

key to the peculiar accident to which the name of the renowned surgeon, Pott, has been attached. The deltoid ligament is composed of two portions, an outer layer broad and thin attached by its upper and narrow extremity to the external surface of the internal malleolus, and by its expanded base to the astragalus, or calcis and scaphoid, but beneath this superficial portion there is a short compact and powerful fasciculus, which embraces the apex of the internal malleolus and binds it with great firmness to the side of the astragalus. This portion of the deltoid is more powerful than the bone itself, hence when force is employed in this neighborhood the ligament resists, but the internal malleolus yields.

CASE II, POTT'S FRACTURE—NO DEFORMITY.

Edward F.—aged 45 years, laborer; Ireland. Admitted June 6th; states that on the previous evening a bank of earth fell upon his right foot against the leg, throwing him to the ground. After being extracted he found that his ankle was so injured that he could not walk. He was brought to the Hospital and an examination showed fracture of the fibula about three inches above the joint, and the internal malleolus broken off. There was no deformity and but little swelling. The limb was placed for two days in a wire cradle, after which it was dressed with side splints. There is not the slightest deformity.

CASE III, POTT'S FRACTURE—DEFORMITY.

John H.—aged 30 years; shoemaker, admitted July 12th. States that while engaged in a friendly scuffle he caught his foot in some way and turned its bottom outward. It gave him great pain. On his admission an examination was made showing the following condition; fibula fractured about two and a half inches above its lower extremity, internal malleolus fractured, a partial dislocation of the foot, and considerable swelling. The leg was placed in an ordinary fracture box. The recovery was rapid, the foot is in proper position, but there is some widening of the ankle and prominence of the internal malleolus.

You will seldom, gentlemen, see three cases of Pott's fracture during one clinical course. In the first case you have witnessed the worst and in the second case the simplest form of this accident. In the one there was no deformity, and but little injury to the soft parts, but in the other the force which broke the bones, destroyed the integrity of the joint, ruptured blood vessels, lacerated muscles, and threw their tendons out of position.—*Cincinnati Lancet and Observer*.

Military Surgery in the French Army.

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The French Surgeons are much exercised at present over the enormous mortality of their military surgery, as compared with that of the English and Americans.

Last year, the *Gazette Hebdomadaire* published articles setting forth the frightful figures connected with the French surgery in the Crimean War. This year, Mons. le Dr. S. C. Chenu has published

a work, in two large quarto volumes, with a folio atlas, on the surgical results of the last French campaign in Italy, at the time Napoleon III. expelled the Austrians from Lombardy. Notwithstanding that Northern Italy has a fine climate, lies close to the borders of France, and abounds in everything necessary for wounded men, the same frightful excess of mortality in French surgery is displayed, which was before seen in the Crimea. The following table illustrates the differences between the different armies:—

OPERATIONS.	U. S. ARMY, War of Seces'n.	English Army, Crimean War.	FRENCH ARMY.	
			Crimean War.	Italian War.
Disarticulation of Shoulder...	39.2	33.3	61.7	52.7
Amputation of Arm	21.2	24.5	55.5	55.3
Amputation of Forearm	16.5	5.9	45.2	42.9
Disarticulation at Hip-joint...	85.7	100.0	100.0	57.1
Amputation of Thigh	64.4	64.0	91.3	73.4
Amputation at Knee	55.1	57.1	91.3	75.0
Amputation of Leg	26.0	35.0	71.0	63.5
	43.2	33.9	72.3	63.9

PER CENT. OF MORTALITY.

From this, it appears that the mortality after French military amputation has been about 60 per cent. greater than in the American army, and nearly one hundred per cent. greater than in the British. The *Gazette Hebdomadaire* takes up the controversy, and attributes this disastrous result to two main causes:—1st. The organization of the army which makes the surgeons dependent on the *Intendant* (a sort of Quartermaster) for supplies; in consequence of which the wounded were often short of good rations, and, 2d. The reckless transfer of patients from one hospital to another. It does not seem to me that the writer in the *Hebdomadaire* makes his points well. In the U. S. Armies, the Medical Department was absolutely dependent on the Quartermaster and Commissary for supplies, and partly so for transportation. All branches of the service are in the same condition in that respect, and, in the nature of the case, must be. In the turmoil of war, rations will get stopped or damaged occasionally; and yet we did not find that short or even damaged rations were half as injurious to the wounded as some other things to be presently mentioned. A similar criticism may be made respecting the assertion, that the transfer from hospital to hospital was necessarily a chief cause of mortality, and a reason why their men suffered more than ours. No doubt, transportation injures some patients, but when done in open, airy, and not crowded conveyances, it does much less harm than we formerly supposed. On Sherman's march to the sea, the wounded were all carried through to Savannah in ambulances, shaking and jolting over bad roads, and yet the amputations recovered magnificently. No set of wounded men ever did better, evidently because they had the freshest of pure air. In active military operations, the hospitals near the front must often be abandoned and the patients transferred; besides, they become overcrowded, and require relief for that reason, otherwise half the patients will die of typhus, erysipelas, hospital gangrene, and pyæmia. I believe we had in our army more such transfers than the French, and yet we suffered