CLINICAL NOTES IN THE PARIS HOSPITALS.

By ERNEST HART.

V.

HÔPITAL ST. LOUIS: OPERATIONS AND CLINICAL DEMONSTRATIONS BY M. PÉAN; THEIR METHOD, MANNER, AND SUBJECT.

Cases of Fibro-Sarcoma of the Scapula; Chronic Hip-Joint Disease.

THE leading surgeons and professors of the French Hospitals have the advantage, for the most part, of very complete arrangements for teaching; the complete control of a highly-skilled staff of *internes*, who serve for three years, and when they are professors of the Faculty, of *chefs de clinique* of thorough training and proved high accomplishment (who serve for five years); their own operation theatre attached to their wards, in which they perform a whole series of operations on their clinical days, uninterrupted by the intervening operations of any other surgeons. There is a staff of nurses, and dressers trained to the methods and special views of the surgeons, so that whatever there is of individuality in the views and methods of the operator, and whatever is special to him in his dressings and instruments, may always be found thoroughly carried out. The surgical services, too, are generally larger and more active than those in the London hospitals; and the training of the surgeons who have passed through a long course of competitive examinations extending up to, and often beyond, the age of 30, and even into middle life, has accustomed them to the art of teaching in a logical and systematic manner. As a rule, in an active surgical clinic, half-a-dozen operations may always be seen performed in succession, and each of these is illustrated by a short preliminary discourse, explaining the grounds for the diagnosis, the surgical and anatomical relations, and the steps of the operation about to be performed; at each stage of the operation, and while operating, the surgeon explains his procedure, or any modification of it which he finds necessary to adopt; and at the close of the operation he describes the result attained, and comments on the course of events. The French hospital surgeon or professor is trained to this end from his earliest career. Unless he is capable of lucid, orderly, and thorough exposition on almost any subject within the range of his art, he can never hope to survive the numerous competitive trials of the kind which he has to pass through at each successive grade of appointment, from that of *interne* to *chef de clinique*, *chirurgien du bureau central*, *agrégé*, etc. No man who was not laborious, studious, conscientious of ability, and capable of the rapid improvisations and dissertations required at every stage, would embark on a career which demands an average of at least ten to fifteen years of continuous work and preparation, and even then only the fittest survive. So that the surgeons, lecturers, and professors can at least all of them operate, lecture, and teach with approved skill and trained powers of exposition and large resource in acquired knowledge of the academic as well as the practical kind.

The surgical service of M. Péan at St. Louis is one of the most active in Paris, and his operating days in the amphitheatre attract a large number of students and of practitioners whose attendance is rewarded by a fluent and instructive clinical commentary as well as brilliant operations which include methods of proceeding, many of them invented and most of them modified by this able and eminent operator. On the day on which I was present in the theatre of St. Louis in the middle of the Christmas vacation there were fewer students than usual, but the cases for operation were as usual numerous, and the whole proceedings were sufficiently characteristic of the special features of the clinical and surgical teaching in the operating theatre to make me think that a pretty full report of the day's work would be of interest as illustrative of a highly instructive method of operation and of demonstration.

CASE I. *Primary Fibro-sarcoma of the Scapula, extending to the Muscles inserted into the Spine of the Bone; Removal by the Piecemeal Proceeding (Morcellement); Resection of the Muscles Invaded.*—M. Péan, addressing the students before proceeding to operate, said: "Gentlemen,—I have to present to you a

patient affected with primary sarcoma of the scapula. In a service so large as this we are sure to encounter at more or less distant intervals tumours of this kind. However, examples of these neoplasms are sufficiently rare to make it easy to count all the cases which are published. Of all the malignant tumours of the scapula which we have had occasion to observe, that is to say, of those which are not inflammatory, such as simple tuberculous or syphilitic osteitis, sarcomata have been most frequent. Then come enchondromata and myeloid sarcomata. This agrees with the statistics which have been published by various authors. In 1873 Demandie for his inaugural thesis collected 63 operations for tumours of the scapula; Chauvel, in the article "Scapula" in the *Dictionnaire Encyclopédique des Sciences Médicales*, adds nine new cases, making in all 72 cases, as follows: exostoses, 8; enchondromata, 14; fibroplastic tumours, 5; myeloid sarcomata, 3; sarcomata, 12; carcinomata, 23; undetermined, 7. These authors remark that tumours published under the title of cancer or carcinoma are most often soft sarcomata composed of small cells, so that the proportion which these statistics would seem to indicate is in reality much higher in respect to sarcomata. Moreover, fibroplastic tumours have been separated from sarcomata, although they belong to the same family, and myeloid sarcomata are also closely allied to them. The most complete study of this subject has been made by Dr. de Langenhagen, who made it the subject of his inaugural thesis in Paris in 1884. Paul Sendler¹ has recorded a case of sarcoma of the scapula for which he performed total extirpation of the bone. The patient died fifteen years afterwards with a recurrence in the cicatrix. K. Doll, in the same serial, reports two cases—the one a fasciculated sarcoma in a man, aged 41; the other an embryonic sarcoma in a girl, aged 14. About the same time was published a case of colossal enchondroma of the scapula reported by Dittel to the Medical Society of Vienna in 1883. The frequency of sarcoma of the scapula is not surprising, for of all non-inflammatory tumours of the skeleton sarcoma is, for some reason which it is not possible to explain, the most usual. This relative frequency explains to you why, finding in our patient a tumour which springs from the scapular spine, and which has extended to the neighbouring muscles, we were led to suspect that it is rather sarcomatous than enchondromatous or osseous. Our diagnosis is, moreover, confirmed by the physical signs characteristic of these tumours; these are their peculiar consistence, their undefined limits, the lancinating pains, and the rapidity of their progress—signs which differ from those of enchondromata, of which the progress is slower, the surface less extensive, more lobulated, more elastic, more circumscribed; and also from those of exostoses, which are harder, and, like enchondromata, push back the neighbouring organs rather than invade them. In our patient the two principal lobes which compose the tumour are united together, although at first the one appears to be bony, the other muscular. But although they have a different consistence there seems no doubt that they have a common origin in the scapula. We shall have recourse to an exploratory incision in order to ascertain their exact extent, and as this incision is equally indicated for surgical treatment we shall make it large enough to enable us to remove the whole tumour. It is unfortunate that the surgeon who performed the primary operation some months ago did not follow this course and contented himself with making a small vertical incision which did not permit him to circumscribe the whole tumour. You will see, gentlemen, that we circumscribe the anterior border, the angle, and the interior border of the shoulder blade by a long curved incision, convex below, which divides the skin and cellular tissue and passes posteriorly through the old cicatrix in order not to multiply uselessly the marks of operation. We now dissect back the integuments from below upwards like a flap, and we lay bare the muscles which cover the posterior surface of the shoulder blade. We recognise that this flap is movable in every direction except at the level of the posterior part of the scapular spine; at this point its deep surface is adherent to the diseased tissue to the extent of 3 centimetres. At this point, before proceeding with the removal of the tumour, we begin by resecting all the suspicious part of the flap. Recognising now that the scapular spine is attacked throughout its length, and that it was it which was

¹ *Archiv f. klin. Chir.*, xxxviii, Heft 2, p. 300.

the point of departure of the portions of the tumour which invaded the trapezius, subscapularis, and rhomboidei muscles, we resect in fragments the whole of this portion of the scapula with our cutting forceps. It is about the size of a fowl's egg. We next remove with bistoury and scissors all the muscular portion, which is of about the same size and which comprises an important part of the trapezius, subscapularis, and rhomboidei muscles as far as the posterior border of the scapula. The whole of this removal is rapidly executed, thanks to the temporary compression of the divided vessels with forceps, which makes ligatures unnecessary. We now pass a drainage tube to the bottom of the wound, fix it to the skin with a suture, according to our custom; we unite the edges of the skin by closely placed hair sutures (*crin de Florence*). The whole is covered with an antiseptic dressing. Everything which has touched the wound, instruments, dressings, water, sponges, ligatures, all have been rigorously antiseptised. We always obtain union by first intention in those vast losses of substance, however wide and deep they may have been, and this all the more surely that we are careful to change the dressings only at long intervals. You have seen, gentlemen, in this patient the advantage which our method of compression of the vessels by bulldog forceps gives—a method which enables us to dispense with ligatures—and also how the removal of the tumour piecemeal with cutting forceps allows one to operate rapidly without encroaching on healthy tissues. The tumour has been removed in less than fifteen minutes, and the patient has hardly lost any blood."

NOTE.—The histological examinations made by MM. Brault and Cornil confirmed the diagnosis; the case was one of hard fibrosarcoma rich in cells. The cells were of two kinds, the most numerous belonging to the fusco-cellular type; the others polyhedral, with two or three nuclei. Experience has shown how rapidly such tumours progress and how advisable it is to remove freely all suspicious parts.

The next case was of a more ordinary character, but not less interesting in respect to the operative proceedings carried out and of the careful explanations given prior to and throughout the operation while in progress. It was a case of old hip-joint disease, and was as follows:—

Old Hip-joint Disease, Suppurating, Complicated with Dislocation Upward and Backward, and Ankylosis; Relapse after Fifteen Years of Apparent Cure; Abscess and Multiple Fistula; Partial Resection of the Head of the Femur and of the Nearthrosis; Reduction of the Dislocation.—Before commencing, M. Péan said to the students: You will recognise at first sight that this patient is suffering from old hip-joint disease, suppurating, complicated with dislocation at the head of the femur, and that the fistulae, the atrophy of the muscles of the thigh, and the considerable shortening of the limb, which is to the extent of 6 centimetres, are the consequences of it. This man is 25 years old. His disease first showed itself when he was only 4 years old, and lasted then for six years. It was during that time that dislocation was produced. Subsequently he thought himself cured, but it was not so. In 1890 in the month of March new abscesses appeared at the hip, opened, and left fistulae. Lately the physician who is looking after him recognised that the bases of the two lungs had become tuberculous, notwithstanding the most rational medical treatment. Is this the usual course of coxalgia? Yes for a certain number of patients; no for some others. Experience has shown that this sort of disease progresses in a manner which varies with each subject. Happily most of those which are suitably treated at the outset recover by repose, the use of cutaneous derivatives, complete immobilisation of the limb, together with general treatment properly directed; but there are some who do not recover under these conditions, not even when the patients belong to the well-to-do class. This is especially the case in those who are predisposed by a bad state of health, hereditary or acquired, to local tuberculous fungosities, abscesses, pulmonary, meningeal, or laryngeal phthisis, etc. In others again, such as our patient, local suppuration declares itself anew and pulmonary tuberculosis occurs when care of the first affection seems to have been obtained, and this new complication shows itself sometimes under a recognisable influence, sometimes without appreciable cause. The return of the abscesses is always troublesome. In our patient you will see that in spite of the most methodical treatment they have

exhausted his strength and led to the development of pulmonary phthisis in the first stage. It is necessary then as soon as they are recognised to hasten to treat them by the methods most favourable to cure, to incise them, clean them out, and leave india-rubber drains *in situ*, which serve for the use of antiseptic dressings at the same time that the region is immobilised. If there are only abscesses in the neighbourhood these means may suffice, but if they are symptomatic of profound changes of the articular surfaces more must be done. Is it easy when the abscesses have been spontaneously or artificially opened before the surgeon has been consulted (and this is the case here) to diagnose what is the state of the synovial membrane, and of the bones of the new and of the old articulation, to recognise if it is the iliac bone, the neck or the head of the femur, which have been primarily effected, and to know what are in such cases the importance and the extent of the lesions? Assuredly not. All that can be affirmed is that for the most part cases of hip disease which end in dislocation, ankylosis, and which relapse at more or less distant dates, are found in scrofulous or tuberculous subjects, and that in them the disease early shows itself by fungosities, which take origin in the synovial membrane more often than in any other constituent part of the articulation. But even when the synovial membrane is destroyed, the femur dislocated, and the stilette and the finger have been introduced into the fistulous track, it is almost always impossible to say *a priori* what is the state of the tissues which have been primarily and secondly invaded. In our patient the stilette may be introduced into several fistulae, but it is always stopped in the muscular interstices without its being possible to reach the articular surface. This is so in most cases. Only an exploratory incision which is necessary for the treatment can show what is the exact state of the synovia and the bones in the old and new articulations. How should this incision be made? Should it be vertical or horizontal, single or double? I prefer to make a cutaneous flap convex at the lower edge, such as I make in almost all resections. For this purpose we make two vertical incisions, one in front, the other behind the great trochanter, and we unite them by a curvilinear incision with convexity downwards. These incisions divide only the skin of the subcutaneous cellular tissue; they allow us to dissect it from below upwards, so as to form a flap which we have raised towards the base. In the present case this method is clearly indicated by reason of the multiplicity of the existing complications. You see that under this flap it is now easy for us to recognise the relations of the bones and muscles at the level of the nearthrosis, and to detach the muscles inserted into the great trochanter by following their borders. You see also that the trochanter forms a too prominent projection, as happens whenever the head of the femur is dislocated, when the articular surfaces are ankylosed, when the muscles are atrophied, and cover a deep part of the fistulous tracks which pass through their interstices. You recognise, also, that the grooved sound, sufficiently long and introduced by the cutaneous orifice of the fistula situated below and behind the great trochanter, passes below the gluteal muscles, turns round the posterior borders of the trochanter and the superior surfaces of the neck; that this long track is filled with pus and with fungosities of tuberculous aspect; and that it is bound down to the periosteum of the ilium very near the coxo-femoral nearthrosis. Thinking that the periosteum and bone are diseased under these fungosities, we scrape them away; it is not so. You will see that the periosteum and the bones are normal, as if the fistulous track was only the result of the neighbouring abscess. But as the presence of the nearthrosis sufficiently indicates that the articular surfaces had been primarily invaded, we may affirm *a priori* that they are still diseased. This opinion, as you see, is confirmed by our now having discovered a large invaded field with creamy pus on the inside of the head of the femur at the point at which it is ankylosed to the iliac bone. Accordingly, after having resected with a saw the superior part of the trochanter, and having removed it as well as the muscles which are inserted in it, we resect in fragments with my large and strong cutting forceps the superior face of the neck and the head of the femur. We see now the latter as well as the portion of the iliac bone which it includes is filled with very old black and purple fungosities. We removed all suspicious parts with

my cutting forceps (*pince emporte-pièce*). We find now externally and behind the neck another fistulous track with pus, which loses itself in the midst of the adductor muscles. We scrape this also in such wise as to leave only healthy tissue. The resection of the osseous surfaces having abolished the ankylosis, we bring the neck—of which we have been able to preserve the healthy part—into contact with the old cotyloid cavity, and we fix it there by two loops of metallic wire. We place there a drainage tube, fastened by a suture of Florence hair at the bottom of the wound at its lower part, and then we suture the divided muscles by means of separate catgut sutures, of which we cut off the ends close to the knots. We conclude by closing up the skin flap with separate sutures of Florence hair, and we apply an iodoform and sublimate dressing with a large compress of cotton wool and a bandage. You see, gentlemen, that notwithstanding the number and importance of the vessels which have been divided in the course of this operation, it has been sufficient to employ temporary hæmostasis by forceps which we have now been able to remove without using any ligature, and the patient has not lost blood either during or after the operation. This favourable circumstance, joined with the care which we have taken in removing the pus and suspicious tissues, explains how easily we obtained a prompt cure and union by first intention. This, in fact, was what happened in this patient. Not only was a favourable result obtained without febrile reaction, but appetite and strength rapidly improved, and the pulmonary tubercle retrogressed so rapidly that there is reason to hope for good result on this side also. The other cases which were operated upon were two interesting cases of lipoma, one subcutaneous in the popliteal space, one deeply submuscular in the upper and outer region of the thigh. A remarkable case of sero-sanguineous cyst of the temporal region in a woman aged 48 was also operated upon. In all three cases the operation was preceded by an interesting detailed and critical discussion on the question of diagnosis, and the customary seats and varieties of such affections, the anatomical condition, and the state of science in respect to the knowledge of them. The operations were then performed under the eyes of the students, with a running commentary throughout as each stage of the operation proceeded, and the wounds closed under the same aseptic precautions as had been observed throughout.

[I regret that space will not allow me to transcribe here the full notes which I have of the clinical observations of M. Péan. In all these cases M. Péan employs free incisions and uses a large number of his hæmostatic bulldog forceps, which enable him almost invariably to dispense with ligature, and which prevent the flow of blood during the course of the operation, so as to enable him to dissect with almost as much ease as on the dead body. He makes very free use also of the forceps by which he removes tumours of all kind and bone tissue by a process of *morcellement*, which is almost peculiar to himself, but which is very effective and makes the operations rapid and complete, with much less disturbance to the surrounding tissues than is often necessary by the customary methods. There are always a great number of visceral operations in M. Péan's clinic and in his private hospital which are well worthy of the study of those interested in abdominal surgery. His method of proceeding is rapid, bold, and often original. The whole cases under his care are carefully reported by the clinical clerks, and the statistics of the surgical service, published annually in what now constitutes a series of volumes, give very favourable results, and constitutes an important body of surgical literature, such as few other clinics can well produce.]

IRISH DISPENSARY DOCTORS.

WHOLESALE SIGNING OF TICKETS.

THE Council of the Irish Medical Association has called the attention of the Local Government Board to a case of abuse of the law in connection with the issue of red tickets in the Castlereagh district of the Belfast Union. It appears that, in reply to an inquiry by one of the members of the Committee, the Local Government Board has written to say that:

"A medical officer is bound to attend on all medical relief tickets presented to him, signed by any person authorised to issue such tickets, and it is not necessary that the particulars in the body of the ticket should be in the

handwriting of the person signing it." The Council entertain the hope that this statement, which seems to be at variance with the Act of Parliament, with the regulations made thereunder by your Board, and with all previous declarations of the opinion of your Board on the subject, has been made inadvertently, but, if not, they most respectfully protest against it for these reasons, and also because it would afford official authority for the wholesale abuse of the medical relief by the vicarious issue of tickets. The Council beg to refer to a letter addressed by them to your Board, on August 17th, 1878, which resulted in the issue by your Board of a circular dated August 31st, 1878, in which the following appear:

"1. A practice on the part of persons who are legally authorised to issue tickets for medical relief of signing blank medical relief tickets *en bloc*, leaving them to be filled up and issued by other persons.

"In regard to the first of these irregularities, there can be no doubt that the practice is not only contrary to the dispensary regulations, in regard to the issue of tickets for medical relief, but is also at variance with the provisions of the Medical Charities Act, the 9th Section of which empowers certain persons, therein described, to afford medical relief by tickets addressed to the medical officer, but does not contain any provision authorising the persons empowered to issue tickets to delegate that power to other persons."

The duty imposed by the law (14 and 15 Vict., cap. 63, sec. 9) upon the medical officers is "to afford advice and medicine, or to attend any poor person resident" in the district to which an authorised person shall have issued a "ticket in such form as the said Commissioners shall prescribe." Under the authority of the same Act, the Commissioners have prescribed as follows (directions for filling up medical relief tickets): "The ticket and counterpart are both to be filled up by the persons authorised to issue the ticket. Care should be taken in the issue of tickets accordingly, and the christian name and surname of the applicant should be inserted in the ticket in full, obviously by the authorised person." It is scarcely necessary for the Council to repeat their contention that the purport and object of Parliament in making the law above quoted, and of the Poor-law Commissioners in wording the regulations was to impose upon the issuer of the ticket the duty of himself considering the circumstances of the applicant before extending to him the relief provided exclusively for poor persons. Nor can it be necessary for the Council to inform your Board that by laxity in the enforcement of this law the grossest abuses of medical relief have become notoriously prevalent, books of tickets being signed *en bloc* by the issuer, and distributed indiscriminately to all comers by third parties, who have no authority whatever under any law to do so. The Council have long been aware that, so far have these abuses extended, medical relief tickets are made habitually the subject of traffic by shopkeepers, who place the signed book of tickets in the hands of the shop assistant on the understanding that they are to be issued to customers; and they are so issued, without any pretence of inquiry as to the fitness of the applicant to receive them.

The decision here given is directly opposed to what the Local Government has declared to be the rule, and we cannot but think that it is due to an imperfect consideration of the circumstances. If it should be maintained, then the Local Government Board will open still wider the way to the continuation of the gross frauds which are committed under the medical relief Acts at present. The Legislature never intended that free medical relief was to be given "in" with the groceries by every person who wished to secure a large trade.

THE NEW MILITARY WEAPONS AND EXPLOSIVES.

By SIR T. LONGMORE, C.B.,
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THE following observations have been forwarded to Geneva by Sir Thomas Longmore, in support of a proposal to consider, at the approaching International Congress of Red Cross Societies at Rome,¹ whether any modifications of existing field hospital arrangements, particularly as regards volunteer aid, are required, owing to the general adoption of the new weapons and explosives in armies, and if any are thought to be needed, in what directions, and to what extent they appear desirable.

Sir T. Longmore remarks: The recently introduced magazine small-calibre rifles and their compound projectiles, together with the new explosives applied to them, will exert so serious an influence on the results of future wars, that it is only prudent to consider well beforehand in what way, not only the arrangements of the official army medical services, but also of the supplementary Red Cross Service, will be affected by them.

In general terms, the following effects may be anticipated to result from the new weapons and explosives:

1. In consequence of the enormous initial velocity impressed by the improved firearms on the projectiles discharged from them, the destructive energy of the new rifle bullets, notwithstanding a certain diminution in their weight,

¹ The date fixed for the opening of the Congress is April 21st, 1892