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