special examination on those branches of science, according to the ordinances of this college relating thereto.

V. Certificates will not be received on more than one branch of science from one and the same lecturer; but Anatomy and Physiology—Demonstrations and Dissections—will be respectively considered as one branch of science.

N.B. In the certificates of attendance on hospital practice and on lectures, it is required that the dates of commencement and termination may be inserted in words at length.

Blank forms of the required certificates may be obtained on application to the secretary, to whom they must be delivered, properly filled up, ten days before the candidate can be admitted to examination; and all such certificates are retained at the College.

By order of the Council,

EDMUND BELFOUR, Sec.

August 20, 1839.

SOCIETY OF APOTHECARIES,

April 23, 1835.

Every candidate for a certificate to practise as an apothecary will be required to produce testimonials—1. Of having served an apprenticeship of not less than five years to an Apothecary;—2. Of having attained the full age of 21 years;—3. And of good moral conduct. Students whose attendance on lectures shall commence on or after the 1st of October, 1835, will also be required to produce proof of having attended, during three winter and two summer sessions, lectures in the following order, and medical practice from the commencement of the second to the termination of the third winter session.

The Winter Medical Session is to be understood as commencing on the 1st of October, and terminating in the middle of April, with a recess of fourteen days at Christmas; the summer session as commencing on the 1st of May, and ending on the 31st of July.

First Winter Session.—Chemistry; Anatomy and Physiology; Anatomical Demonstrations; Materia Medica and Therapeutics.

First Summer Session.—Botany; and such other branches of study as may improve the student's general education.

Second Winter Session.—Anatomy and Physiology; Anatomical Demonstrations; Dissections; Principles and Practice of Medicine; Medical Practice of an Hospital.

Second Summer Session.—Botany, if not attended during the First Summer Session; Midwifery and Diseases of Women and Children; Forensic Medicine; Medical Practice of an Hospital.

Third Winter Session.—Dissections; Principles and Practice of Medicine; Midwifery, with attendance on cases; Medical Practice of an Hospital or Dispensary.

The student is required to attend the medical practice of a recognized hospital, from the commencement of the Second Winter to the termination of the Second Summer Session, and from time to time to the end of the Third Winter Session, at a hospital or recognized dispensary.

The sessional course of instruction in each respective subject of study is to consist of not less than the following number of lectures, viz.—100 on Chemistry; 100 on Materia Medica and Therapeutics; 100 on the Principles and Practice of Medicine; 60 on Midwifery and the Diseases of Women and Children; 50 on Forensic Medicine; 50 on Botany.

The number of lectures on anatomy and physiology, and of anatomical demonstrations, must be in conformity with the regulations of the Royal College of Surgeons of London on these subjects. The lectures required in each course respectively must be given on separate days. Students, when they present themselves for examination, must bring testimonials of having received instruction in practical chemistry during their attendance upon the lectures on chemistry, materia medica, or forensic medicine; and also of having attended a full course of clinical lectures, and such instruction in morbid anatomy as may be afforded them during their attendance at an hospital. Every student will be required to produce proof of having dissected the whole of the body, once at least.

COURSE OF CLINICAL LECTURES

ON

SURGICAL DISEASES,

DELIVERED AT THE HOSPITAL OF LA CHARITE'.

BY PROFESSOR VELPEAU.

LECTURE XI.

PERMANENT CONTRACTION OF THE FINGERS.

GENTLEMEN,—Permanent flexion or contraction of the fingers depends on a great number of causes; it may arise from wounds, paralysis of the extensor muscles, ankylosis of the joints, tumors, shortening of the tendons, irregular cicatrices, &c. On the present occasion, however, I wish to direct your notice to that form which depends on contraction of the palmar fascia, or on the formation of fibrous bands extending from the palm of the hand to the fingers, and binding down the latter in their irregular position.

Before the remarks published in 1831, by Dupuytren, followed up by those of MM. Lemoine, Mandet, Vidal, Goyraud, &c., permanent contraction of the fingers had not been much noticed by surgeons. Boyer alludes to the affection under the name of *crispatura tendinum*; Sir Astley Cooper, also, speaks of permanent retraction of the fingers and toes, which he attributes to contraction of the sheaths of the tendons or of the palmar and plantar aponeuroses. Dupuytren has clearly shown that the tendons are seldom engaged in this affection, but he has not so evidently demonstrated that it depends on induration, or shortening of one or more bands of the palmar fascia.

The disease now under consideration is characterised by the formation of certain bands or chords, which are elevated beneath the skin, and extend along a considerable portion of the palmar surface

of the finger; these bands generally occupy the median line, and are attached usually to the first phalanx, but sometimes prolonged to the second or third. According to Dupuytren, this disease generally begins on the ring finger, and thence extends to the little finger; it increases gradually, without occasioning pain; the patient, at first, experiences a feeling of stiffness in the palm of the hand, and is unable to extend one or more fingers; the latter soon become contracted, and in extreme cases, the tip of the finger rests on the palm of the hand. On examination, the first thing which we notice is a chord extending along the palm and finger: if you attempt to straighten the finger, this chord becomes more tense, and it disappears when you flex the finger completely; it is rounded off in shape, and forms a kind of bridge or prominence at the metacarpo-phalangeal joint. The skin is wrinkled into arched folds, extending from the middle of the palm of the hand to the base of the finger. The disease, thus progressing, may attain its maximum degree of severity without causing any pain, or appearance of ankylosis; the joints are easily flexed, but cannot be extended by the most powerful efforts; Dupuytren has seen 150 pounds weight suspended on the bent finger, without producing any effect on it.

This retraction of the fingers is a very disagreeable affection; it prevents the patient from seizing any large body, and when he closes the fingers strongly, severe pain is felt. Persons labouring under permanent contraction of the fingers, are usually those who have made violent efforts with the palm of the hand, or been employed in occupations during which the palm and fingers are frequently pressed against hard bodies. Thus, it is met with amongst masons, ploughmen, watermen, coachmen, &c. Dupuytren mentions the case of a literary personage who was attacked in consequence of frequently using a round-handled office-seal for his letters.

What is the anatomical lesion which characterizes permanent contraction of the fingers? Upon this point there exists a variety of opinions. Some attribute it to thickening and contraction of the skin; others to spasm of the muscles; disease of the flexor tendons; inflammation and contraction of the sheaths of the tendons; some change in the joints and their lateral ligaments; finally, contraction of the palmar fascia. This latter idea was chiefly supported by Dupuytren and Sir Astley Cooper; the following case was the one which influenced Dupuytren's opinion:—An old man, who had been affected for many years with retraction of the fingers, died in the Hôtel-Dieu; Dupuytren examined the parts with great care; on removing the skin from the palm of the hand, it was found that the folds of integument completely disappeared; the palmar fascia was contracted and shortened, and several bands passed from its lower part to the sides of the deformed finger. On endeavouring to extend the fingers, Dupuytren perceived that the fascia and these bands were rendered more tense; he divided the bands, and effected, at once, complete extension of the contracted fingers; the tendons and their sheaths had not been touched; the joints likewise and bones were completely free from any appearance of alteration. From this case Dupuytren naturally concluded that the disease originated in abnormal tension of the palmar fascia, a tension

depending on contraction excited by the pressure of some hard substance on the palm of the hand. The case certainly shows that contraction of the fingers may sometimes depend on a change in the palmar fascia, but it does not prove that this is always the cause. The bands or hard chords which, as I have already mentioned to you, are seen projecting under the skin, extend to the palmar surface of the first phalanx, and sometimes to the second or third phalanx. Now we know that the palmar fascia terminates at the root of the finger, by becoming attached to the sheaths of the tendons and ligaments; besides, the fascia does not cover the ball of the thumb or extend to its root, yet we have permanent contraction of the thumb, with the subcutaneous chords already noticed. Having determined, by dissection, that the palmar fascia remained sometimes intact, after the removal of these chords, I announced, in 1833, that the prolongations mentioned by Dupuytren were not always formed by the palmar fascia; but that they seemed to me to depend on transformation of the subcutaneous cellular tissue into fibrous bands. M. Goyraud, surgeon to the Hôtel-Dieu of Aix, has proved the correctness of this opinion by his researches on permanent contraction of the finger, published in the third volume of the *Memoirs of the Royal Academy of Medicine*. In addition to a carefully performed dissection, M. Goyraud relates the following case, which confirms my view of the nature of this disease.

“M. Chaîne, steward of the hospital, presents a remarkable example of the permanent contraction of the fingers. The three last fingers of the right hand are flexed; of the left, the four last fingers are in the same condition. The left ring-finger is more flexed than the others; on the right side, the little finger is the one most contracted; the middle fingers are only semi-flexed. The contraction came on gradually, and without any pain. M. Chaîne is now 58 years of age; when at the age of 42, he first perceived that he was unable to extend the left ring-finger completely. The latter became gradually contracted, and the affection soon extended to the two neighbouring fingers. Shortly afterwards, the right little finger began to contract, and then the ring and middle fingers of the same hand. The first phalanges are now flexed at a right angle on the metacarpal bones, and the second phalanges at various angles on the first. On attempting to extend the fingers, it is evident that they are retained in the flexed position by a number of bands running from the palmar fascia to the middle part of the fingers.”

In this case, the disease consists in flexion of the first phalanx on the metacarpal bone, and of the second phalanx on the first; the joints of the third phalanges are completely free.

Hence, since contraction of the palmar fascia and its digital prolongations could only influence the first phalanx, it is evident that the contraction of the second phalanx must depend on some other cause. Even in the lectures of Dupuytren, we may find a proof of this. M. L. had contraction of the ring and little fingers of the left hand, which were completely flexed on the palm; the second phalanx was bent on the first, and the tip of the third applied to the ulnar edge of the palm; the little finger was constantly flexed on the palm of

the hand also. Mr. Dupuytren operated in the following manner:—He commenced by making a transverse incision, ten lines in length, opposite the metacarpo-phalangeal joint of the ring-finger; the knife divided first the skin, and then the palmar fascia. The ring-finger was now reduced nearly to its natural position.

Being desirous of sparing the pain of a second incision, Dupuytren endeavoured to prolong the incision of the palmar fascia, towards the ulnar edge of the hand, but could not succeed; he was therefore compelled to make a second transverse incision opposite the articulation between the first and second phalanx of the little finger, and thus separated its point from the palm, but the remainder of the finger was still immovable. A third incision divided the skin and fascia, opposite the metacarpo-phalangeal joint of the little finger; the benefit was very slight, and he was forced to make an incision opposite the middle of the last phalanx, when the finger at once became straight. Is it not clear, from this case, that other parts besides the palmar fascia were engaged in the disease? Do not we all know that the prolongations of this fascia are attached to the sides and not to the middle of the first phalanx?

From the facts which have been just mentioned, M. Goyraud concludes that permanent contraction of the fingers never depends on the palmar fascia; that we should avoid dividing this latter in any operation for the relief of the disease, and that Dupuytren, probably, divided the subcutaneous bands developed in the cellular tissue, and not prolongations from the palmar aponeurosis.

This opinion seems to me to be too exclusive, and I agree with M. Sanson in thinking that permanent contraction of the fingers may depend on the palmar fascia, on the skin, or more frequently on transformation of the cellular tissue into fibrous bands.

The treatment of this affection is exclusively surgical; we can expect no benefit from any other means than division of the fibrous bands by which the finger is retained in the flexed position. Dupuytren made an assistant extend the fingers as far as possible, and then divided the most tense part of the band; if the finger could now be straightened completely, the operation was finished; if not, he made one or more incisions above or below the first one. When the fingers became free, he maintained them in the extended position by means of bandages and splints, for a month or six weeks; but as soon as the state of the wound permitted, he commenced movements of flexion and extension.

M. Goyraud operates in a different way: he makes his incision along the side of the band, and in the same direction with it, and then divides the band in various places, or excises a portion of it. This method has many advantages over that of Dupuytren; the patient runs less risk of inflammation extending along the sheaths of the tendons, or palm of the hand; it allows us to commence moving the fingers at an earlier period, and leaves a much smaller cicatrix. When we have restored the finger to its natural position by means of operation, we are not to think that the patient is free from the danger of relapse. Considerable care must be bestowed on the after-treatment; the joints must be frequently moved; discutient lotions, &c. applied, and the patient must

be particularly cautioned against using any hard bodies, or employing himself in any occupation by which the palm of the hand may be irritated.

CASE OF EVERSION OF THE UTERUS.

By ROBERT STORRS, Esq. Surgeon, Doncaster.

MRS. LOWTHER. æt. twenty-two, a stout, good looking woman, of lymphatic temperament, was delivered, after a tedious labour, of her first child, on the morning of the 6th of November, 1839. The labour was natural, and the placenta came away without any difficulty, about a quarter of an hour after the birth of the child. As is my usual practice, I made pressure with the hand over the region of the uterus, and felt it distinctly. There was considerable hæmorrhage after the birth of the placenta, and much more pain than is usual after a first child. On my second visit that evening, I observed her to be more pale than I expected, with rather a quiet and weak pulse, which I attributed to the more than ordinary discharge she had had. She had considerable pain at intervals, like the after pains of persons having had several children.

During the following day, the 7th, the discharge of blood continued, and very little urine was evacuated, perhaps about half a pint; I did not see it, however; I was only told by her mother that she had but a small quantity. During the early part of the morning of the 8th the pains increased, and became much like labour pains, until about four o'clock A.M., when she said something had come away from her. I did not receive any message for some hours afterwards, (about half-past eight,) when I was requested to go in immediately. The mother told me she had had much pain, which had abated since a substance had appeared externally. I requested to be allowed to examine, and found the uterus everted, about the size and shape of a large India-rubber bottle, lying out of the os externum. Its surface was becoming a dark red, and its fundus cold. She was in a state of extreme exhaustion; pulse about 150, very feeble; countenance pale, and the bed-clothes saturated with bloody and serous discharge. I immediately introduced the uterus into the vagina; I then sent for Dr. Scholfield, who remained with me after he arrived, until the uterus was quite reduced to its natural situation. The urine, previous to attempting further reduction, was evacuated by the catheter, and the rectum emptied by an enema; the bladder was very full.

The means I took to return the uterus from its inverted state in the vagina to its natural position, were, in the first place, by introducing my hand doubled against the fundus, and forcing it gently as high up as possible, and then gradually pushing up the centre of the inverted fundus, by raising my first and second fingers out of their closed position.

I think (but I did not look at my watch at the time) that it was more than an hour before I could distinctly feel the fundus pass beyond what appeared to be the neck of the uterus; after this, however, I speedily introduced my hand into its proper cavity, and withdrawing it very gently, kept my two fingers at the neck of the uterus, until I found it contract upon them so firmly as to preclude the probability of the uterus again descending. Half