rection; and what I am concerned to assert is this, that nine out of ten of the practising part of the profession would most thankfully receive from this Society detailed *schemata* for the treatment of various typical forms of eye-disease. Let me further add, without, I hope, hurting anyone's feelings, that I feel sure that the use of them would tend immensely to the benefit of their patients, as compared with the extemporised prescriptions now employed. It is not in the power, even of the most laborious of those engaged in family practice, to keep their minds well stored with details respecting the management of diseases, which, although very common with us, are rarities to them.

I might easily mention a number of special types and forms of eye-disease, purulent ophthalmia, rheumatic iritis, episcleritis, catarrhal ophthalmia, glaucoma, and the like, for which definite schemes of treatment could easily be laid down.

It will, I have no doubt, be objected that, after all, successful treatment depends upon the correctness of the diagnosis. This statement is almost as obvious as was the famous injunction to first catch your hare. It is no reason that, because diagnosis is difficult, therapeutics should be left in a muddle also. I might urge, further, that I believe, working in the same lines, this Society might do much to put the diagnosis of eye-diseases more easily within the reach of British practitioners in general. There is no one present who has not been pained over and over again by having to treat cases of glaucoma which were brought to him too late. In spite of all that has been done by specialists, and in spite of the fame which iridectomy-cures have obtained, it is still the fact that a large proportion of cases of acute glaucoma are unrecognised during the first fortnight by those under whose observation the patients come. Practitioners of the most scrupulous care, of wide general information, and the most conscientious regard for their patients' good, are yet very commonly misled by the acute congestion and severe constitutional symptoms which often attend the early stages of this disease. It was my fortune, some years ago, to operate upon three cases of this kind in one week, in all of which the proper time for interference had been allowed to pass by, on account of the patient's severe general illness. In one instance, I became acquainted with the facts of a case, in which a benevolent country surgeon, aided by two or three friends, was himself maintaining a lady who had lost her sight, and consequently her occupation, from double acute glaucoma. He had himself attended her from the beginning; and when I gently hinted at the possibility—to me a practical certainty—that iridectomy at the proper time would have saved the lady's sight for the rest of her life, he promptly replied, "that the eyes were so much inflamed in the first instance, and the patient so ill, that he was quite sure I should never have thought of operating. I said no more; for it would have been cruel to tell him that these were the very symptoms which denoted the necessity for an operation.

Some years ago, in the early days of the keratome, I felt so strongly on this subject, that I had some thoughts of engaging a full page in a medical paper for a big red-lettered anonymous advertisement, so stating that all must read it, stating, in a dozen words, the symptoms and inevitable result of glaucoma, together with the certainty of its cure by operation. And now, looking back upon such impulses of enthusiasm, I do deliberately declare my conviction that a Society like our own would have been more than justified in taking such a step. At that time, acute glaucoma probably had, on British soil alone, its daily victim whom it left in irrevocable blindness. In the present day, the number has been greatly diminished, but it is still, no doubt, very considerable. Our confidence in the remedy which we then hailed has remained unshaken; and it is most certainly a very melancholy thought that there are thousands now living without sight who might have saved it very easily had there existed any efficient means for the rapid diffusion of the new knowledge.

I must not trespass further upon your patience in this matter. Briefly, what I desire to urge, is this: that we ought not to be content with doing our utmost to make knowledge perfect, and to secure its application in our own immediate spheres of action, but it is well worth a thought whether societies like our own have not duties to perform in respect to its diffusion. I will not for a moment, doubt that a subject so important will receive from you such attention as your judgments may deem it entitled to.

Is it too much to hope that something of the nature of a compendium of ophthalmic therapeutics may sometime be prepared, which shall bear the authority of a society's consensus? Such a code should, of course, be destined to modification from time to time; but it would probably, from the first, be a great advance upon the

statements of any individual, both in explicitness, in brevity, and in the amount of practical experience which it would summarise.

Should the Society see its way in the future to any action in this matter, much collateral advantage might be expected by the more detailed attention to therapeutics, which could be given by the committees appointed to report.

Had time permitted, I might have ventured to bring before you a few other suggestions, as to work which the Society might undertake collectively. Such, for instance, as systematic examination of symptoms, with the object of defining and describing them more accurately, of preparing detailed lists of the more rare types and forms of disease, and giving to each its concise description; and possibly, after this were done, of preparing nosological lists, which might assist the labours of hospital registrars.

CLINICAL LECTURE

TIBIO-FEMORAL IMPACTION: A NEW METHOD OF PERFORMING RESECTION OF THE KNEE-JOINT.

(Delivered July 13th, 1883.)

By RICHARD DAVY, M.B., F.R.C.S.,

Surgeon to, and Lecturer on Practical Surgery at, the Westminster Hospital and Medical School.

GENTLEMEN,—I shall endeavour to-day to interest you on an operation recently performed by myself on a patient in this hospital, and shall preface my lecture by some general observations on resection of the knee-joint, and then, concisely state the clinical facts relating to this special case.

Resection of the knee-joint was originally practised by Park of Liverpool, and especially promoted by the late Sir William Fergusson; it is now generally practised by operating surgeons, except in the case of young children. I myself do not adhere to this exception; my reasons will be given later on. It is somewhat strange that comparisons are still made between excisions of the elbow and those of the knee. The two extremities are diametrically opposed both in function, in operative detail, and wished-for result after the operation. Let me briefly point out some of the many differences. Fergusson pithily states that "the upper extremity is carried; the lower has to carry." One is the representative instrument of the most varied, delicately educated motion; the other, the columnar support in locomotion. The one is active; the other, comparatively passive. In the two operations—excision of the elbow and knee—the first is carried out by a longitudinal, the second by a transverse incision; the elbow-case is set up in the flexed, the knee in the straight position; passive movement is granted to the one, the utmost fixity to the other. And the wished-for result, after an excision of the elbow-joint, is free and complete mobility; after an excision of the knee, the surgeon's aim is absolute and rigid osseous ankylosis. The two extremes meet in common, surrendering the articular ends of their component bones, and leaving somewhat shortened limbs.

I place before you twenty-one cases of excision of the knee performed by myself in this hospital, showing the duration of treatment, the disease, and the results. As you all know, no special antiseptic precautions in the way of dressings are practised by myself; only those which, I trust, are ever at the hands of well-trained, clean, and careful surgeons. A hair-brush will remove discharge painlessly; but, in my opinion, the less a wound is meddled with, the better. By good luck, I have never lost a case of excision at the knee-joint, and have only been compelled to amputate once (Case 14). This man had extreme rectangular deformity of his knee; and bringing his limb down to the straight line apparently stretched his popliteal artery so far as to cause flattening of its walls and more or less obstruction to the circulation of his leg and foot. Gangrene supervened, and was checked by amputation so planned as to divide only the soft structures, which were left undivided by the previous excision.

My cases fully corroborate the views of Humphry and Pemberton, with regard to the non-symmetrical growth of the lower limb, after intrusion on the epiphyseal ends of the femur and tibia. The following is the history of my last case.

Susan Burls, aged 16, Brixton, was admitted into Percy Ward,

List of Cases: Resection of the Knee.

No.	Sex.	Age.	Admission.	Year.	Day of Operation.	Complaint.	Nature of Operation.	Days in Hospital.	Days after Operation.	Discharge.	Result.
1	Boy	13	May 23	1871	May 30	Disease of the right knee: genu valgum	Excision of internal condyle of femur	84	77	Aug. 15	Recovery.
2	Girl	2	April 15	1872	May 14	Deformity: left ankylosis	Excision of bony wedge	78	48	July 2	..
3	"	1	Feb. 24	1873	March 4	Deformity: right ankylosis	Ditto ditto.	149	110	July 23	..
4	Boy	8	July 21	1873	July 28	Suppuration of right knee-joint	Excision of right knee-joint	80	82	Oct. 18	..
5	"	4	Jan. 1	1874	Jan. 13	Suppuration of right knee-joint	Ditto ditto.	119	115	April 29	..
6	"	3	March 2	1874	March 24	Right fibrous ankylosis	Ditto ditto.	86	64	May 27	..
7	"	8	May 16	1874	May 19	Ankylosis: left deformity after resection	Excision of previously excised knee-joint	81	78	August 5	..
8	Girl	11	April 14	1875	May 18	Right chronic synovitis with deformity	Excision	110	76	August 25	..
9	Boy	14	May 25	1875	June 1	Right genu valgum	Ditto.	162	156	Oct. 28	..
10	Girl	4	Nov. 2	1875	Nov. 9	Strumous degeneration and right dislocation	Ditto.	110	103	Feb. 20	..
11	Boy	14	May 6	1876	May 9	Left deformity and ankylosis	Excision of the whole joint	72	69	July 17	..
12	Girl	11	March 6	1878	March 13	Right synovitis	Excision	76	69	May 28	..
13	"	9	Feb. 15	1878	Feb. 26	Right acute synovitis	Ditto.	92	81	May 16	..
14	Man	24	March 16	1878	March 19	Left rectangular deformity	Ditto.	54	51	May 9	..
15	Girl	15	June 20	1878	July 2	Right rectangular deformity	Wedge freely cut out	104	92	Oct. 2	..
16	Boy	5	Feb. 7	1879	Feb. 11	Dislocation: right old synovitis and necrosis	Wedge cut out	102	98	May 20	..
17	"	6	July 28	1879	July 24	Right synovitis	Excision	109	108	Nov. 15	..
18	Woman	30	May 16	1879	May 27	Left synovitis	Ditto.	63	52	July 29	..
19	Boy	6	Jan. 5	1880	Jan. 20	Left ankylosis	Ditto.	152	138	June 7	..
20	Girl	11	Jan. 14	1880	Jan. 27	Chronic right synovitis	Ditto.	68	55	March 23	..
21	Girl	15	Feb. 5	1883	Feb. 13	Deformity after resection, 1870	Tibio-femoral impaction	138	130	June 24	..

Osseous ankylosis occurred in all cases, excepting Cases 1 and 14.

under my care, on February 5th, 1883. In 1870, when three years old, she was admitted into St. Thomas's Hospital. Mr. Croft excised her left knee-joint for synovitis, set up by a fall on a greasy floor. She recovered; but, shortly after her leaving the hospital, her left leg was drawn back by the hamstring group, and by the superimposed weight of her body, until the back of the thigh rested on and touched the back of her leg. (A cast was shown of the deformity.) The patten on which she walked measured twelve inches; and she

and shaped the femur as a tenon; placed the femur in the head of the tibia, and applied direct pressure on the left foot, until impaction resulted up to fixity of tenure. The leg was placed in the splint here shown; and, without a single bad symptom, and without any dressings, the patient made a steady recovery. (Cast shown of the thigh and leg after operation.) She gained thirteen inches in height, and walks famously with a cork boot. My colleague, Mr. Macnamara, repeated this operation in my presence on July 14th, 1883; Mr. Macnamara's case had been a long sufferer, and her thigh had been condemned for amputation. She is yet in the hospital. The annexed woodcut shows well the result of the tibio-femoral impaction.

1. The tibia.

2. Wedge-shaped end of femur, driven into the head of the tibia, marked by a dotted line.

3. Shaft of the femur.

Tenon and Mortise.

We will now discuss the reasons for advocating tibio-femoral impaction in cases of resection of the knee; especially in cases of ankylosis, or relapsed cases. Let me impress on you two grand maxims bearing on this operation.

1. Maintain the bones in absolute fixity.

2. Do not meddle with the case from the day of operation until recovery is established.

By this new method of tibio-femoral impaction, osseous ankylosis (so to speak) is established before the patient leaves the operating table; and many surgical contentions are removed, such as the misplacement of the bones by startings, jerks, or inefficient bandaging. In Case XVII, the boy had convulsions for twenty-four hours after the operation; and, thanks to the sister's and my own bedside restraint of the ends of the bones, grating injury was partly prevented. The circumstance made a very forcible impression on my mind; and I consider that tibio-femoral impaction relieves the surgeon from this grave source of anxiety. I have constantly seen an excision case neatly and accurately adjusted on the operating table, displaced antero-posteriorly or laterally by the time the bedside is reached; due to the transit of the patient and involuntary spasm; and what surgeon worthy of the name has not felt a pang at so quick a secondary interference? Place your patient's limb at once in a swing cradle, hitching up the

had to stoop on the right leg to accommodate her left contracted one. On February 13th, 1883, I removed a rectangular wedge of bone from her femur and tibia, cut a mortise in the head of the tibia,

side-irons to a convenient height, and, so far as possible, in a position comfortable to the owner. The splint engraved above is a very excellent one for the purpose; fixing the knee, the foot, and the limb; with wide margins at the heel, ankle, and knee; it is capable of the most accurate adjustment. And then, do withhold your interference, either by dressings or readjustments. If your antiseptic dressings are potent enough to kill the supposed germs, they run a risk of killing your patient; cleanliness is all that is wanted; and, in my opinion, the only advantage gained by the antiseptic method is to remind the careless to be careful. There are some who accept the variegated light of a stained glass window, and clerical formalities, as accessories to religious fervour; there are others who can do their duty perfectly well without them.

Lastly, we must allude to the comparisons which are made between the remnant after an excision of the knee, and a stump after amputation of the thigh. In my judgment, decision must be given in favour of the remnant after excision, both in length of limb, utility, and even appearance.

Some surgeons say that the intrusion on the epiphyses in excision of the knee interferes with the growth of the limb, and that such dwindled limbs prevent their performing this operation on children. Does not amputation of the thigh, by one fell swoop, interfere far more with the growth of the limb? Is not even half a limb better than no limb at all? Tibio-femoral impaction secures osseous ankylosis, and prevents relapsing distortion; and is not a human foot at the end of an osseously fixed limb (shorten it as you please) the best finish? Does there exist such an enthusiastic machine-maker as will pit his contrivance, however ingenious, against his Creator's model? I protest, in the plainest English at my command, against any operator pruning a limb so as to fit the stereotyped patterns of any tradesman. And with reference to appearance, I have never yet seen a stump so graceful as to drown the floating thought "abruptly unnatural." Strip the two cases naked, excision of knee, and amputation of thigh; the former will be less likely to offend our senses than the latter.

I must take exception to a common error, quoted by Fergusson and other surgeons, in comparing the advantages of excision of the knee with an amputation of the thigh. Fergusson speaks of an amputation of the thigh as "a formidable operation which involved great risk to life, and included the actual loss of wellnigh *one-fourth* of the frame." Feeling how exaggerated this argument was, I took the weight of an emaciated woman (*post mortem*); then amputated her right thigh as high up as the trochanters permitted, and weighed the limb. I found the proportion in pounds was as 56 (the whole body) to 6 (weight of the limb); so that the proportion relatively is reduced from one-fourth to about one-ninth or one-tenth.

I trust that in these comments on resection of the knee I have pointed out a mechanical plan of treating these operations which will help to ensure success, prevent relapse, and render the operation available for young persons. The same method of impaction is applicable also to ununited fractures, and will, may be, lead to further improvement in the practice of our surgical art.

TWO CASES OF URINARY ABSCESS FOLLOWED BY FISTULÆ IN PERINÆO: PERINEAL SECTION: CURE: WITH REMARKS.

Read before the West Kent District of the South-Eastern Branch.

By F. BOWREMAN JESSETT, F.R.C.S. Eng.

CASE I.—J. B., aged 38, was, in May 1868, at a field-day, at Bangalore, in India. When attempting to jump a ditch, his horse refused, and he was pitched on to the pommel of the saddle, receiving a severe bruise in the perinæum and scrotum. This caused retention of urine, of which he took no notice for two days, when he was obliged to be carried to the hospital. At this time, there was extensive extravasation of urine into the scrotum and over the abdomen, extending as high as the umbilicus, the result of rupture of the urethra caused by the accident. He was placed under the influence of chloroform, and thirteen incisions made in the scrotum, perinæum, and abdomen. He remained in a very precarious state for some time; but, after several weeks, an improvement took place. The surgeon under whose care he then was, tried to pass a catheter, but failed; after this, the man became worse, but soon rallied, and shortly afterwards was discharged from the hospital, as he was getting low-spirited, and the surgeon thought a change would be beneficial to him. He was shortly afterwards invalided and sent home; during the voyage, all the wounds healed, and he arrived at

Netley Hospital, convalescent, on November 2nd, 1869. On December 14th of the same year, he was discharged from the hospital and the service.

In March 1871, a swelling formed in the perinæum, for which he went to St. Mary's Hospital; here the surgeon endeavoured to pass a catheter, but failed. He was discharged after being in the hospital for ten days. Some time after this, an abscess formed in the perinæum and broke, and urine escaped through the opening. This did not prevent him from continuing his work. He kept in much the same condition until 1875, when matters became very much worse; there was much swelling over the perinæum and scrotum. He then went into St. Bartholomew's Hospital, where he was treated with hot fomentations and poultices, and, after many trials, a No. 3 gum-elastic catheter was passed into his bladder. After six or seven weeks, he was discharged, being told "that nothing more could be done for him;" he was sufficiently improved, however, to enable him to return to his work.

In 1879, he again became very much worse, and was admitted into the Erith Cottage Hospital under my care. I endeavoured to pass a catheter, but failed. At this time, he had three fistulous openings in the perinæum and one in the scrotum. The tissues of the scrotum and penis were very much thickened. The prepuce was elongated and infiltrated, and he had a very tight phymosis, so much so that it was difficult to hit upon the orifice of the urethra. The urine dribbled away by the urethra, but the larger quantity passed through the fistula. I placed him under chloroform, slit up the prepuce, and endeavoured to pass a catheter, but failed. He was kept in bed for some weeks, and hot fomentations and poultices applied. As he refused to submit to any operation, he was discharged, much improved in health, and passing much more urine by the urethra, although I was still unable to pass an instrument.

In September 1880, he returned, and I found him in a sad plight; scarcely any water passed by his urethra, and that only in drops. He had four or five fistulæ in his perinæum and two in his scrotum. The scrotum and prepuce were enormously hypertrophied, and the latter was so inconvenient that I determined to remove it. He had an enlargement in the perinæum, of the size of a chestnut, behind which the chief fistulous opening existed; this lump was hard and felt of almost cartilaginous consistence. The man was much affected in his mind, owing to his infirmities; his clothes always being saturated with urine, he smelt so that his wife loathed him, and his fellow-workmen shunned him; his life was a burden to him, and he got so low-spirited, that he often felt inclined to make away with himself. He now begged me to do anything for him I thought best. He had a tight stricture at the orifice of the urethra, and the whole canal was thickened and rough as far as I could pass an instrument.

After a good dose of aperients, on September 22nd, I had him placed under chloroform; and first removing the prepuce in the ordinary way, I passed a grooved staff as far down as I could. I had him tied up in lithotomy position, and made a free incision in the middle line of the perinæum down to the point of the staff, dividing the urethra upon the groove of the instrument, and bringing the point out through the wound. I then, keeping in the middle line, carried my incision freely and deeply, dissecting along the course of the urethra, when I came without difficulty upon the dilated end of the urethra on the cystic side of the stricture. Then, passing a No. 10 silver catheter in the place of the grooved staff, I, by means of a broad grooved director which I passed into the bladder through the wound, conducted the catheter into the bladder, and tied it in. The patient was then returned to bed, and given a full dose of opium.

I did in this case what I always do when having to tie a catheter into the bladder, that is, I fastened a long piece of India-rubber tubing on to the end of the instrument, and conducted it into a vessel under the bed. This I find in practice most useful; it saves an infinity of trouble to oneself and nurse, and inconvenience to the patient, besides having the advantage of always keeping the patient's linen sweet and clean, the bladder empty, and thus giving the wound a much better chance of healing.

After the operation, the temperature rose to 100°. He had no rigors, and in three days all the urine passed by the catheter. On the eighth day, I withdrew the catheter, and he passed a good stream of water by the urethra without pain or trouble, a very few drops passing by the wound. On the eleventh day, this had completely ceased, and the wound healed rapidly. An instrument was passed for him from time to time; and a few months ago I saw him, and he was quite well, there was no appearance of sinus, and he passed a good stream of urine.