ness or rashness, but in that of increased caution, combined with an earnest desire that we should avail ourselves of the means of knowledge placed before us.

My cases were all treated on Listerian principles, the pedicles trans-fixed and tied with carbolised silk, and enclosed within the abdominal cavity.

PERINEAL CURVE AXIS-TRACTION FORCEPS.

By S. MACVIE, M.B., C.M., CHIRNSIDE, N.B.

RECENT attempts to obtain the advantages of axis-traction in forceps operations have resulted in contrivances so cumbrous as little likely to be adopted by the main body of the profession. I am, therefore, induced to describe a modification of the double curved forceps for the attainment of the same object, which I have lately successfully employed, and which has the merit of simplicity to recommend it. This modification does away with the necessity for traction-rods and all other extra aids; and consists simply in the addition of a perineal curve to the ordinary double curved forceps.

Taking Simpson's "intermediate" forceps to work upon, I have added about two inches to the length of the stem of the blades, that is, of the part intervening between the commencement of the cranial curve and the lock. This additional length I have so bent that, with the blade *in situ*, it shall curve round the fourchette and pass backwards over the perinæum until it touches a line prolonged downwards through the traction axis of the blades. At this point, I have again bent the stem, so that the remaining part of the added length and the handle thereon shall continue in the traction axis line.

Such is the modification. Briefly, I have neutralised the pelvic curve by the addition of a perineal curve, so that the focus of resistance lies in the line of traction; and the instrument, in this respect, becomes practically a straight forceps. Nor is this advantage obtained at any cost, except the addition of one-and-a-half inches to the total length of the instrument. The "perineal curve" simply re-confers the power of axis traction which was sacrificed by the adoption of the pelvic curve, and without limiting the range of applicability bestowed by the latter. Therefore in the ordinary "intermediate" forceps, thus modified, we have an instrument of the widest utility, endowed with the power of axis traction; suitable wherever forceps are required, except where the obstruction is exceedingly high; and neither unhandy in the simplest nor inefficient in the most difficult cases. This modification is also valuable since it is equally applicable to the "long" forceps, and, moreover, it deprives the short straight forceps of the single superiority it possesses.

I do not pause to contrast in detail the merits of the "perineal curve" with other contrivances for the same purpose. In principle, they are identical. But in efficiency the former is fully equal to the latter; while for handiness and simplicity it is much superior. But I may mention a few particulars in which my experience shows that it excels the instrument out of which it has grown.

1. With the tip of the blade directly in the line of the handle, its introduction is easier and its adaptation more precise.

2. When the under (posterior) blade is introduced first, the handle lies far behind the fourchette, and entirely out of the way of the introduction of the upper blade.

3. For the same reason, the operator is less interfered with by the patient's thighs, both while introducing the blades, and during the extraction of the head; and suffers less loss of power from the handles projecting far in front when the head is passing under the pubic arch. In fact, from first to last, the operator occupies a more commanding position.

4. The lock, being well behind the fourchette, cannot possibly inflict any injury upon the soft parts during the adjustment of the handles.

5. The instrument, being practically straight, is capable, when the head has fully entered the pelvis, of aiding the movement of rotation. This is an advantage afforded by no other instrument whatever at such an early stage.

6. Lastly, and mainly, it confers all the advantages of axis-traction. These need not be enumerated. But it may be permitted to say, that it does so with the slightest departure from the simplicity of the instruments in common use; and with no departure whatever from the manipulative procedure at present practised.

Messrs. Young and Sons, North Bridge, Edinburgh, are the makers.

DR. J. E. A. BALL, of Biard, Texas, reports, in an American contemporary, the case of a negro woman who gave birth to a child at the age of sixty. The age of the mother was authenticated by the record of her birth, in possession of her former owner.

ON A CASE OF ECTROPION SUCCESSFULLY TREATED BY TRANSPLANTATION OF SKIN FROM THE ARM.

By LOUIS H. TOSSWILL, M.B.,
Surgeon to the West of England Eye Infirmary at Exeter.

At a meeting of the South-Western Branch of the Association held at Exeter on October 5th, 1881, I showed a patient from whose arm and forearm I had removed large pieces of skin on July 28th, 1881, transplanting them to his left upper and lower eyelid respectively. The operation has proved so successful, that I propose to describe the case somewhat in detail; and I have the more reason for doing so, because the operation in question appears to have been but rarely performed in this country.

C. W., a boy, aged 10, was severely burnt about the head and face several years before he came under my care, the result being an amount of disfigurement which exceeded anything that I remembered to have ever seen before. The whole of the left side of the face and forehead presented one uniform surface of dull white cicatricial tissue; the outer two-thirds of the left upper lid was much everted, even when the boy looked straight in front of him. The edge of the upper lid was dragged up close to the margin of the brow, against which the lashes rested, with their points directed upwards; and when the boy attempted to close his eye, or to look downwards, the eversion became still more marked. There was considerable corneitis with opacity present in the left eye, due in part probably to the eyeball remaining uncovered during sleep, so that he appeared to be staring at anyone standing by his bedside. The position of the edge of the left lower lid was shown by a row of lashes, apparently growing from the cheek, an inch or so below the eyeball, and the mucous membrane was to a considerable extent replaced by what could not be distinguished from ordinary skin. Over this surface the tears were continually flowing, and had produced an excoriation. In addition, the almost complete eversion of the lower lip, over which the saliva was constantly running, the right eye with an opaque and staphyломatous cornea (sight quite lost), and a considerable ectropion of the right lower lid, produced an amount of deformity which was certainly unusual in its extent. As the dense cicatricial tissue extended over the whole of the left side of the face, and along the forehead to the outer side of the right eye, and also partly involved the right side of the nose, and the skin immediately beneath the right lower lid, there was no healthy skin available for the formation of a flap, whether sliding or otherwise, and it appeared to me that there was only one operation which presented even the very faintest hope of success. The boy being placed under chloroform, I made an incision parallel with the edge of the left upper lid, as shown by the row of lashes mentioned before, and about a quarter of an inch above it, and dissected the remains of the lid well down over the eyeball. I then made a similar incision just below the edge of the lower lid, as evidenced by the lashes growing from the cheek, and dissected up the remains of the lid, until the two lids thus formed could be easily approximated, leaving a large raw surface above and below the eye, from which the bleeding was so free, that one or two small arteries had to be twisted. I then pared slightly the edge of each lid, and united them with two or three strong silk sutures; next, I cut off from his right arm, with a sharp triangular knife, a semicircular piece of integument, about two and a quarter inches in length, by one and an eighth in breadth, carefully cleaned it from all areolar tissue and fat, and secured it in the gap above the eye by means of four fine silk sutures. The flap for the raw surface beneath the eye was obtained from the forearm, and was about two-thirds as large as the flap from the arm. It was carefully cleaned of areolar tissue like the other, and fastened into its bed by means of five fine silk sutures. Goldbeaters'-skin was placed over both lids, and over this abundance of cotton-wool, which was kept in its place by an ordinary roller bandage. The outer dressings were changed at the end of four days, but the goldbeaters'-skin was not removed until the sixth day, when some of the stitches were removed from the flaps. The remaining sutures were removed two days later. Eleven days after the operation, the stitches which united the lids were removed, and the latter were found to be firmly grown together. On the following day, the lids were separated by means of a bistoury, when the cornea was found to be much improved in appearance. The dressings were gradually left off, but were not entirely discontinued until about a month after the operation.

The graft on the upper lid remains almost exactly the same in size as when first placed in its bed; and even now, four months after the operation,

its boundaries can be distinctly traced, from its colour offering a considerable contrast to the cicatricial tissue round it. The same remarks apply, word for word, to the graft on the lower lid, save that the outline of the latter is not so well defined, and that I think a part of it was lost by ulceration.

The ectropion of the upper lid has been completely cured by the operation, and the conjunctival surface is no longer exposed, not even when the patient looks downwards. In the lower lid, notwithstanding the presence of the large skin-graft, the deficiency of lid-tissue is shown by its still slanting downwards unduly, but this defect I hope to rectify at some future date by a similar operation. I must add that, in sleep, his eyeball is now quite covered, and that his cornea now presents a nearly normal appearance.

THE REDUCTION OF DISLOCATIONS BY MANIPULATION.

By J. H. ANDERSON, M.D.,
Surgeon, Royal Navy.

In the *Lancet* of May 7th, 1881, I read with much interest a letter by Mr. C. H. Greene, of London, on "Dislocation of the Shoulder-Joint, and Death from Chloroform," in which he recommended a plan for the reduction of dislocations, very similar to one which was first suggested to me by Professor Gordon, of Belfast, and which I invariably practised during the years 1869-71, when I held the appointment of house surgeon to a general hospital in a large manufacturing town in the north of Ireland, where all the serious accidents—and they were not a few—occurring among the working classes, were brought for treatment; and among them dislocations were of frequent occurrence.

I can remember only one instance in which the plan I refer to failed, and that in a very muscular man in whom the luxation—of the shoulder—was of nearly three weeks' standing.

In several cases the ordinary plans for reduction had been tried and failed, before or after admission; and one case, I remember distinctly, of subcoracoid dislocation of the shoulder-joint, in which the ordinary plans of "the heel in the axilla," etc., had been tried for nearly an hour, and without success, and which I reduced without any difficulty by manipulation. Another case, I can recall, of dislocation of the head of the femur on the dorsum ilii, in which the reduction was effected without any difficulty whatever, and with very little pain. In no instance have I found it necessary to use anæsthetics. The plan too is so simple that, after a little practice, the operator will find that he has little or no trouble in reducing any recent simple dislocation.

In order to make it as plain as possible, I shall now describe the mode of procedure, and take a case of dislocation of the right shoulder-joint as an example.

I placed myself on the same level as the patient, and on his right side, but in front of the limb, raised to a right angle, or higher or lower as I found most convenient, the elbow also being bent to nearly a right angle, and allowing the latter to rest on my left shoulder or upper arm, and using my left hand to steady the upper part of the arm, or control the scapula, if necessary, I inserted the tips of the fingers of my right hand into the axilla beneath, and to the inner and anterior or posterior part—according to the nature of the dislocation—of the head of the humerus, and, by gradually increasing pressure, lifted it quietly into the glenoid cavity, where I generally found it would go without much difficulty. If the bone got jammed at all, or the patient were very muscular, a slight amount of traction, with or without a little rotatory motion, or manipulation of the scapula with the left hand, I found would almost entirely overcome the difficulty; and the pressure on the head of the bone being continued, it would slip into its place. On the left side the treatment was just the same, the opposite hands, of course, being brought into use.

Dislocations of the elbow-joint I found most easy to reduce. I merely bent the patient's forearm on the arm to a right angle, or angle of 120°, and allowed his forearm to rest on my right forearm—in the case of a right dislocation, or on my left forearm—in the case of a left dislocation; or I supported the forearm with the inner fingers of both hands; and with the other fingers applied on the highest point of the bone dislocated upwards and backwards, and the thumbs on the lowest point of the humerus dislocated downwards and forwards, pressed the bones into their proper places. This dislocation can often be reduced by one hand only.

Although in luxation of the forearm backwards the coronoid process of the ulna is frequently broken off, it does not give any trouble. Other joints are treated on the same principle.

In the one case of dislocation of the hip, to which I referred, the man was brought in with the characteristic deformity of luxation of the head

of the femur on the dorsum ilii, and was at once placed in an arm chair in a semi-recumbent position. I requested an assistant to raise the foot off the floor to a height of about twelve inches, and to rotate gently, whilst I placed my fingers beneath the head of the bone, and lifted it towards the acetabulum, into which it slipped without any difficulty.

Having as briefly as possible described my mode of procedure, I shall now conclude by stating what I consider the advantages of this plan.

1. It is simpler and more easy of application than the ordinary plans, and can be adopted anywhere and at once, as no surgical appliances are required.

2. As a consequence of the latter, no injury need be done to the limb or the parts around the joint, as the dragging of pulleys, bandages, heel in axilla, etc., are liable to do, owing to the fact that the fingers are the principal means employed for employing force, and there the sense of touch serves us.

3. It is attended with very little pain to the patient, and anæsthetics are seldom or never required.

P.S.—Since writing the above, two short papers have appeared in the *BRITISH MEDICAL JOURNAL* on the subject of reduction of dislocations by manipulation; but neither of them appear to me to have the advantages of the plan above described.

CLINICAL MEMORANDA.

ENTERIC FEVER IN INDIA.

SOME of the readers of the *JOURNAL* who take an interest in the causation of enteric fever in India, so destructive to young soldiers there, who attended the section of military medicine and surgery at the International Medical Congress, held in London last August, may remember a paper read by me on this subject, and the interesting discussion which followed. Some of the highest authorities on tropical medicine took part in this discussion; prominent amongst whom were Drs. Norman, Chevers, Scriven, Ewart, Sir Joseph Fayrer, and Dr. Billings of Washington, U.S. My contention, both in the paper and in the debate, was: 1. That enteric fever is not a new disease in India; 2. That in innumerable examples, this disease has passed for the adynamic form of remittent fever, and in its mildest form is often included in military medical "returns" as "simple continued fever"; 3. That the diagnosis is often obscured by malarial complications, that this was so, particularly in the days preceding medical thermometry; 4. That the disease, as seen in India, is due to the same cause as in Europe, viz., pythogenic impurities, introduced into the system through the same channels as here—air, water, food. My contention under the last head was controverted in a very animated way by some of the speakers in the debate. What appears to me an important piece of evidence in support of my argument has just come to hand from a source above all suspicion of partisanship. Surgeon-General Sir Anthony D. Home, V.C., K.C.B., on the 8th of November, 1881, forwarded to the Acting-Secretary to Government Military Department, Madras, a report on the prevalence of enteric fever in the Madras command during 1808, compiled by Surgeon-Major Bidie, M.D., Statistical Officer, from which the following extract is taken.

"During the third quarter of the year, there occurred in the 2-13th Regiment at Kamptee twenty-seven cases of fever, of which eight were returned as enteric, and the rest as simple continued fever. Regarding the latter, it has to be observed that, from the description given, they appear to have also been cases of mild enteric fever, although the distinctive symptoms were not considered sufficiently marked by the executive medical officer to warrant his returning them under the head of enteric fever. The twenty-seven men attacked belonged to various blocks in the barracks, and no room seemed to be more obnoxious to the disease than another. The latrines were all in fair order, and no suspicion attached to them. The drinking-water supplied to the barrack-room was taken from a well specially conserved for the supply of drinking-water. This water was also carefully filtered. The milk also was beyond suspicion. After a time, it was noticed that nearly all the men attacked were 'teetotallers'. Of the eight cases of undoubted enteric fever, seven occurred in men belonging to this class; and of the nineteen attacks returned as continued fever, thirteen were in total abstainers. Further inquiry elicited the fact that the teetotallers had a recreation-room where tea, coffee, and aerated waters were supplied, and that the water used there was taken, not from the well set apart for drinking purposes, but from another close at hand, the water of which was considered fit for cooking purposes only. This well was situated close to the site of former latrines; the surface-drain from the washhouse passed within four feet of it, and, on closer examination, signs were discovered of percolation from the drain into the well. On