sutures, just enough to assist in making a moderate pressure on the bladder, and keep it from much movement. I may add, that I have often resorted with success to this method when other methods had failed.

[To be continued.]

ANCIENT TRACES OF ANTISEPTIC TREATMENT IN MEDICINE AND SURGERY.

By GEORGE F. ELLIOTT, M.D.,

Physician to the General Infirmary, Hull.

At a time when the antiseptic treatment of both local and constitutional diseases is justly looked upon with favour, I hope to interest your readers by showing that some of our ancestors were in the habit of using and appreciating the value of antiseptic remedies, although they may not have given them with the same views of the etiology of certain diseases as are generally entertained at the present day. By antiseptic treatment in surgery, it is scarcely necessary for me to say that I allude to Mr. Lister's treatment by carbolic acid. As regards the practice of medicine, I may explain that I allude particularly to the treatment of zymotic diseases by the sulphites, as proposed some years ago by Professor Polli of Milan.

In turning over some of the many old works in our Infirmary library, I recently found a curious and interesting book, entitled *A Treatise on Alkali and Acid*, by John Colbatch, M.R.C.P.; published in London in the year 1698. This Dr. Colbatch appears to have been in practice in London at this time, and was previously on service with the army of William III at the siege of Namur; indeed, he says it was during his leisure moments on this service that he composed the treatise to which I allude. He was a man, I think, considerably in advance of his time; and he appears to have incurred a good deal of enmity for what were then unorthodox opinions; to which enmity he makes the following graphic allusion: "He that would pass the course of his life without envy, must believe what is generally believed, and speak as others do; and whoever takes upon him to do otherwise, let the success of his undertaking be what it will, the reward he is like to meet with from the generality of mankind, is to be reproached". I have said that he was in advance of his contemporaries, because he appears to have anticipated some recent conclusions as to certain properties of the blood in health and disease; for instance, he distinctly states that a volatile alkali can be obtained from the blood; also, that he believes this alkali to be increased during fevers, and that, by its excess, it breaks up the blood-corpuscles; and, looking to this alkalinity of the blood, he strongly recommends the administration of acids in fevers. Among the acids he speaks of, is one which bears particularly on the question of antiseptic treatment. I mentioned Professor Polli's recommendation of the sulphites, the active agent of which, sulphurous acid, has found a place in the *Pharmacopœia* of the present day. Now, Dr. Colbatch alludes to this preparation under the name of "gas sulphuris"; and gives directions for preparing it by, as he describes it, "impregnating water with the volatile acid steams of sulphur"; and thus he makes a compound differing only as to the manner of its preparation from the present pharmacopœial one. After enumerating many diseases in which he has found it of benefit, he thus finally sums up his opinion of it. "This medicine, given liberally in malignant fevers, has done wonders, even where people have been given over as dead. It is an excellent medicine, being taken by way of prevention in infectious seasons; and I think, if any medicine deserves that name, this doth deserve to be called the true prophylacticon." I am not prepared to go as far as our author in the way of eulogium concerning this medicine; but I may here say, that I have lately been using it in typhoid fever, and in cases of diarrhoea suspected to be due either to tainted water or unhealthy emanations, and I have reason to speak highly of it.

Appended to this *Treatise on Alkali and Acid*, was another entitled the *Noëum Lumen Chirurgicum*, setting forth the virtues of a certain vulnerary powder. I regret that I have not been able to find out the composition of this (for certain reasons he says he kept it secret for a time); but, among the other virtues he claims for it, is that of being a powerful styptic. Trivial as reference to a matter of this sort may, at first sight, appear, it will however, I think, be granted that, in connection with the question of antiseptic treatment, the following passage is of much interest. Speaking of a wound which had been dressed with this powder, he says: "About four days after (*i.e.*, the first application), the wound was opened again to make a fresh dressing, which we found in a very good condition, and not in the least digested, or brought to suppuration; but a thin serous matter a little tinged with redness, which I suppose to be discharged out of the glands and lymphatic vessels, came away, which, when it had lain some time upon the dressings, was subject to

stink; but that which came fresh out of the wound was as sweet as a rose." Now, *minus* the otto of rose part of the question, which we may pass over as a bit of pardonable enthusiasm on the part of our author, there is a remarkable similarity between what he claims to be the result of the application of this powder, and that which is attributed to the use of carbolic acid. There is no evidence as to what he supposed to be its *modus operandi*; but what I wish particularly to point out is this, it is evident that he attributed its good effects to the prevention of suppuration. Moreover, he elsewhere in the book ridicules the system then prevalent of keeping wounds open with tents, and dressing them with stimulating applications, in order to facilitate the expulsion of peccant matters.

Such are the foreshadowings of antiseptic treatment evident in the practice of one of our profession nearly two hundred years ago.

CASE OF TRANSVERSE FRACTURE OF THE PATELLA, WITH BONY UNION.

By D. DYCE BROWN, M.A., M.D.,

One of the Medical Officers of the Aberdeen General Dispensary, and late Assistant Professor of Materia Medica in the University of Aberdeen.

THE interest of the following case lies, not in the nature of the injury, which is common enough, but in the rarity with which bony union occurs after a transverse fracture of the patella.

William Wishart, a dispensary patient, aged 40, a butcher, given to drinking habits, had been unfortunate enough previously to have had four separate fractures of the leg, two in each. On coming home on the evening of December 17th, 1867, in a state of intoxication, he fell on a stone stair upon the front of the right knee. The swelling round the right knee-joint was so great that nothing in the shape of a patella, or other part of the knee-joint, could be distinguished. There was great tenderness, with much discoloration and ecchymosis. The limb was raised gently on a pillow, arnica lotion applied, and over the latter a linseed-poultice. This treatment gave considerable ease, and assisted in the reduction of the swelling. When the swelling had sufficiently fallen to enable one to handle the limb without pain, and to distinguish the parts, it was evident that there was a transverse fracture of the patella. The state of parts was as follows. The movement of the limb, as a whole, was wonderfully good. He could bend the leg at the knee, and, with a little difficulty, could raise the limb unbent for a few inches off the pillow. When the limb lay extended, and resting on its posterior surface, hardly any depression could be felt with the finger between the fragments. On bending the knee, the depression between the fragments was about a finger's breadth; the width of the depression varying as the limb was flexed or extended. When the limb was extended, the fragments lay in such close apposition that, without at all pushing them towards each other, distinct crepitus could be made out on moving the fragments from side to side. The case was seen at this time by Dr. Alexander Ogston, who satisfied himself on the above points.

By way of treatment, I first applied two broad strips of diachylon plaster, heated in hot water so as to make them lie to the shape of the parts to which they were applied. The one was placed with its middle part pressing as firmly as possible against the inferior edge of the lower fragment; the ends being then drawn tightly up, and made to adhere to the sides of the thigh; while the other piece of strapping was put in the reverse position, its middle portion pressing as firmly as possible against the upper edge of the superior fragment, with the ends pulled tightly down, and made to adhere to the sides of the leg; the two pieces of strapping thus crossing one another in a horse-shoe shape. This appliance seemed to keep the fragments in close apposition. This being followed by no additional swelling, in two days I put a pasteboard splint behind the limb, from the middle of the thigh to near the ankle, and bandaged it from the toe upwards to the middle of the thigh, making each turn of the bandage about the knee press as much as possible on the upper and lower edges respectively of the two fragments.

After a month all but two days, the bony union seemed fairly firm. I therefore put on a gum and chalk bandage, and let him get up. In a month longer, the stiff bandage was removed, the bony union being then strong. The superior edge of the lower fragment was very slightly raised above the level of the inferior edge of the upper one, which gave, at first sight, the feeling of a slight depression still remaining. On more careful examination, however, there was evidently no depression, but merely the slight difference in level just mentioned. I read the case before the Aberdeen Medico-Chirurgical Society, and brought up the patient to be seen. Those gentlemen who saw him were satisfied that the union was bony and complete.

In this case, everything was in favour of bony union; and the com-

paratively small space which existed at first between the fragments showed that the aponeurotic expansion from the muscles over the bone must have been either not lacerated, or only to a slight extent.

RUPTURE OF THE BLADDER, MISTAKEN FOR OBSTRUCTION OF THE BOWEL AND OPIUM-POISONING.

By HORACE DOBELL, M.D., etc., Physician to the Royal Hospital for Diseases of the Chest.

THE case reported by Dr. Andrews in the BRITISH MEDICAL JOURNAL of October 24th, under the heading "Rupture of the Bladder and Enteritis," recalled to my mind one which occurred to me some years ago. As the case may be of interest in conjunction with that of Dr. Andrews, I have extracted the following nearly *verbatim* from my case-book.

On Thursday, June 7th, 1860, I was requested by a surgeon in great haste to see Mr. R., as he thought him dying from opium administered in treatment. I learnt that, during the last thirty-six hours, the following had been given: twenty minims of tincture of opium, followed by sickness; a grain of solid opium, followed by sickness, but possibly retained; a drachm of tincture of opium in an enema, only partly retained. After a careful examination, I gave the opinion that the patient was suffering from uræmic poisoning, and would shortly die. He died half an hour afterwards. The account I obtained from the surgeon was as follows.

On Saturday night last, Mr. R. was in his usual health, sat late at home drinking gin and water with some friends, took more than usual, and was slightly intoxicated. He got up to go to bed, stumbled, and fell with his stomach on the arm of his chair. He groaned at the moment, but quickly said, "It is all right, I am not hurt;" walked into the adjoining room, and went to bed. He was asked how he was after going to bed; and he said again, "All right," and went to sleep. The bowels had acted before the fall. Next morning (Sunday), he felt ill; he had sharp pain in the umbilical region, and said that he felt he could not strain to get the bowels open; and they did not act. Some castor-oil was given, but did not act; and, after some time, he brought it up. The vomiting continued after this; and towards night, the patient, finding that he had passed no urine all day, sent again for his doctor, who passed a catheter, and drew off a very little. This was slightly tinged with blood, but so slightly that it was thought to be only due to the passage of the catheter; and the absence of urine in the bladder was supposed to be accounted for by the repeated vomiting. Another dose of castor-oil and a calomel and colocynth pill were given; but the bowels did not act. There was very little pain in the abdomen, the principal symptoms continuing to be a feeling that the patient could not strain to get a motion, and that he wanted some assistance to make the bowels act. An enema of soap and water was given, which brought away a little pale fecal matter. A larger one was given, with similar result; neither was attended with any unusual discomfort. The patient continued constantly sick, not retching with any force, but eructating everything, even water, a few minutes after swallowing it. The sense of inability to strain disappeared after the second enema, and a very small quantity of urine was passed naturally while at stool. The catheter was used night and morning, and two or three ounces of urine removed each time, without any blood after the first time. On Wednesday, the day before death, no natural action of the bowels had occurred since the fall; the eructation of everything taken into the stomach continued. There was very little pain, and that was about the umbilicus, and rather to the right of it, and extending up towards the hypochondrium. The region of pain was slightly dull on percussion. The whole abdomen was slightly distended, but soft, and not tender, except in the region of pain; and no part of the alimentary canal was morbidly distended by either solid or gas. The breathing was very quick and thoracic; pulse feeble, 120, not sharp or hard. The patient was rather faint, but clear in intellect. He had had no sleep since the accident. He thought he could sleep but for the sickness and "fidgety sort of pain" in the bowels; but the pain was not paroxysmal, and not enough of itself to prevent sleep. It was now considered by the surgeon that some serious obstruction in the bowels had been caused by the fall; that the suppression of urine was due to the constant ejection of fluid from the stomach; and it was decided to do nothing but keep the patient quiet, give opiates, use the catheter if required by distension of the bladder, and continue enemata. It was early next morning that I was called in, half an hour before death, as stated in the commencement; when I obtained the foregoing history of the case.

Post Mortem Examination, the following morning.—The abdominal

viscera were healthy. There were no signs of inflammation; and, on careful examination from the stomach to the rectum, no obstruction was found in the intestines, which were nearly empty. The cæcum was adherent to the iliac fossa by some bands of old lymph. There were no signs of recent action. The abdomen was full of very high coloured fluid, which had a very strong smell, but more peritoneal than uræmic. On passing the hand into the pelvis, in search of the bladder, none could be felt; but the finger went into a fossa at the entrance to the urethra. On careful examination, the bladder was found completely shrivelled up round the entrance to the urethra, with a rent two inches long in the anterior free portion of the fundus. The rent was quite patent. There were no signs of inflammation either in or about it, but considerable purple ecchymosis in the coats of the bladder leading from the rent.

Although suppression of urine is a constant occurrence in obstruction of the intestines high up, and to a certain extent of all other diseases attended by continued sickness; and although the concurrence of inaction of the bowels, obstinate sickness, and pain, following a twist or blow to the abdomen, might fairly lead to the suspicion of intestinal obstruction; and the detection of some amount of dulness about the right upper portion of the abdomen, and the absence of any pelvic pain, certainly complicated the diagnosis in this case; still I think that the unusual freedom from *tormina*, and the absence of any fecal odour in the vomited matters from first to last, together with the character of the accident—viz., a blow from a prominent object on the abdomen, after sitting for some hours drinking—might have suggested a different diagnosis. And the practical hint may be taken from the case, that, in cases of suspected obstruction of the intestines, it is wise to wait for distinct *painful peristaltic action* before beginning to administer opium; and it is a good illustration of the importance, in all cases of obscurity, of *reconsidering* the whole of the circumstances, signs, and symptoms, at each visit.

CLINICAL MEMORANDA.

[Under this head, we shall publish from time to time, as materials accumulate, short records of remarkable cases in practice which are sufficiently rare, interesting, or instructive, to deserve record, but do not call for lengthened statement or comment. Brevity and point should be the valuable characteristics of cases forwarded for this column.]

FRACTURE OF THE SKULL, WITH ABSENCE OF SYMPTOMS.

By J. T. HESTER, F.R.C.S., Hastings; late Senior Surgeon to the Radcliffe Infirmary, Oxford.

THE "remarkable case of fracture of the skull, under the care of Mr. Charles Moore," at the Middlesex Hospital, reported in the JOURNAL of October 24th, recalls one to my mind still more remarkable. I did not see the patient till after death.

A young lady, eighteen years of age, was thrown out of a carriage, which, in consequence of the horse running away, was dragged over a heap of stones. She immediately rose, and ran two miles after the carriage, being anxious to ascertain the safety of her father, who was in it. She returned home, and appeared so little the worse for the accident, that she objected to any treatment. She at last, however, submitted to be bled, that being the practice of the time (thirty years ago). On the following day, as she had a headache, a few leeches were applied. Feeling a little faint, she asked to be lifted up in the bed; and, on being so, instantly fell back dead. On the next day, I was requested to assist at the *post mortem* examination.

The skull, which was the thinnest I have ever seen (light could be seen through it), was literally split into two halves by a fracture which passed through the occipital in front and behind the foramen magnum, dividing the parietal, passing through the frontal, ethmoid, and sphenoid bones, without the slightest depression or starring in any part. I need hardly say there was no diploë. Between the dura and pia mater, there was a very considerable extravasation of blood on the upper surface of the brain, but none at its base. I was led to account for the entire want of symptoms of pressure, from the peculiar nature and extent of the fracture allowing the cranium to expand. The most extraordinary parts of the case are, that such a fracture could take place under the circumstances, and that the patient was not stunned by a fall which could occasion it.

I have no notes of the case, but write from memory; but the facts of it are indelibly impressed on my mind.