SKIN APPPOSITION WITHOUT SUPERFICIAL
SUTURES.

BY

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WHEN closing an incision it is only necessary to bring the edges of the skin accurately together. A good scar depends upon accurate skin apposition. A method which will do this without sutures will save time and trouble. I have found I get more perfect scars by the following method: Put two or three deep sutures, depending on the size of the wound, through fat and skin, but do not tie them. Take each end of the incision with a pair of artery forceps and pull taut. Rapidly clamp the skin edges with artery forceps, starting at one end; the forceps are to be about a quarter of an inch apart, and should take each skin edge accurately in its grip. The forceps hold in their grip about a quarter of an inch—of skin above, and skin and fat below. The forceps are carried along the whole length of the incision, and are held by an assistant as they are clamped. When the last is in position, the first is taken off, and then the second, and so on along the whole length of the incision. The skin will be found to be tightly glued together. The deep sutures are then tied over a roll of gauze, as in an ordinary bonbon dressing.

The advantages of skin clamping are (1) accurate skin apposition with no turning in of skin, (2) rapidity, (3) very few stitches to remove. The results in my experience and in that of those who have tried this method are excellent, and a most perfect scar can be obtained.

It might be asked: "Is there no sloughing of skin?" I have used the method extensively and never seen sloughing happen. The mark of the artery forceps remains for about fourteen days, and then disappears.

The disadvantage is that occasionally a part of the wound gapes and requires a suture, and I have not found it successful in very fat people, over the symphysis pubis, and in scar tissue. On the other hand, in certain places, such as the neck, where the incision is in the line of cleavage of the skin, no deep sutures are necessary, skin clamping being alone sufficient.

I first tried this method some years ago with circumcisions, clamping skin and mucous membrane without any suture, and finding the result admirable I have extended it to every variety of incision. I experimented with an instrument made with a blade one inch in length, but have not found it nearly as successful as simple artery forceps.

My partner and colleague, Mr. H. L. Martyn, F.R.C.S., who has often used this method, and is most enthusiastic about it, has kindly prepared a drawing (reproduced above) showing the artery forceps in position.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

FREE GAS IN THE PERITONEUM AND SUBSEQUENT SUBCUTANEOUS EMPHYSEMA.

It is recognized that general subcutaneous emphysema is a rare complication of perforation of the stomach from ulcer. Demarquay¹ was the first to call attention to cutaneous emphysema after solutions of continuity occurring in the stomach or the intestinal tract. He showed that perforation of the gastro-intestinal tract, followed by the entrance of gas into the free abdominal cavity, may lead to cutaneous emphysema if at the same time the parietal peritoneum is injured, as, for instance, after performing traumata of the abdominal wall and the intestine, or traumatic lesions of the parietal peritoneum and the intestinal canal without perforation of the abdominal walls. In the case here recorded there was nothing in the

previous history suggesting a gastric or duodenal ulcer, and the patient had not sustained a recent trauma. That it was a perforation is, I think, obvious, but it was surely of an unusual type, and the sequelae were remarkable.

E. W., male, aged 54, was admitted into the Royal South Hants and Southampton Hospital on October 31st, 1917, with a diagnosis of intestinal obstruction. The history he gave was that he had had no action of his bowels for four days prior to admission, and he had occasional vomiting, indefinite pain and increasing distension of his abdomen. His temperature was normal, pulse 90. On examination, his abdomen was greatly distended and tympanitic all over. There was no visible peristalsis. On palpation there was indefinite tenderness, but nothing else to specially note. Rectal examination was negative. An enema was returned unaltered, and no flatus was passed. From the age of the patient, the history, and the physical signs, the provisional diagnosis was adhered to and laparotomy was forthwith performed. A middle line incision below the umbilicus was made, and as soon as the peritoneum was opened there was an immediate rush of odourless gas and the abdomen went down flat. There was a singular lack of fluid in the peritoneal cavity, and the intestines were collapsed. A perforated gastric or duodenal ulcer was sought for in vain, and no other lesion could be discovered to account for the free gas. As there was no fluid or other infective material present the abdomen was closed without drainage.

A remarkable thing now happened in that twelve hours later the patient was almost unrecognizable. The incision into the peritoneum had permitted the escape of gas into the subcutaneous cellular tissues, and the gas had infiltrated in these tissues from head to foot. His eyes were closed with the swelling of the lids, and breathing was becoming difficult. He was taken down to the theatre immediately, some stitches were removed and a tube inserted into the peritoneal cavity. Thereafter he made an uninterrupted recovery, the emphysema rapidly clearing up. The tube was removed on the sixth day, the wound healed rapidly, and he was discharged from the hospital on December 1st, 1917.

I am indebted to Mr. J. R. Keele, senior surgeon to the hospital, for permission to publish the case.

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ARREST OF GROWTH IN "INOPERABLE CANCER
OF THE JAW."

I SHOULD like to draw attention to the changes that have taken place in two cases of inoperable cancer of the jaw under my treatment in this hospital.

1. H. M., aged 68, was admitted on May 12th, 1919, with an epithelioma of the dorsum of the tongue, accompanied by very enlarged glands in the neck. He was unable to take anything beyond small quantities of fluid. He gave a history of severe haemorrhage, and his condition had been reported inoperable at the General Hospital. Two days later I was called to see him for severe haemorrhage, and found him apparently dying. I injected a phial of pituitary extract (Ferris) into the growth of the tongue, and all bleeding stopped at once, and did not recur. I noticed a decided decrease in the size of the glands, and no further enlargement or ulceration of the growth. I gave him some further injections. He put on flesh; no enlargement of new glands occurred, and he could take food with comfort. He remained nine months in this state, and then secondary troubles in the liver appeared, and although the primary growth became no larger, the one enlarged gland increased in size. He died on April 27th, 1920, living eleven months after this one and only severe haemorrhage in this hospital.

2. J. J. R., aged 56, admitted March 16th, 1920, had been seen at the Bristol Royal Infirmary and General Hospital, and pronounced "inoperable" by the surgeons. He had a large growth underneath the tongue, extending up the left side of the lower jaw, and forming a fungating growth on the neck; all the tissues of the chin were indurated and presented small "truffle"-like excrescences. He gave a history of frequent and severe haemorrhages, and he had a further severe one in the ambulance on the way to this hospital. The growth had first been noticed sixteen months earlier. He was emaciated, very bloodless on admission, and there was a horrible fetor of the mouth. I was summoned to see him because of a very severe haemorrhage. I at once injected a phial of pituitary extract into the growth beneath the tongue; the bleeding ceased at once, and the growth shrank. This has continued, under injections given weekly or twice a week. He can now move his tongue freely and touch his lower lip. The growth in the neck has shrunk to the angle of the jaw; there is a slight purulent discharge, but no fetor from the tongue and neck. He can eat solid food, has put on weight, has lost his anaemic appearance, and there is no haemorrhage. These injections give him little pain at the time, but in about two minutes he has severe pain lasting two minutes down his spine and becomes very pallid, and then says he is quite all right. Sections of the growth made at the Royal Infirmary demonstrated malignant disease. He has little if any pain now, and no new enlarged glands.

I venture to record these two cases in the hope that others will try this treatment, which is almost painless,

¹ Nothnagel, *Diseases of the Stomach*.