A METHOD OF OBTAINING RAPID HEALING OF ACUTE ABSCESES.

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FOR seven or eight years past my partner, Dr. Handcock, and I have been treating acute abscesses systematically by a method which, although not at all original, has probably been used more regularly by us than by most medical men; it possesses advantages which perhaps make it worth while to describe it here.

The method is based on the theory that if all the dead material in a localized abscess is removed, and means taken to prevent the collection of further dead material in the abscess cavity to act as a culture medium, rapid healing will take place.

"In union by the first intention," says Erichsen, "after the surfaces of the wound are brought into apposition and put at perfect rest, every source of infection is absent, and consequently inflammation, with its accompanying exudation, ceases as soon as the injured tissues have recovered from the . . . injury. In wounds which unite by granulation there is always some source of irritation present which continues to act for a considerable time after the injury, and thus gives rise to a prolongation of the inflammatory process with the formation of pus."

My contention is that in almost every case of acute abscess there need not be left any "source of irritation" to "continue to act for a considerable time" and that unless dead bone or some other irremovable irritant is present, something not unlike primary union can be obtained.

METHOD.

1. Cleanse the skin as in operating on sterile tissues.
2. Make an incision long enough to permit of the pus being freely evacuated and the pyogenic membrane rubbed clean and smooth with gauze wrapped round the finger.
3. Having emptied the abscess cavity as completely as possible, pack it tightly with gauze (we use 1 in 1,000 mercury perchloride gauze, dry) and apply a wool dressing and bandage as firmly as possible.
4. At the end of forty-eight hours remove the packing and dress the wound as if it were a simple incision; that is, do not pack or drain at all, but simply fix a gauze and wool dressing firmly in place with a bandage. This dressing will require changing only once in three or four days until the incision is soundly healed, and it will be found that the sides of the abscess cavity unite promptly and that there is no outpouring of pus from it. From the time when the packing is removed it is practically a simple incised wound that is being treated.

Illustrative Cases.

CASE I.—In January, 1907, I was asked to see the sister of a medical man, who, following influenza with throat symptoms, had developed an abscess in the neck. Under ether an incision was made in front of the sterno-mastoid, and on burrowing beneath that muscle two or three ounces of pus were evacuated. The cavity was rubbed clean with gauze and packed tightly. Two days later the packing was removed and a superficial dressing was applied. The temperature never rose after the operation; the patient almost at once felt quite well; there was never any discharge of pus and the incision healed quickly and perfectly.

CASE II.—Mrs. W. was seen on May 9th, 1907, and then had a right mastitis, and as on May 16th there was certainly pus present, the breast was incised under ether, the pus let out, loculi broken down, all debris cleared out, and the cavity packed tightly. The temperature at once dropped from 103° to normal, and did not rise again. The packing was removed on the second day and a simple dressing applied. Next day the patient was attending to her household duties with her right arm in a sling; she felt well, and was eating ordinary diet. The wound was looked at two or three times until the incision was firmly healed.

CASE III.—Mrs. G., who had suffered from anal pain for several days, was found on October 20th, 1907, to have a perirectal abscess. Under ether the sphincter ani was stretched, and the abscess found to extend upwards some 2 in. or 3 in., burrowing between the rectum and vagina. It was opened by dividing the sphincter freely, cleaned and tightly packed. On going to remove the packing forty-eight hours later, it was found that the patient had had a motion and that the packing had come away. No more packing was used, but a daily sitz bath and a perineal pad of boracic wool were ordered. On examining the parts on the ninth day, the cavity was found to be completely closed, and only a superficial

ulcer, about 1½ in. by ¼ in., remained, which had healed in another week. The patient was in bed only six days after the operation.

CASE IV.—In cases of small abscesses, general anaesthesia is not required. Mr. C. attended at the surgery on November 28th, 1907, with an ulcer inside the left cheek, produced by the sharp edge of a carious tooth. The skin of the cheek was red and indurated. The tooth was removed and the ulcer soon healed, but a small abscess developed and pointed externally. On December 7th, 1907, the skin was cleaned and anaesthetized with a streak of pure carbolic acid and incised. The pus was squeezed out and the cavity packed with gauze, which was fixed with strapping. The gauze was removed after forty-eight hours and not replaced, but a simple gauze dressing was applied, which was changed by the patient every morning after his toilet. There was no discharge, and the incision was soundly healed in a week.

At my suggestion, the infirmary residents have treated cases similarly. Here are notes of two cases.

CASE V.—E. B. was admitted to the infirmary on November 4th, 1907, suffering from an acute glandular abscess in the femoral region. Mr. McEwan incised it, rubbed it clean with gauze and packed it tightly. Two days later the packing was removed and a simple dressing applied. Practically primary union took place, the incision being looked at only on two other occasions—namely, November 13th and 15th. The patient was up on November 20th, and after the first dressing the temperature never rose above 99°, or the pulse over 84.

CASE VI.—Mrs. C. was admitted to the infirmary on January 6th, 1907, under the card of Mr. Horrocks (whom I have to thank for permission to quote the case). She was suffering from puerperal pyaemia; her temperature was 102.2°, and pulse 118. Both forearms were red and swollen, being practically bags of pus. There were similar but smaller abscesses over the left tibial tuberosity and the left buttock. Under ether Mr. McEwan evacuated all these and scraped them out with gauze and tightly packed them. His note says "the amount of pus evacuated was remarkable for its quantity." The packing was removed two days later (January 8th). On January 10th another abscess formed, and had to be emptied and packed. Mr. McEwan appears from the notes to have repacked the abscess cavities every second day for some time, which I think was probably unnecessary; but, even so, the patient was disturbed only once in forty-eight hours instead of every four hours, as in the treatment by fomentations. From January 26th, when the septicaemia appears to have expended itself, the temperature remained about normal, except for a couple of days after the patient was allowed up. She was discharged cured on March 16th.

We claim for this method that it results in rapid healing; that constitutional symptoms are got rid of almost at once; that as the dressing requires doing so seldom the doctor can do it himself and so avoid the risk of a secondary mixed infection, of which one has seen some ghastly examples where the patient's friends have been doing the dressings; and that it effects quite a marked economy in dressings—just think what amount of dressings would have been required had the pyaemic patient I have quoted been on four-hourly fomentations instead of the dressings which were used!

TUMOUR OF THE ORBIT REMOVED WITHOUT ENUCLEATION AND WITHOUT LOSS OF SIGHT.

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As the reported cases of removal of tumours from the depths of the orbit without enucleation and without removal of the outer bony wall of the orbit (Krönlein's operation) are rare, and with the retention of useful vision still rarer, the following case is of some interest.

History.

Mrs. G., aged 24, married, consulted me in November, 1895, on account of gradually-increasing prominence during the previous three years, with loss of sight, of the right eye. Her general health was good. There was no history of injury, no pain or tenderness, no enlargement of the thyroid gland nor of any of the cervical glands, no bruit, no cardiac signs; the pulse was normal. There was well-marked proptosis of the right eye, the eye being pushed directly forwards. The movements of the eye were fairly free in all directions, and the lids just able to close over the cornea. Pupillary action was normal. Right vision was reduced to perception of shadows. Left vision ½ and J. 1.

Ophthalmoscopic examination showed the media clear and some congestion of the optic disc. The field of vision was not taken.