opinions to him, and stated to him at the same time the extraordinary circumstances which had begotten, for me, such a lively interest in the son of Dr. X. In the course of a few days I was informed that an inquiry had been held by the medical staff; that the boy had been sent for and privately examined (though not ostensibly ill in any sense); and that it was, beyond all doubt, considered to be a case of leprosy. The medical authorities decided, however, that under the circumstances it was not their duty to sound the alarm, or in any way to disturb the boy's education.

From this time onwards (except the death of the first patient soon afterwards) I heard nothing more of these matters till a few weeks ago, when I was asked to see Dr. X.'s son professionally on behalf of the school-authorities; and, if so advised, to request Dr. Anderson also to give an opinion as to the present state of health of this young man, who happened at the time to be visiting some friends in Glasgow. It was represented to me that he had maintained, on the whole, fairly good health since I last heard of him through my medical friend, and had not been incapacitated from school-work except on account of a contagious eczema which had been prevailing, and with which he had been affected in common with other boys. Apparently, however, the opinion had arisen that his general health was not quite so good, and that in view of a cutaneous affection of this kind, apparently communicable, existing, it was no longer expedient that he should remain at the school. Indeed, I could not but come to the conclusion that his removal, on public grounds, had been practically settled; and with every desire to soften the blow as much as possible to the poor boy, it was felt to be necessary that his guardian, at least, should receive unequivocal and unbiassed testimony as to the actual state of the facts and circumstances under which the decision was arrived at. Under these circumstances I saw and examined this boy, and made a report, along with Dr. Anderson, to the effect that the disease was evidently leprosy, though of a remarkably mild type, as shown by discolorations and cicatrices, and also by large anæsthetic areas on the back of one limb. All breaches of surface, however, and all discharge had ceased at the time of our report, and Dr. Anderson felt still in a position to affirm that no danger to others could occur from the boy's remaining at school. On this last point I did not feel able to give an unqualified assent to my colleague's opinion; but as regards the matters of fact and observation there was no doubt whatever, and our report accordingly on these was substantially as above.

A NEW OPERATION FOR HEPATIC ABSCESS.

By GEORGE ZANCAROL, M.D. Paris,
Surgeon to the Greek Hospital, Alexandria, Egypt.

THE following operation has been performed by me with excellent results for more than two years. I therefore think that a short account of my method may be of interest to surgeons and practitioners who may have cases under their care.

The operation consists in making a large opening sufficient to expose the whole cavity of the abscess, and in thoroughly cleansing it of all pus and debris of sloughing hepatic tissue. It may be divided into three stages: 1. Exploration of the liver; 2. Opening the abscess; 3. Cleansing the abscess-cavity.

1. *Exploration of the Liver.*—After having well washed the skin with a brush and soap and water and a 2 per cent. solution of carbolic acid, an exploring trocar is plunged into the liver to find the abscess; this exploratory puncture may have to be repeated several times, so that a good idea may be formed of the size and direction of the abscess.

2. *Opening the Abscess.*—An opening is made with the thermo-cautery into the lower third of the abscess, five to seven centimetres (two to nearly three inches) long, according to the size of the abscess, and as much as possible in the direction of its greatest diameter. This opening must be sufficiently large to enable the surgeon to see the whole cavity with ease when the edges of the opening are held well apart by retractors. To obtain this result in abscesses of the left lobe an opening in the soft parts will suffice; but if the abscess is in the right lobe, resection of one or two ribs will be necessary. This resection is also performed with the thermo-cautery, using an elevator to detach the periosteum, and Liston's bone-forceps, care being taken not to wound the intercostal artery; should this, however, happen, the hæmorrhage will cease as soon as the abscess is opened. After resection of the bone, the abscess is opened with the thermo-cautery, keeping always in the direction of the resected rib, and with the aid of two strong retractors held by an assistant, while the margins of the incision are kept open, they are pressed against the liver, and kept in close contact with the abdominal and thoracic walls, so as to prevent either pus, or the liquids used for washing out the abscess, from find-

ing their way into the abdominal or pleural cavities. If this precaution be observed, no harm will result, even should there be no adhesion between the wall of the abscess and the parietal peritoneum; for when once the abscess has been thoroughly washed and cleansed, adhesions will be established before fresh pus can accumulate. In fifty such operations performed by me during the last two years, no purulent matter has ever escaped into the pleural or peritoneal cavities, although cases were operated upon in which no adhesions existed.

3. *Cleansing the Abscess-Cavity.*—The retractors being still held in the position already described by an assistant, a strong current of warm distilled water is allowed to play within the abscess-cavity by means of a siphon; every particle of adherent pus and necrosed tissue is removed with the fingers, or with sponges fitted to proper holders, and the washing-out is continued until the walls of the cavity look perfectly clean, often granulating, and the water returns clear. The retractors are then withdrawn, two drainage-tubes of large calibre are inserted in the cavity, and the dressings applied, which are left undisturbed for twenty-four hours; the cavity is then washed out again with warm distilled water, as above described, and the current kept on until the water returns perfectly clear.

As a rule, the temperature becomes normal immediately after the first washing, but if fever should reappear, or if the pus is abundant, the washing-out should be repeated every twelve hours; if, in spite of all this, the fever persists, or diarrhoea sets in, this would indicate that other abscesses exist in the liver, and such cases are invariably fatal.

OPHTHALMIC REPAIR AND SENILE DECAY.

By ANDERSON CRITCHETT, M.A. CANTAB.,
Ophthalmic Surgeon to, and Lecturer on Ophthalmic Surgery at, St. Mary's Hospital.

AMONGST the many interesting facts which Professor Humphry has noted in connection with longevity, there is none which at the first glance causes more surprise than that people of advanced age possess, as a rule, remarkably good healing power. Every experienced surgeon could, however, bear witness to the correctness of the Professor's observation, and I have recently had several cases under my care which show that not only will wounds in such a delicate organ as the eye unite by first intention in very aged patients, but that the healing process may make steady progress towards completion while the physical powers are in the last stage of exhaustion and decay.

I had arranged to operate for cataract in the spring of last year on a nobleman, aged 84, when I was informed by his medical attendant, Mr. Tegart, that the patient was suffering from gangrene of the foot, which, of course, necessitated the postponement of the ophthalmic operation. The patient was, however, extremely anxious that an effort should be made to restore his sight, and in the following September he had recovered a sufficient measure of health and strength to justify me in removing the cataract. The eye was rendered completely anæsthetic with cocaine, and I made my incision at the corneal-scleral margin, completing it through the tissue of an arcus senilis, which I have always found to possess good healing capacity. As the lens did not yield readily to moderate pressure, I removed it with a spoon, and without any loss of vitreous. All went well till the fifth day, when the patient had an alarming fainting fit, and remained in a state of collapse for some hours.

Although he rallied somewhat from this attack, he speedily relapsed into others of a similar character, and in spite of the most careful nursing and the constant attendance of Sir William Jenner and Mr. Tegart, he gradually grew weaker, and sank at the end of six weeks from the commencement of his last illness. I frequently examined the operated eye and tested the sight, and I was surprised to find that, notwithstanding the great physical weakness, the process of repair proceeded at the usual rate and in the most perfect manner. The vision was excellent, the patient being delighted to recognise the faces of those around him, and, with a suitable lens, telling the time by a watch correctly.

I had a similar experience last year with a lady, aged 93, who, despite an attack of apoplexy with hemiplegia six days after an operation for cataract, was able to heal my incision by first intention. I have quite recently operated for cataract on two clergymen, aged respectively 92 and 96; and in both cases, although the patients were in feeble health, the elder of them being unable to move from chair to chair without assistance, the wounds have healed well, and the sight has been fully up to the usual standard. Encouraged by these results, I lately offered to operate on a lady in reduced circumstances, who has

cataract in both eyes, and is within a few months of completing her century. She took a fortnight to consider my proposal, and then, exercising the undoubted prerogative of her sex, and perhaps, also, at such an exceptionally advanced age, a wise discretion, declined it.

In three of the four cases I have mentioned I had performed a preliminary iridectomy some months before the removal of the cataracts, and I shall in future, if opportunity favour me, adopt a similar precaution in operating upon patients of advanced age, as I am convinced that by so doing a higher average of success is achieved. Mr. Higgins, not long ago, published a series of cataract-operations on old people in which he had obtained very excellent results, and I hope that his experience and my own may encourage others to attempt the storming of these ancient citadels, for the gift of sight is none the less prized and gratefully welcomed by the aged, because it comes to them in the sunset of their life.

A CASE OF VARICOSE ANEURYSM OF THE FEMORAL ARTERY AND VEIN.¹

By BRIGADE-SURGEON C. H. Y. GODWIN, M.S.,
Assistant Professor of Military Surgery, Royal Victoria Hospital, Netley.

A SERGEANT, aged 29, on March 21st, 1886, in a rush upon a stockade in Burmah, was wounded by a pointed bamboo stake which had been purposely fastened into the ground. The point entered the right thigh one inch and a half above the patella, and passed upwards and inwards for about two inches. Its withdrawal was followed by a gush of arterial blood. A comrade bound it up with a handkerchief, which he tightened by twisting it round with a sword. Upon reaching a surgeon some time after, the bandage was removed, when free bleeding again ensued, but the blood was dark in colour, and did not come in gushes as before. The bleeding was quite controlled by a bandage. The wound healed up in a fortnight, but the limb was greatly discoloured from blood infiltration.

On April 11th he noticed a swelling on the inner side of the middle third of the thigh, and subsequently a second swelling of a more diffused character lower down, and upon the anterior and inner surface of the thigh. The tumours gave all the indications of an aneurysm, and they were treated by digital pressure of the artery by relays of men for fourteen hours a day for a considerable time. Under this treatment the tumours are said to have become smaller. He arrived at Netley on December 8th, 1886, in good health, and was able to move about with great facility and without pain or inconvenience. He had a scar an inch and a half above the right patella. About six inches above the knee a distinct swelling was plainly visible, ovoid in form; and higher up, but more on the inner aspect of the leg, another tumour was apparent, but not so distinct in outline as the lower one. They both gave evidence of a distinct pulsation, with an impulse given to both swellings; in either swelling a thrill was perceptible to the hand. A loud, rasping, harsh, and continuous *bruit* could be heard, which was completely silenced by pressure upon the femoral artery. The sounds in the upper tumour were of the same character as those in the lower one, but not so intense.

REMARKS.—No doubt both artery and vein were wounded. Were the swellings distinct, or were they connected? Distinct swellings could be accounted for by the lower and anterior tumour being a traumatic aneurysm connected with the wound in the anterior wall of the artery, and the upper and inner one a varicose aneurysm connected with the wound of the artery and vein. As the tumours were quite stationary, or, as the man thought, were getting smaller, and as there was no swelling of the leg or other inconvenience, it was not thought advisable to interfere surgically in this case.

A CASE OF ANGIOMA OF THE PHARYNX.

By R. NORRIS WOLFENDEN, M.D. CANTAB.,
Senior Physician to the Throat Hospital, Golden Square.

THIS case, apparently unique, seems worthy of record. The patient, a young girl, aged 25, of good general health, occupied as a nursery governess, was sent to me on October 25th, 1886, for advice as to the condition of her throat. What had attracted the attention of a suburban practitioner was a swelling in the front of the neck on the right side, about the level of the hyoid bone, and of the size of a hen's egg. This, however, gave rise to no inconvenience. It was soft, and was thought by us to be of lymphatic nature. Coursing through it could be felt some hard cordy vessels. On the back of the neck, chiefly

on the right side and at the level of the pharyngeal tumour to be mentioned presently, there was a collection of hard, superficial, varicose veins. The back of the pharynx presented the most curious aspect. On illuminating the throat, a large angioma was seen to occupy the whole of the right side of the posterior wall of the pharynx, in the pharyngo-oral region. It appeared to spring from the posterior and lateral wall of the pharynx, behind the posterior faucial pillar, was considerably raised above the surface, and extended as far as the middle line of the pharynx. It was knotty, dense, and of purple colour. A small portion extended over to the left of the median line. Above, it reached to a little higher than the level of the soft palate, when raised on phonation; below, the mass extended to the level of the base of the tongue, and, as far as could be seen, some varicose veins extended down towards the œsophagus. The tumour was thus of considerable size, and of remarkable appearance. The tonsils being very small, it was visible on simply opening the mouth. Some tortuous varicose vessels coursed along the right anterior faucial pillar and along the right side of the uvula. The most remarkable feature of this curious condition was that the patient had never suffered the slightest inconvenience from it. Just occasionally she had felt a "lump in the throat" when she had taken cold. Though the tumour encroached upon the lumen of the pharynx, there was no interference with swallowing. The patient was apparently unaware of the fact that she possessed this angioma, and the only history to be obtained was that the soft (? lymphatic) tumour in the front of the neck was first noticed when she was seven years old. My colleague, Dr. Morell Mackenzie, to whom I showed the patient, informs me that he has never seen a similar case.

Small angiomata, particularly about the base of the tongue and the larynx, are not infrequently met with. I cannot find any such case as this, however, recorded, and the condition is probably quite unique. As the vascular tumour gave rise to no inconvenience, it was judged expedient, from its size and extent, to leave it untouched. I append a drawing of the pharynx, reproduced from one kindly made for me by Mr. P. S. Hutchinson, resident medical officer at the Throat Hospital.

In the *Annales des Maladies de l'Oreille, du Larynx, etc.*, of February, 1887, is an interesting contribution from Farlow, of Boston,¹ giving details of five cases of voluminous arteries (pulsatile and visible to the naked eye) of the posterior pharyngeal wall. It is concluded that the vessels implicated in these cases were the ascending pharyngeal branches of the external carotid arteries. Pulsating

¹ "Cinq cas d'artères volumineuses, visibles à l'œil nu, et pulsatiles de la paroi postérieure du pharynx, avec remarques," p. 59. See also *Boston Medical and Surgical Journal*, March 31st, 1887.

¹ Read before the Southampton Branch of the British Medical Association.