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Hospital Reports.

BRISTOL GENERAL HOSPITAL.

CASE OF EXCISION OF THE OS CALCIS: RECOVERY.

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[Read at the Meeting of the Bath and Bristol Branch, April 24th, 1856.]

CASE. William Senyer, a pale, weakly-looking man, consulted me August 15th, 1854, for an affection of the right foot, the result of an injury received some time previous. He gave me the following history. He was 34 years old, a blacksmith. On the 23rd November, 1851, he fell about eighteen feet into a ship's hold, when he pitched on both his feet and right hand. He was able to move about for a few days after the fall, but then began to suffer from pricking and shooting pain in the right heel, accompanied with swelling. He was treated for rheumatism, without any reference to his fall. In three months, an abscess broke in the back part of the foot, which after a time healed, but it soon broke out again, and then went on for some time healing and breaking out alternately, the foot always becoming more swollen and painful after the closing of the external wounds; at length the openings became permanently established. He has never been able to move about except on crutches, since a few days after the accident. He has been under the care of different surgeons, who each advised him to have the foot removed.

On examining the foot, I found the soft tissues round the heel, and in the neighbourhood of the ankle-joint, very much swollen, and of a brawny hardness, as if from fibrinous effusion into the areolar tissue; also the openings of two sinuses, one under the outer ankle, the other more posterior, near the tendo Achillis; they both led to dead bone in the os calcis, which I ascertained to be extensively diseased. The irritation appeared to be propagated upwards towards the ankle-joint, rather than forwards towards the other tarsal bones. The ankle-joint, however, was free from any serious lesion; but of the condition of the astragalo-calcaneal joint I was not so certain.

I recommended excision of the calcaneum, and that without delay. He at once consented, and I admitted him into the Bristol General Hospital on August 17th.

August 22nd, I removed the bone, with the concurrence of my colleagues. On September 17th, he was dismissed, well, with the exception of a minute opening, which discharged a scarcely appreciable quantity of pus.

In six weeks from the time of his leaving the hospital, he gave up one crutch; in six weeks more, he threw away the other, and used only an ordinary walking stick. He can now (a year and eight months after the operation) walk more than ten miles a day without inconvenience, and with very little perceptible peculiarity in his gait.

Though pleased to be able to show so successful a case of conservative surgery, yet my principal reason for bringing it under your notice is to draw attention more particularly to the operative proceeding adopted, as I have now found, from the experience of three cases (I hope to bring the other two before you at some future time) that

that mode, or some trifling modification of it, gives the power of removing with comparative ease either or both of the posterior bones of the tarsus, together with the ankle-joint, without inflicting any injury on the numerous tendons in the neighbourhood, and without necessarily wounding either plantar artery or nerve.

The following is an account of the operation, with an enumeration of those anatomical points which determined the course adopted.

A line carried backwards on the dorsum of the foot, from the centre of the third toe, will exactly pass over the junction of the astragalus and calcaneum anteriorly. At a finger's breadth behind the projection of the posterior extremity of the fifth metatarsal bone is the calcaneo-cuboid joint. If a line be drawn from this point upon the dorsum of the foot, so that it fall somewhat obliquely across the first line, making an angle of 75° with it, this line will exactly correspond with the direction of the calcaneo-cuboid joint in this situation. The first incision should be begun at the point of intersection of the two lines, which will be just where the calcaneum, astragalus, scaphoid, and cuboid bones meet; then it should be carried outwards across the dorsum of the foot, in the direction of the second line, over the outer edge of the foot, a finger's breadth behind the projection of the fifth metatarsal bone, and directly inwards across the sole of the foot, as far as a line carried back from the centre of the fourth toe. By taking care not to prolong the cut beyond this point, in all probability the external plantar nerve and artery will escape injury.

The second incision is begun where the first was terminated, and is carried backwards, nearly at right angles to it, through the prominent part of the outer side of the heel, inclining the incision upwards and slightly inwards towards its termination, so as to reach the inner side of the tendo Achillis an inch above its insertion into the os calcis.

The first incision should only pass through the skin, to avoid wounding the peroneal tendons; whilst, in making the second, the knife should be plunged right down to the bone, and kept in contact with it until the cut is nearly completed.

A flap will thus be formed of three unequal sides, the lower edge being the longest, the anterior one the next in length, the posterior being the shortest. After dissecting down and exposing the peroneal tendons, the flap beginning at its anterior inferior angle should be turned up as far as the level of the inferior extremity of the external malleolus, keeping the knife close to the bone, except where it is crossed by the peroneal tendons, which must be left lying on it. Then, after dividing the tendo Achillis, and freeing the bone on its under and internal surface as far as possible, the knife should be entered in the hollow in front between the calcaneum and astragalus, immediately above the greater tuberosity of the former, and thrust deeply backwards between the two bones, so as to divide the strong interosseous ligament between them.

The calcaneo-cuboid joint, which exactly corresponds to the first incision, should now be laid open, and the knife passed vertically downwards between the os calcis and astragalus anteriorly. The calcaneo-astragaloid joint must then be opened by passing the knife horizontally inwards behind the peroneal tendons, just at the level of the point of the external malleolus, taking care to avoid injuring the tendon of the flexor longus pollicis muscle.

The bone will now be found to be pretty moveable, and only retained in position by the parts in connexion with its internal tuberosity; viz., the capsular ligament of the in-

ternal astragalo-calcaneal joint, some fibres of the internal lateral ligament of the ankle-joint, and the tendons, artery, and nerve, which pass under the inner malleolus.

The real difficulty of the operation now commences; for the parts are so deep in the wound as to be barely felt, and cannot be seen, from the bone being in the way. It is at this stage that the posterior tibial artery and nerve are in danger of being wounded. However, by keeping the knife close to the bone, and carefully guarding it with the point of the finger, the tendons, artery, and nerve, can be separated from the groove under the inner ankle without injury, and the fibres of the internal lateral ligament cut through; yet to do it successfully requires a perfect knowledge of the anatomy of the parts, and the power of recognising the anatomical details by the touch.

I have described thus minutely the steps of the dissection I employ in removing this bone, because I consider it of the greatest importance, as regards the future well-being of the patient, that there should be no violent tearing away, and no using one of the sound bones as a fulcrum for the purpose of prizing out the diseased one; for by so doing it is more than probable that some morbid action will be set up in one or more of the remaining bones, even though quite sound before the operation. These remarks are more especially applicable to removal of any of the tarsal or carpal bones. An excision of either of them should be a simple dissection, and not any more traction should be made upon the bone than can be exercised by the fingers, and then only for the purpose of ascertaining at what points the bone is fixed to the surrounding parts.

Although we know that perfect and strong union takes place between the cut ends of tendons, yet there is a great advantage in not cutting them in this particular operation, on account of the great difficulty there would be in ensuring apposition of the ends if they were divided, and so of restoring the proper function of the attached muscles; and it is of infinite importance to the patient that he should retain the power of raising himself on his toes, flexing them, and extending his foot, all of which he can do if the tendons be left intact.

On looking at the excised bone, you will perceive that it is affected by very extensive caries, including nearly all its central portion; that the hard shell, on its external aspect, is necrosed, and entirely separated from the adjoining bone; and finally, that the cartilages of the calcaneo-astragaloid joints are slightly ulcerated, that of the larger one being the more affected.

I have brought the man for your inspection, that you may see how useful a foot has been preserved for him.

Hospital Gleanings.

PECULIAR FORM OF STRICTURE IN INGUINAL HERNIA.

THE following case of hernia, under the care of Mr. SKEY last week, caused an unusual share of interest at St. Bartholomew's Hospital; not so much, perhaps, from anything that appeared at first sight in the case (one of strangulated inguinal hernia), as in the nature of the constriction, and the peculiar measures adopted for its relief. The seat of stricture proved to be in a small aperture opening out from the sac of a congenital hernia in the fascia propria of the spermatic cord: all the usual landmarks of ordinary hernia were perhaps of little or lesser moment.

CASE. F. T., aged 21 years, otherwise a healthy looking man, was admitted, April 29th, into St. Bartholomew's Hospital, under the care of Mr. Skey. As the taxis failed to reduce the gut—indeed, as the parts had undergone considerable manipulation already, with no good result, Mr. Skey was obliged to operate. The process of chloroformisation, in place of facilitating the return of the intestine, was attended by a much greater enlargement of the parts—a

state of things we do not often observe in these cases; while, as Mr. Skey proceeded to dissect down towards the seat of stricture, fully two feet of the intestine, in fact, had rushed out through an opening in the fascia propria of the cord. Part of the gut was dark coloured, and inflamed: the testis was bare. This singular new ring was well defined or shaped, and, to an operator less of an anatomist than Mr. Skey, might have proved very embarrassing. Mr. Skey, however, carefully slit up the fascia of the cord, and returned the gut, though the appearance presented by the intestine, as observed at the time, was not very promising. The parts were now completely brought together, and the man removed to bed.

Immediately after the operation, a full dose of tincture of opium was administered. At half-past nine o'clock that night, thirty drops more were given, and seventy drops during the night, which seemed to afford very great relief.

April 30th. At our visit to day with Mr. Skey, the poor man appeared to himself relieved. His breathing was laboured, however; he could not retain food on his stomach; he had indistinct hiccup. Mr. Skey seemed very apprehensive for the result, but spoke cheerfully to the man. He ordered a little brandy to be given, and warm fomentations to be used for the first forty-eight hours. We regret, however, to state that the man sank in the evening.

RELATION OF "ADENOID" GROWTHS TO CANCER, AND DOUBTFULNESS OF "HEREDITARY TAINT" AS A CAUSE OF CANCER.

The particular relation which cancerous growths of the breast are found to bear to previous attacks of adenoid or other diseases in females, begins to wear something of a newer aspect recently in hospital practice, since the introduction of chloroform, and since the able researches of M. Velpeau in Paris and Mr. Birkett in London, as to the microscopic elements of cancer and adenoid growths. A case just operated on at St. Thomas's Hospital, and one operated on a little before at the Middlesex Hospital, neither of which presented any peculiarity of any moment out of the common, as regarded their previous growth, afforded the pupils an opportunity of seeing well marked scirrhus.

Mr. M'MURDO, in operating on the 3rd inst. at St. Thomas's, stated his belief that, at least in this case, nothing could be gained by operation; so he had rather dissuaded the patient from the danger likely to result from the shock; yet, as the poor woman wished it to be removed, he had, though unwillingly, decided to comply with her desire.

As to the hereditary character of cancer of the breast, so much dwelt upon by superficial writers, Mr. BIRKETT stated, some short time since, at Guy's, that he did not find that statistics of a large number of cases of diseased breast at all corroborated this opinion of hereditariness in the degree generally suspected. There is no cause to prevent a healthy woman, for instance, especially if she goes through the ordinary periods of lactation and pregnancy, escaping cancer altogether, though her sisters or mother may have had disease of breast at some period of life. It often occurs that a patient with cancer of the breast, on her attention being called especially to the subject, will tell of obscure tumours of the breast in sisters or mother, which she will believe to have been cancer, but must, even from the history of the case, have been abscess or adenoid. Mr. Birkett seems inclined to the impression that a far more interesting point in cases of cancer is the age of the patient—the general cachectic condition of the whole system which comes on after the climacteric period, and perhaps with cod-liver oil and other alteratives might be easily prevented. The tendency, on the other hand, is too great to pronounce all kinds of "adenoid" growths as cancer, from the single feature of hereditariness; and much additional mental suffering is thus added to the other symptoms.

PROTRACTED DISEASE OF FEMUR: OPERATION OF REMOVAL OF DEAD BONE: PROBABILITY OF A SOUND LIMB.

A very interesting and anxious consultation was held one day last week by Mr. STANLEY and his colleagues in a