

vous, that of anointing the cut surfaces, and of leaving in the wound perforated pieces of linen loaded with simple or other cerate, according to the fancy of the surgeon, as surgeons within my own day have done.

Still, while now-a-days we avoid those extremes of mischievous meddling, we sometimes drift into a meddlesomeness not less mischievous, and with less excuse than had those who preceded us.

The practice, until thirty years ago, was not immediately to approximate the surfaces of wounds after amputations. British surgeons, led by Hey, adopted it generally; French surgeons, and chiefly Pelletan and Larrey opposed it; but equally great men, and chiefly Dupuytren, Delpech and Roux advocated it, and it at length became as general in Paris as in London. But again the practice was called in question, and chiefly by the men who had recommended it whom I have already named.

It will, I think, be readily conceded by every surgeon that the proper dressing of a wound after an operation has as much to do with its success as has the mode of its performance.

Is it desirable to have union by first intention, or is it desirable to have what is termed a healthy suppurating wound to unite by second intention? Most surgeons now-a-days are of opinion that the former method is desirable where practicable; most, yet not all, for some contend that, while union by second intention is more tedious, the suppuration established prepares the patient for those changes which *must* take place in his system as a result of the operation; whereas others hold that in union by first intention patients suffer less, pain is slight, there is no fever, no inflammation, no suppuration, and a better and a firmer stump. Arguments such as these long ago induced military surgeons to endeavor to obtain this much-desired union, while surgeons in civil practice pretended they had even better grounds for not desiring primary union. It was formerly claimed by the opponents of primary union, as it is claimed by them to-day, that effusions of blood between the cut surfaces, and beneath the muscles, must necessarily lead to suppuration. In my early days ample provision was made between the sutures, and at the most dependent part of the wound, for the escape of the looked for pus. It never occurred to one to doubt the formation, in

due time, of pus. I had never seen but one amputation without subsequent suppuration, and why there had been no suppuration in that as in other cases I could not determine. It never occurred to me to doubt the advantage of primary union in cases where the soft parts could be easily brought together, and when the flaps, and the parts they cover, are healthy; but the confounding of tissues so diverse, as skin, muscle, tendon, bone, connective tissues, nerves and blood vessels and blood clots, besides the foreign bodies from without, seemed sufficient to shut out all hope of union by first intention. I was surgeon for several years to the Hotel-Dieu, without having, but once, seen complete and entire primary union of a large surgical wound. Experience now tells me that primary and permanent union can be obtained in by far the greater number of surgical wounds by attention to details which, at first thought, may appear quite unimportant. Chief among these details, may be mentioned the following:

1st. The soft parts must have been divided cleanly and by a single stroke. There must be no deviation of the trenchant instrument from its *continuous* course; no partial withdrawing of the knife to again advance it, not always, perhaps, in precisely the same line, thereby leaving tissue wholly or partially separated from the general organism.

2nd. The flaps must be constructed so as to fall easily and neatly into the desired position and be sufficient without stretching, dragging or even coaxing.

3rd. Before being brought together, the wound must be quite dry. No bleeding, no sweating, even, of the surfaces must exist. Every vessel must have been closed *without* ligature, either by forcipressure, acupressure or torsion. (I mention these methods in the order, as they appear to me, of their general value.) If the vessels are small, forcipressure always; if large, acupressure generally, and sometimes torsion, though I rarely, very rarely, adopt the latter method.

4th. Before approximation of the surfaces everything must have been removed. And here perhaps one of the most important details in the dressing is systematically neglected. To dry the free surface with a sponge; or to dip down into the little wells and cavities of the