Fourteen Cases as Illustrations of Surgery as seen in a Colliery Practice

by a

Colliery Surgeon.

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11 1890

Introductory Remarks

Attendance on Surgical Cases in the Wards & Out-patients' rooms of an Hospital is always very interesting and full of instruction to the Student of Medicine from the beginning to the end of his career. I can now recall to my mind very vividly many interesting cases seen ten years ago at the Western Infirmary.

Theoretical & practical instruction must necessarily go hand in hand to adequately comprehend & understand a given case;

but, I think, that special attention by students to the latter is highly essential not, of course, to the neglect of lectures and book-work.

But the great and increasing number of subjects, which the student of Medicine has to pursue in a curriculum of four years' duration, makes it difficult, if not indeed impossible, for him to enter fully into them all. Some of them may be well picked up more fully and perhaps equally well in the earlier years of practice, but there are others which can be mastered only by observation in the Wards as practised by

Experienced and competent hands. To the student of of Surgery, I consider it is very necessary to do all he can to see as much as possible of practical work during his student days. Opportunities then neglected cannot be supplied afterwards, and no amount of reading can supply the loss. For example, Wood's operation for the radical cure of hernia is, to my mind, not very difficult to understand after it is seen once performed by a competent Surgeon, but, if attempted from description given in Works on Surgery, the undertaking is impossible - or, at best,

most difficult and unsatisfactory. Again, in closing a cleft palate, dividing the tensor palati muscle is most difficult & impossible from description given in text books, but very simple after once seen done.

Thus, I am strongly inclined to the belief that, although we should always do what we can to be well-versed in theory — and, indeed without this knowledge as foundation, we cannot be up in its practice, yet, as is seen in after life — too much stress cannot be laid on the Χειρ ἔργον part of our curriculum. I speak simply of my own personal experience. As a student,

‡ But, I must add that I look back with pleasure at the 2½ years of practical instruction I received as assistant to a very competent surgeon in the Rhondda Valley after I obtained my M.B. This was to me a real pupilage. I was inducted into many things which naturally could not be gained at the Hospital. Here I began to learn confidence and caution & to begin to rely on my own doings. Here also I began to find the weight and responsibility of practice and the anxiety incidental to having the care and responsibility of bad cases in my charge. Still, I was conscious I had one to fall back on to who would help me.

I did a fair average of practical work at the Hospital, but, if I were to commence again I should endeavor to observe a great deal more of work as done by others. Of my friends in this district, instructed in various schools of Medicine in England, Scotland and Ireland, very few can be said to be proficient in auscultating the lungs or in defining by percussion the limits of the heart or Spleen. Want of application in these our student days makes it so difficult in after life to arrive at definite conclusions in diagnosing and treating our cases. ***

It has been my lot to become Medical Officer to some coal-works in this district (Risca, Monmouthshire) where I have now been in practice over four years. Considering the class of patients I have to attend, I naturally see a good deal of the shady side of Nature. By daily intermingling with many of the 1000 to 1500 colliers and their families which are living in this neighbourhood & habited in cottages with, by no means the best of sanitary ~~of surroundings~~ surroundings, we have to combat with disease very much handicapped & also meet with all kinds of diseases and accidents, incidental to colliery life.

The life of a Colliery Surgeon is in general * hard and laborious - very different, indeed, from what our more fortunate town brethren enjoy. Still, perhaps such a practice as this is more eventful & brings with it more interest - variety professionally. There is here a good deal of everything to be seen and done. Thus, often we dispense a hundred medicines (and more) in a day! An assistant and myself will frequently visit daily as many houses - ~~besides the minor and other surgery~~. Morning and evening attendance at the Surgery includes also minor surgery generally, such as tooth

-extraction, galvanising wasting or paralised muscles, insufflating and catheterising the eustacheon tubes, dressing wounds, &c, &c. A busy life it is, and our more fortunate town practitioners will, I am sure, forgive much shortcoming on our part because of the amount of work we have to do. It is well nigh impossible to follow carefully & take daily note of many an interesting case we come across from press of work. But yet, we have a lull now and again after a period of high pressure. The activity we had to display during the recent visit of the Influenza Epidemic, I hope we shall not soon

he called upon to speak.

The Sanitary Condition of Most of our Colliery districts is sadly deficient and neglected. Thickly populated as Risca is, we have no main-drains to carry our sewage away. W.C.'s are generally built very near the houses & badly kept. The effluvia from these is often very potent in the dwellings. The houses are mostly provided with Earth-closets or the bucket-system, but in general are neglected. The sanitary officers (under our Local Board) do their work imperfectly, because they do not care to offend their friends, (The house-owners.

As to the cottages themselves, they are generally tenanted by two, often three, families - such is the scarcity of houses in the district.

Colliers' wives, as a rule, are very bad cooks and very wasteful. The consequence is there is a great deal of illness due to improper feeding.

Picture a compound fracture case in one of these cottages. Is it any wonder if it does not do well? What a contrast, a patient in one of these cottages in a low-lying street with such bad sanitary surroundings and a similar case in Western Infirmary, where, as far as I remember, everything was perfection.

Yet, with all these drawbacks, it is surprising how well medical, surgical & midwifery cases do here; & that too with very little use of antiseptics: and it is equally surprising how free we are from Epidemics such as typhoid, diphtheria &c.

In recent years Cottage Hospitals have been started in several of our mining towns and villages to give the sick and injured better nursing, attendance and sanitary surrounding than they can obtain at their own homes. The idea, of course, is good, but practically it is generally a failure.

Why? Well, when a Collier receives an injury at the pit he prefers to be conveyed home to be nursed by his wife or sisters and up, a bed improvised in the corner of the room, where the family live and take their meals, & in the enjoyment of their company with the freedom it entails to the, to him, monotonous & perhaps stringent rules of a Cottage Hospital - though he is offer "fully aware of the superior attendance, nursing and Comfort to be obtained there. Hospitals are always popular - for consultation, but not for residence. A Collier generally wants a great deal of freedom - even when ill.

In Rieca we have in hand a good sum of money (about £500) for some years for the purpose of erecting a Cottage Hospital, but seeing the poor success of such undertakings with our neighbours we are chary in starting one ourselves, although everyone is convinced that the principle is thoroughly good & sound.

Case T. Strangulated omental Hernia in an old man with Chronic Bronchitis &c: hernotom death.

I shall now give a brief account of some of the Surgical cases I have had under my care within the last four years.

The very day I commenced practice in Risca I was summoned to see

Case I. A. Hamilton, ab. 75, an old man with one arm, who was said to have stoppage of the bowel following a fit of coughing two days previously.

The patient I found had been confined to bed for three weeks with a severe cough & tightness of the chest.

I found he had been subject to Winter's cough & gradually increasing shortness of breath

7: which was constructed more for support than to prevent protrusion,

large scrotal ~~hernia~~ tumor which he supported with flexed thighs. It felt solid and firm, and tender when pressed. He experiences dragging pain in the region of umbilicus. On percussion it was found to be dull all over; it did not transmit light. On coughing it gave no perceptible impulse. Patient informed me that he had been subject to rupture on that side for great many years that had always worn a truss but that ~~he~~ while confined to bed with his bronchitis he had left it off. He said that the lump had been getting gradually larger year after year that from time to time many attempts

had been made to reduce it, but with no success. The present symptoms, he said, set in after sudden increase in size of tumor two days previously. He said he had taken two doses castor oil & other purgatives but with no effect.

I diagnosed strangulated hernia, - a fresh protrusion supervening on an old irreducible mass.

I applied taxis for about ¼ hour, but with no benefit. Soon afterwards, I used evaporating lotion of ether & followed this again with taxis, but with no better result. On neither occasion did I persist long in taxis fearing to

damage the bowel. I had to tell my patient and his friends now of the gravity of his condition, but mentioning that there was a remote chance of saving his life with herniotomy. I explained the pros and cons of that operation & left them to consider what they wished me to do. In an hour, I returned prepared for herniotomy, if they should so decide. ~~When I returned~~ I found them anxious to give him the last chance & urged me to do my best for him.

I began to prepare the patient for operating by administering the A·C·E mixture, but he could not tolerate it as it embarrassed

his breathing very considerably. I had hoped, indeed, that the breathing would have improved with this anaesthetic by acting as a stimulating anti-spasmodic - and, I believe, such would have been the effect too if it had been persisted in a little longer. At his request I gave him a good dose of brandy & proceeded with the operation. An incision was made through skin & subjacent facia and with director & knife (& the frequent use of index finger) I gradually and cautiously dissected through layer after layer of fibrous & areolar tissue expecting to be rewarded by coming to

sheath and bowel. I kept on patiently for nearly an hour when I got fairly through the whole mass but without finding any trace of bowel - which I all along anticipated to find imbedded in the protruded & adherent omentum. The patient kept up well & bore the pain without a groan. I nicked the constricted parts in canal & after putting on a stout ligature, the protruded mass was excised & dissected off where adherent; which was not extensive. The ligature was brought out through incision in skin & secured by plaster One stitch above & below were

applied to the wound, which had ample room for discharge of drainage. It was then dressed with iodiform & Gamgee's absorbent tissue. By this the patient was very much exhausted but a subcutaneous injection of ether and digitalis & application of heat to heart and extremities revived him gradually. During the next eight or twelve hours he had several quantities of brandy & beef-tea but the still-persistent vomiting kept up in spite of soda-water ice which had been administered. But to my joy on visiting him early next morning he said he had passed flatus twice since

I left the night before. An enema 24 hours after the operation considerably relieved the distressing feeling at umbilicus & & hypogastrium brought with it one or two hard masses of scybula. The vomiting eased gradually from second day. However, the shock of operation was too great for him, his breathing became more impeded, his face more livid & cold & on the fourth day after the herniotomy he died - apparently from the chest complaint.

Case II. Comp: Communited fract: of both legs in a bow-legged + knock-kneed lad. Specially constructed box splints Complications – enlargements of spleen + liver &c: bronchitis Complete recovery.

Case II. On a cold Winter's Morning about 4 a.m., I was called to a Colliery accident. On approaching the house indicated, I could see the dull lights of about a 100 Colliers' lamps swaying to & fro as their bearers slowly approached in the distance walking four deep. On nearing the house I discerned the ambulance stretcher on which was placed the injured covered with brattice cloth & workmen's coats. The stretcher & its burden were ~~Laid~~ laid on the floor near the fire where he was stripped of his boots & clothes while a bed was rigged out in the corner. The patient, ~~I found~~ who had bled a great deal, but has now pretty nearly ceased was a

lad of 14 years of age, rickety and overgrown & with genu valgus of right knee & genu varus of left together with corresponding talipes of feet. A tram full of coal had gone over both his legs about midway between knees and ankles with the result that he had compound comminuted fracture of both ~~legs~~. Under chloroform, I removed several pieces of sequestra from both legs, set the fractures & dressed the wounds with carbolised lint & oakum tapplies padded Clines' splints. The larger blood vessels in both legs were uninjured. These splints, which were not "interrupted" were quite unsuitable as they pressed on wounds on side of legs & made access to them

impossible without their removal. So, on the third day I substituted for them a pair of fenestrated box splints (made by some colliery carpenters) which were so constructed that the pieces on the bottom (on which the legs rested) extended from middle of thigh to a foot beyond the heal; but their peculiarity was the angle at the knee to fit the deformity in each leg. The foot had rest pieces + each was provided with appropriate fenestrated side piece. When these were well padded + legs evenly bandaged the patient expressed himself considerably eased. Without their removal I could dress the wounds by simply taking off the local dressings. The slanting head boards were

made sufficiently long to keep off pressure of bed clothes so do instead of bed-rest.

During first weeks the Ldd's temperature varied about 100-101°; his digestion & appetite remained fair on the whole but failing now and again after pain or want of sleep. Occasionally I had to give him a little opium, but I abstained from giving him only as little as possible. The wounds were dressed every day or every second day (as was necessary) with carbolised lint, protected with oiled silk, & covered over with oakum. By means of a pulley fixed in a rafter the patient could help in being placed on the pan &c. During a long process of healing several small sequestra were discharged from both legs

Some adjusting of padding, tightening or slackening of bandages had to be done daily for weeks. In about four months, I was able to remove the "box" splints & substitute for them one "bracketed" cline for each leg. I now commenced gentle motion of knee & ankle joints which were getting very stiff, but as the sores were still unhealed & discharging pieces of bone occasionally, I still refrained from much ~~active~~ passive motion. Indeed, the wounds were not finally healed until nearly eighteen months after the accident. After the bracketed Clines had been on for five weeks, I substituted a simple roller bandage and local dressings, but with the patient still in bed but encouraged to use the

limbs and move the joints. The Knees and ankles has become partially anchylosed by long rest: but with persistent active and passive motion & the application of Unq: hydrarg: iodid: rubr. & Linit. iodid the action of the joints returned perfectly. The wasted muscles were galvanised for some time with a weak current.

Gradually the strength & power of walking returned. After using crutches for many weeks, he gained in health and strength in spite of several serious complications which also menaced his life.

In about two months after the accident, when the wounds were discharging pretty profusely, his liver and spleen became considerably (& tender) Enlarged & the abdomen tense and

tympanitic. With this there was considerable pyrexia, loss of appetite and general failure of power. The wounds were then daily dressed & good exit allowed for discharge of matter. He was well fed and allowed fair amount of portwine. For medicine he had at first appearance of complications small does of salicylic acid & afterwards citrate of iron and quinine with a teaspoonful of Kepler's extract of malt and cod liver oil night and morning. Gradually the hepatic and splenic enlargement disappeared taking months really before no ~~pain~~ enlargement could be detected.

During his illness he had a very severe attack of

bronchitis with symptoms of phthisis: but this also disappeared.

Four years have now elapsed since the accident + during the past year the lad has worked regularly in the mine. A few days ago I examined him again. Both legs straight + quite healed; patient thinks the deformity at knees less since accident. The abdominal organs appear normal. He says he has not lost a day's work for months + is quite satisfied with results.

Case III. Necrosis of ilium sequestrum out with perfect recovery.

Case III. Gomer Lewis, ætat 20, consulted me for discharging sores on upper part of right thigh. Patient, a grocer, has strumous relatives but appears himself in very good health. On examination I found he had two sinuses in the neighbourhood of hip joint, one opened a little behind and below trochanter major the other just above that prominence. These patient said were the remains of a gathering in that neighbourhood which occurred two & a half years previously. He had been to Bristol Infirmary about a year before I saw him previously & was operated on for "diseased muscles of hip", but with no benefit. With aid of probe &

found that the two openings communicated & that a sinus passed from upper opening towards crest of ilium. Where its point came prominent under the skin, after it was passed up full length from upper sore, I cut into so as to reintroduce the probe. After introducing it here I was able to pass it easily to ~~posterior~~ little below posterior spine of crest of pubis, where I at once ~~detected~~ detected diseased bone.

With the patient anaesthetised, I exposed & gouged out diseased bone; left in wound a drainage tube which made its exit at the upper sinus opening. The parts below this were brushed with solution of chloride of zinc

after the channel had been well scraped first. The whole was dressed with carbolised lint & Iodoform. The patient and his friends were soon able to dress the wound themselves as he lived some distance away from me. In four weeks after operation the patient found he had lost the drainage tube (now considerably shortened). On examining the thigh in a few days after its disappearance I found that all the wounds were healed over - the top one had just closed. In consequence of this, though I suspected the tube to be in the sinus, I did not attempt to make any Exploration.

In nine days it was discharged through upper and recently made opening. At end of a fortnight after this every part was healed up & finally, for he has had no return of it for over a 12-month.

When first I examined this young man I certainly did not expect to find disease bone, especially after the diagnosis & treatment at Bristol Infirmary. But from the beginning, considering the easy and perfect motion of hip joint, the aid of other negative symptoms, I did not much suspect disease of hip joint.

Case IV. Burns of both feet resulting in excision of os calcis of left foot ~~+ [illegible] of~~ + fifth metatarsal of both feet: skin grafting: perfect recovery.

Case IV. E. Carpenter, æt. 9 years, had extensive burns of both feet through sleeping over a lime-kiln where he went to hide from his mother after breaking the glass of a street-lamp. When discovered he was nearly dead from asphyxia through inhaling the fumes of the carbonic acid gas. When I saw him soon after he was brought home, his skin was clammy & very pallid & pupils widely dilated, pulse feeble & slow.

With the application of heat and administration of weak stimulants he gradually recovered from this alarming condition.

When the charred boots were taken off (by cutting to), his feet presented extensive

burns of both soles and adjacent parts of back. After poulticing for three weeks to separate the sloughs, their appearance was as follow—

The sole of left foot was completely denuded of skin and superficial fascia up to the base of the toes, completely exposing plantar fascia &c: the calcaneum was projecting through retracted flesh and bare for 2/3 of its extent. The Cuboid bone was in view where it formed the former. From this to base of toes the plantar fascia was fully exposed. On its outer aspect, the fifth metatarsal bone was in view in the whole of its length. The skin & subjacent fascia destroyed up to the level of the external malleolus.

and down to the little toe. On inner side the burn was not so deep nor extended so high up the dorsum. The toes although burnt escaped pretty well. The right foot was not quite so bad. Its outer side was burnt most. All the fleshy part of the little toe came off in poulticing leaving the bones bare. The fifth meta-tarsal was exposed as in left foot. The heal though burnt saved its flesh, but the soft parts of the outer half of the sole for the anterior two thirds of its length, together with external and adjacent portion of dorsum were burnt to the 3rd or 4th degree.

On March 9th, three weeks after the misfortune, & when the sloughs were pretty well separated

with the patient under chloroform, I removed nearly the whole of the left calcaneum, leaving but a thin layer where it joined the astragalus and cuboid bones, gouging it out after sawing through the bone high up. I then excised the fifth meta-tarsals and toes of both feet by dividing the ligaments and tendons attached.

I had no edges to approximate with sutures in consequence of the loss of skin and other tissue, both feet presenting large ~~holes~~ open wounds, and the left a fossa in place of heel. The bleeding was pretty easily controlled with cold water as all the main blood vessels were unmjured. Each was dressed with strips of lint saturated with carbolised

oil and applied firmly, especially where calcaneum was removed. These were covered with oiled silk & tow padding & finally bandaged over with a roller. The lad was restless and in some pain the first night so he had 1/4 gram of opium. Next day, when visited he was sweating profusely; pulse, 102, regular; temperature 100·1°F Expression placid & he appeared comfortable. During the succeeding days the appetite was fair & thirst but little. I was determined not to dress the feet for 4 or 5 days unless pain or symptoms necessitated my doing so, so as not to disturb the wounds & give them rest & keep out the air. I had purposely used abundant padding in the dressing to do this.

On March 15th they were dressed the second time. Both feet looked doing well; granulations, red and injected, bleeding when touched: discharge not great: gap in left heal filled with organising clot. After mopping the well of all discharge, they were dressed as before. Appetite from this improves considerably & the temperature was not much above normal: he also became more cheerful. From this time on he was, as a rule, dressed every two or three days according to the quantity of matter present. During the first month or so, the temperature ran up on one or two occasions to about 102°F, but the pyrexia to subsided each time after fresh dressing or a mild purgative.

Note written April 21st —

"Gap in heel is quite covered over with granulations: extension of skin from sides to plantar surface, which progressed pretty rapidly at first, very slow for the last fortnight. So today I grafted numerous small flakes of epidermis shaved from tender skin on my forearm, hiding them by the sides of prominent granulations."

Note on May 6th —

"Several of the skin-grafts placed on wounds on ap 21st & afterwards have taken: progress of general skin extension slow: discharge more copious lately, so have used weak solution of sulphate of zinc instead of carbolic oil with benefit. The last is

to be taken out and placed on a couch every fine day as the room is very unhealthy and close, to say nothing of the dirt."

In July the patient was able to go about on crutches. The right foot was quite healed over & the left nearly so. He pulled up wonderfully after ~~case~~ he began to be out of doors - gaining in weight & appetite.

In August he was able to walk without any support, both ~~feet~~ feet being quite healed over, & a very good heal for left foot. The calcaneum is partially reproduced & forms a solid useful pad. The contraction of cicatrices is not

very much; all that can be seen from this is the abduction of the forth or outer toes – a result not altogether a disadvantage!

Oct. 6. 89. The boy was in the surgery this morning & was examined. He has attended school for the past five weeks: is able to walk & run without any lameness whatever. When I saw him about a month ago the cicatrices were tender or rather tickled by the boots, so he was inclined to walk on the inside of his soles. The knees were getting to look as if he suffered from knock-knees. I then cautioned his mother against his doing this & now he has got quite out of it & walks quite natural. He has a small padding of lint to support left heel.

The house where the patient lives is a small cottage in a row of houses. It consists of only two rooms above and two below stairs. There is a small garden in front. I can safely say it can take the first prize for filth & dirt. Again, the parents are both drunkards & have a large family of half clad urchins. During the whole of this illness the patient was lying on an old settle in the kitchen or living room below stairs & covered with more old rags & coats than bed clothes. Soon after he began going about, I met him one day playing in the street without a shirt on his back! The food & nourishment what the poor lad had when laid up were

generally inferior in quality and quantity.

Remarks. I debated in my mind for some days whether I should try and save the left foot or amputate it.

Here was a lad weakened already by the burns, ill-fed living in a house of filth with his bed [if] may so call it) in the Kitchen & surrounded by five or six dirty children.

The wound was extensive and necessitated the removal of an important part of foot, & it would take a long time before the skin could cover it.

On the other hand he had youth on his side & the loss of a foot was a serious loss, so I determined to try & save it.

Case V.

Siporma of scalp: Excision. Recovery. Rapid healing with absorbent dressing + pressure.

Case V. Mrs Allen, at 54 years, a tall spare woman, had a large ~~tumor~~ oval tumor over right parietal and frontal bones. It was firm but somewhat elastic the size of a duck's Egg. It had commenced growing 24 years ago + was stationary of late years. It was unsightly + inconvenient, but painless. After making an incision in its long axis, it was dissected out. Three sutures of silver wire were ~~used~~ used + it was dressed with Gamgee's absorbent tissue. On third day it was quite healed + the sutures were removed. It was dressed as before once again + when this was removed on the fifth day it looked quite firm. The result was very satisfactory.

The tumor appeared to be a lipoma. When placed in ~~to~~ spirits with an incision in its long axis it looked very much like a ripe peach.

Case VI. Sarcoma of Knee following injury and "bone setting": amputation: recurrence.

Case VI. H. Watts, ab. 13 years, who has hitherto enjoyed good health, sprained his Knee in playing football in the beginning of Feb. '90. When he consulted me a few days after I found a little swelling, as if from effusion, on each side of patellar ligament. I recommended rest and the application of Lini. Sodi. I did not see him again for six weeks, but during the interval he was treated by a bone-setter, who, with great force "reduced a sinew out of place", but as he was getting worse I was called in. The Knee then appeared considerably swelled over the joint, tender on pressure, partially flexed and painful in movement. The skin was tense, injected & shiny, and

it gave a hard elastic feeling to the touch. The swelling appeared spreading up the thigh on inner side. I feared sarcoma and communicated my suspicions to the parents who then decided to send the patient to Newport Infirmary where my suspicions were shared by the staff. He remained @ the Infirmary nearly a month when he was discharged as the parents ~~had~~ desired to have him home to have his leg amputated, a treatment that was urged ~~on them~~ to be done without delay. On examination the day after he arrived home, I found the swelling to have extended + increased in size very considerably. It now reached up beyond the middle of the thigh (especially on inside)

below the Knee the extension was not so great: dark veins coursed the injected tense skin: girth at Knee ~~was~~ measured 18 inches against in the right: but general Character was very much as mentioned above, except more pronounced: body health, face, except emaciation which was considerable.

On March, 19th I amputated the leg high up very near the trochanter major, making equal flaps in front & behind (modified circular). As the swelling extended so rapidly & was already so high up, I wished to keep as far as possible from diseased part in taking my flaps & not use ~~diseased~~ suspicious flesh. The femoral artery and one or two minor branches were ligatured & the flaps brought together

with silver sutures. The operation was done with no antiseptics except the carbolised oil in the dressing. The hæmorrhage was not great, but the operation prostrated the lad very much: & he laid in a state of deep shock: skin was cold & face blanched with pupils dilated: pulse thready & nearly imperceptible. He revived gradually with the external application of heat & the administration of brandy and warm milk by mouth & ether & digitalis sub cutis.

P.M. appearance of joint &c. —

Following an incision into the swelling the wound gaped & the bones at knee & beyond were destroyed as if by acute caries. Thick & dark grumous matter from broken down tissue

studded the bones and soft parts. Beyond it was dark-grey shading into reddish from fibrous tissue. The joint and surrounding appeared to be in a state of acute degeneration.

I had no means of making a microscopic examination.

Suffice to mention that after the operation the stump appeared to do well and he had no bad symptom up until it was nearly healed all along, which it had done in three weeks when he appeared gaining in appetite and general health. However, a fortnight after the operation, one of the drainage tubes got lost in the stump- through

loosening of the ligature attached to it. attempts to probe and extract it proved unsuccessful, but in five days after, the now closed wound of union ~~gave~~ became inflamed in the middle ~~gave~~ way discharging the tube. This unfortunate incident ~~was~~ marked a turning point for the bad. Up to this everything appeared to do well and I anticipated a good recovery. After this, slowly but surely, the little stump became larger and angry looking, opening up also at the cicatrix, exposing black material like clot ~~+~~ full of coarse fibres. The gaping edges of the wound became hypertrophied, ~~and~~ hard and everted ~~+~~ the discharge dark grumous ~~+~~ offensive but not great

The temperature now steadily rose from the normal to where it was settling to about 102°7. He has run down hill ever since & at the time of writing (June 17) he is just alive, and that's all. The stump is now so much enlarged that it is about five times its original size — or, in an other way, it is ~~the weight~~ equal in weight to about ½ the body-weight.

At the amputation, I had the advice and assistance of two colleagues. The question arose whether having in view the rapid extension of the disease the leg should not be taken off at the hip. However, taking into consideration the much greater mortality of this to

amputation at upper third and the already weakened condition of the patient, we decided to take it off high up the thigh with circular incision & cuts on each side, as a long flap anywhere would only set so much nearer the disease.

~~Again~~

The origin of the disease is worth noticing. What had that slight injury or the rough handling of the bone-setter to do with its malignancy? There is no family history of malignancy or of anything that can throw light on this

Anchylosis of Joints after injuries:—

Case VIII. Stiff shoulder: alcoholism: ~~asphyxia~~ asphyxia under chloroform & recovery: dislocated in using passive motion & reduction. Result.

The next ~~three~~ four cases are examples of anchylosis, or stiff joints.

Case VII. R. Hill, ætat years, a quarryman and a person who had for many years been much given to drink, had a stiff shoulder joint following an injury & subsequent neglect of it. Arcus senilis well marked & pulse habitually intermittent. Local applications & passive motion had been regularly persisted in for weeks but with no benefit. Accordingly, I recommended motion under chloroform to which he consented. We (my assistant & myself) proceeded to do this next day at his house. While I was administering chloroform and the assistant watching

drew out his tongue & depressed & drew forwards the jaw.

the pulse everything went on well for about two minutes when suddenly, without any warning the respiration ceased - the pulse still going but feeble. The face became livid lips purple: We dashed cold that water in succession over his face & chest* & proceeded with artificial respiration (according to Sylvester) for some time, being rewarded at last by return of breathing spontaneously. I shall spare the reader the descriptions of my feelings then and after. After an interval of half an hour when he was pretty well himself ~~again~~ I again cautiously administered the A·C·E mixture & got him

under without any further mishap & proceeded with passive movement of the stiffened shoulder joint. but in my manipulations I had the misfortune to dislocate the head into the axilla! With the head in arm pit I got it reduced again.
Patient felt very sore for days & no wonder.

The result of all this was that the motion of the joint was - well, no worse. Further comments on this would be useless, still I do not wish to hide any of my failings and misfortunes: hence my mention of this case.

Case VIII Anchylosis and chronic rheumatism. passive motion be -

Case IX. Anchylosis of Elbow

Case VIII. Robert Hopkins, ætat. 65 years, a collier suffered from a stiff shoulder joint the result of an accident. He had for years been the subject of dry arthritic rheumatism + crack-lings of joints, which was greatly influenced by alterations in the weather.

Considering his age, rheumatic tendency and my experience gained in Case VII., I refrained from active measures under chloroform but used shampooing, active + passive motion daily at the surgery. He improved somewhat but not a great deal.

Case IX. A. Hicks, ætat 38. a collier had a stiff elbow following an injury which he had neglected by keeping his arm stiff for some

Case X. Anchylosis of Elbow after dislocation; motion under chloroform: perfect recovery.

weeks. Was put under chloroform three times at intervals of a week or so for passive motion. He improves considerably ~~in~~ in motion but muscles were much wated & were galvanised with much benefit. Result, satisfactory but motion not perfect. He can bring his hand to his face & mouth which is a great advantage.

Case X. Lewis Thomas, ab 15 years had stiffness of elbow joint following dislocation backwards of ulna. Patient passive motion with & without chloroform resulted in almost perfect movement of joint.

Anchylosis of joints is common in cutlery districts.

but the prognosis, as a rule, is unsatisfactory. I find it favourable in young people: but when the patient is advanced in years or subject to rheumatism or feeble health it is very unsatisfactory.

The cases mentioned are only examples of many treated within the last four years.

Chronic Ulcers of leg -

Chronic Ulcers of leg. —

These are very common and difficult to treat. The chronic callous ulcer is very intractable. Patients, as a rule, will not let their limbs have proper rest, elevation &c. for successful treatment. I find that ~~to a rule~~ old standing sores of leg are brought into a healthy condition best & speediest by application of small blisters, which bring floor and edges into healthy looking granulation tissue. These ~~destroys~~ convert the hard edges into healthy and healing condition destroying the dead epithelium & stimulating the growth of healthy granulation on the floor

A small sprinkling of iodiform afterwards is often beneficial. When these old ulcers are brought into a healing condition I generally cover them over with a piece of Gamgee's absorbent dressing slightly overlapping the sore & then strap the leg up with plaster. The dressing and plaster are changed every three or four days, according to quantity of discharge and degree of comfort. The treatment is nearly always successful but often slow. When the wound or surrounding is inflamed, astringent lotions of lead or zinc and poulticing help to ease the pain & bring on healthy action.

Case XI.

Chronic tertiary ulcer over knee joint of 11 years standing. Recovery under antisyphilitic treatment, immobility and strapping.

Whatever is placed direct on the wound, the best agent, I find, to heal these sores is equable strapping.

As to medicine, blue pill and potassium iodide seem to benefit nine cases out of ten. Accordingly, I have made it a rule to administer these in all cases, even though there is no suspicion of syphilis.

Mrs Goff, at 39 years, had history of syphilis. Over right knee there was a large irregularly crescentic deep ulcer measuring six inches by four; edges were abrupt & base here & there excavated. The surrounding was coppery in tint. It first broke out eleven years previously and

Ulceration after 37 years' standing yielding to arsenic iodide of potassium te

for
Seven months previous to my first seeing her, she was almost constantly confined to bed ~~[illegible]~~ on account of the pain in movement of joint ~~and~~ in walking. Two months anti-syphilitic treatment and stopping, with iodiform to on sore completely cured her. There has been no recurrance for two years.

Case XII. Mrs Hopkins, ætat 59 years, had extensive ulcer on front of left leg. It ~~was~~ first appeared 3½ yrs previously! Base, dry and discharge scanty: Edges shallow & crusty with scaly epithelium surrounding, dry & hard. The persistant use of

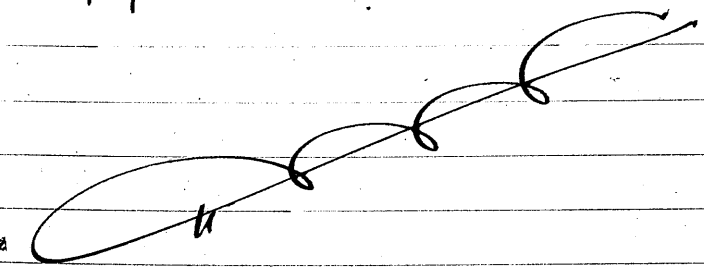
Recurrence of Specific
Ulcers of legs

of Potassium iodide and liquor arsenicalis completely cured her.

Case XIII Mrs Lowe, at 28 years, has specific ulcer of leg - with general syphilitic characters. It yielded to mercury and iodide of potassium in about a month. Soon after, however, a similar sore broke out in other leg, which also yielded to similar treatment; but no sooner was it healed over than another sore broke out the other leg. However, after the third was cured there has been no fresh outbreak, & she has ~~now~~ enjoyed good health since.

Rest + position as
cure for ulcer of leg.

Case XIV. James Coomber, ob 35 years, a powerfully built collier, had an old callous ulcer of leg, cured by water dressing, and rest in bed necessitated by Pirogoff's amputation of foot.



Conclusion — I shall not trouble the Examiners with any more of my cass to weary them. I am fully aware of the very imperfect manner I have written, and on reading over ~~again~~ the foregoing pages I find that the handwriting is not of the most legible Kind. It was my purpose at the commencement to rewrite the whole & improve the grammar & style, but flecting hours & press of work Compelled me to abandon this.

In Conclusion, let me wish my old Alma Mater to have a future equal to its past, and continue to merit its motto + via, veritas, vita.