REMARKS ON CLEFT-PALATE OPERATION—WOUNDS HEALING BY SECOND INTENTION.

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AN incised wound which does not heal by immediate union of its apposed edges is apt, to say the least, to be associated with disappointment. If the wound is in the inguinal region, as after the radical operation upon a hernia or the removal of an appendix, the disappointment quickly gives place to a feeling of confidence, for the surgeon knows perfectly well that the wound will eventually heal, and that consolidation of the tissues will become perfect, even though somewhat delayed. So he covers up the wound with gauze and bandage, and in a sure and certain hope. Probably he does not say much to the patient or to the friends about his passing disappointment. He keeps his own counsel, and trusts to Time—Time, the Healer by granulations—and when at last the dressings are permanently removed everybody is contented.

Cleft of soft and of chief part of hard palate, the subject of these remarks.

How different is the picture when the line of suturing after an operation on a cleft-palate has given way! The surgeon is helpless and almost friendless, but he need not be hopeless. He may, perhaps, ask the parents not to look into the child's mouth for a little while, but he cannot conceal the failure. He cannot cover the wound, and hide it beneath bulky dressings. It is foul and naked, and its swollen edges are thickly covered with muco-purulent discharge. There is no getting away from the fact that the operation is a thorough failure, as any one can see for himself on getting the child to open his mouth or on looking into it when he cries; and the parents are very apt to do this.

I suppose that every surgeon who has operated on cleft palates has had this unhappy experience, especially in hospital work. The trouble is due to septic inoculation of the wound, against which no care on the part of the surgeon before the operation could make the patient proof.

In past years I used to send such children into the country as quickly as I could, so that they might get well from the septic poisoning, and then, months later, perhaps, I used to go through the whole operation again. But now if a palate operation "goes septic" (to use a student's expression), the edges of the cleft falling asunder and leaving, perhaps, the gap more widely gaping than before, I stand by the case and hopefully look forward to a cure with the help of Time—Time the Healer by second intention. Here is the short history of such a case:—

A girl of 8 years was sent to me last October by Mr. Morton Smale. She had a rather wide cleft of the soft and of the hinder part of the hard palate, and her father said that three attempts had already been made to close the cleft, the last having been made twelve months previously. He also said that he had given up all hope of the cleft ever being closed, as after each operation the wound had broken down completely.

At the operation (which I did on October 17th) I found the muco-periosteal tissues hardened by the scarring of the former operations, and the bleeding was, for some reason or other, unusually free. The breathing, too, was troubled, and I found that I could not get on with the work unless I had the child placed upon her side; the head-downward position did

not answer with her. In due course, however, I got the edges together without strain, fixing them by nine silver stitches.

On the third day the edges of the wound were sloughy and foul, and the child looked ill and yellow; and on the following day thick, ropy mucus was hanging about the palate and fouling the mouth. Every stitch threatened to give way, and already the cleft looked almost as bad as it did before the operation.

On the fifth day after the operation I sent the child round to Dr. Leslie Eastes's laboratory, so that I might learn the precise nature of the septic infection. The following was his reply:

62, Queen Anne Street, London, W., October 24th, 1904.

A film preparation made directly from the swab showed numerous micro-organisms of various kinds. Diplococci occurred most frequently, in large and small forms. Staphylococci were also numerous, but rods were scanty. After incubation on agar and blood serum, the profuse growth obtained consisted in both cases of the staphylococcus pyogenes aureus.

Needless to say, the wound broke down in its entire length. All that we could do was to look after the child's general health (sending her out of doors as much as possible) and to hurry on the cleansing of the mouth by washings and swabbing.

By the end of another week she was bright and well, and the mouth was once more quite clean; so on October 29th, the twelfth day after my first operation, I did the whole business over again, cutting a thin film from the granulating edges of the wound, and bringing the freshened borders together by seven wire stitches. This time everything went well: the wound kept clean, the edges joined at once, and we got a solid union from stem to stern. The child had undergone an auto-inoculation, and her palate had, in consequence, quite lost the power of cultivating staphylococci.

I have had several cases like this of palates hopelessly breaking down after operation, the children showing much general and local disturbance, and the operations, after great anxiety and disappointment, ending as happily as a fairy tale.

The circumstances of this particular case suggest two questions: First, can anything be done before operating to make the child safe against a growth of these vexing germs? I think not. All that the surgeon can do is to get the child and the mouth into the most wholesome state possible, the injection of serums being, in the present state of our knowledge, of real danger and of doubtful value.

Secondly, what is the proper term to be given to the manner of healing which takes place when the edges of the wound are freshened up and brought together for the second time within a fortnight? It cannot be called "primary union," yet, so far as one could see, the joining was as quick and quiet as in a primary union. At any rate, it was not a "healing by granulation," for the edges which were brought together were fresh and raw, and they stuck together at once without any sign of granulation-tissue.

I have called it "healing by second intention," but I am not at all sure that this is the right term for it.

OBSERVATIONS ON DWARFISM AND INFANTILISM.

Made at the Spring Meeting of the Ulster Branch and at a Clinical Lecture in the Royal Victoria Hospital, Belfast.

By WILLIAM CALWELL, M.A., M.D.,

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THE two living cases which I bring before you to-day furnish a striking clinical contrast, and are well worthy of study. The first is that of W. M'C., a boy, for he is a boy in reality, although in his twenty-first year; he is 4 ft. 4½ in. in height, and 4 st. 7½ lb. in weight. The relative length of limb to that of trunk is about normal; his abdomen is rather full; the face has a wizened aspect, and presents a certain patchy pigment; there is no hair on face, armpit, or pubis, or but the slightest trace; there is some knock-knee, and both tibiae are rather swollen and tender, as if a chronic inactive periostitis were present. One cannot say he is deficient mentally, but he does not possess the average mental calibre of twenty-one, and is rather shy. From the photograph you can see the relative size of a well-developed boy of twelve, and of a student of 5 ft. 9 in.

On admission to hospital there was considerable paresis of