st. On making an incision below the cartilages of the ribs, the collapsed colon came into view, and was at first taken for the stomach. This organ, however, lay far back below the diaphragm, at the extreme depth of my finger from the wound. It was drawn down, and attached by sutures to the margins of the opening in the abdominal wall, the whole proceedings being rather more difficult than I anticipated. The patient, who was in a most critical state, during the operation, rallied well; but, on the following day, he began to breathe with difficulty, secretion accumulating in the trachea, and he died within thirty-six hours. On *post mortem* examination, it was found that the cancer had ulcerated completely, through from the oesophagus to the trachea, and that the latter was full of secretion from the growth, which, in his exhausted state, the patient had been unable to expectorate. The stomach was adherent to the circumference of the wound throughout. None of the sutures had penetrated its mucous lining, and there was no trace of peritonitis from the wound. So far as it went, the object aimed at in this, the first and most important stage of gastrostomy, had been attained, and the case may be regarded as telling in favour of the operation in simple insuperable stricture of the oesophagus; but, in cases of malignant disease, I would never urge, indeed, hardly recommend, an operation, the object of which is merely to prolong life, while leaving the disease itself untouched. Cases of gastrostomy, ending as did this case, are, I doubt not, far more common than public records would lead us to suppose. That a man should die as did my patient is nothing extraordinary; that he should recover is so, and it is the extraordinary, not the ordinary case, which is usually published.

Case III, herniotomy, is of interest, as the patient had been operated on for strangulation of the same rupture three months before, by Dr. Cane. This caused no special difficulty in the second operation. It was performed under the spray, the wound healing in three days without suppuration; a result, I might say, which I have occasionally obtained without Listerism, where the wound has remained septic.

Case IV, hysterectomy, is, from the comparative novelty, rarity, and magnitude of the operation, of some interest, and calls for more detail. Mrs. K., aged 35, a multipara, consulted Dr. Kirkwood, my partner, in October, 1881, believing herself to be pregnant. The abdomen was enlarged, and she had constant sanious discharge. A tumour was diagnosed, and the patient was not seen again for four

¹ Read before the Huntingdon Medico-Chirurgical Society.