

made an admirable summary of the most accepted methods of dressing at present employed. His great experience and the authority of his name gave considerable interest to his address. If under certain circumstances, he said, union of large wounds by first intention be possible, applied under unfavourable hygienic conditions it always fails. The dressing of wounds is a very old question, but, nevertheless, always a new one. A better proof could not be given of its importance and its unsettled condition. "It is necessary to well define the subject. By a wound, the consequence of amputation, we mean a clean section made by a cutting instrument—regular, self-adapting, involving various textures, and offering several forms which can be reduced to two principal types, the concave and the angular. The incised parts include the skin, muscles, bones, vessels, &c., and, however perfect the contact, the centre forms a virtual cavity. Given such a wound, what treatment should be applied to it?"

It may be left exposed, but this method is full of inconveniences: it leaves uncovered a large and painful wound, considerable suppuration follows, and the cicatrization is slow. It offers, however, one advantage—an easy exit of the discharge from the wound. But if we wish to protect the wound, we have first the simple dressing method which was almost exclusively adopted till the first third of this century. It will suffice to say that it is a bad dressing. A second method of protection is the complete and immediate union of the wound, otherwise called by first intention. The advantages of this method are, the limitation of inflammation, the absence of suppuration, and the rapidity of recovery. But, on the other hand, none of its advantages are reaped if applied to amputations; in such cases, union by first intention, if not impossible, is at least very rarely obtained. From a comparison of these advantages and disadvantages arose the idea of partial union, which limits the time necessary to the healing of the wound, and lessens the extent of exposed surface; but hitherto most of the methods created by the idea have not taken into consideration the retention of pus in the deep parts of the wound. However, I must say that the method advocated by Dr. Azam meets this indication. During the last few years two systems have sprung up, both based on the germ theory, otherwise on the unhealthy media in which operations are generally performed. The first is Lister's antiseptic treatment, with its repeated dressings and its constant pursuit of the deleterious and infectious agent. Lister pretends that by his method he obtains a moderate inflammation, no suppuration (or very trifling), and an insignificant absorption. On the other hand, this method is difficult of application, and is followed by slow recoveries. Whilst Lister endeavoured to destroy the germs *in situ*, Langier with the gold-beater's skin, and Chassaignac with the diachylon, endeavoured to protect the wound against this agency by hermetically closed dressings. This idea was improved upon by Dr. A. Guérin, and to him we owe the cotton-wool dressing. In order to be able to compare the cotton-wool dressing with the method communicated to us by

Dr. Azam, we must take into consideration above all things the danger to which our amputated are exposed. I teach nothing when I advance that the conditions under which we operate in our Paris hospitals are most unfavourable. Our hospitals, beautiful monuments, utterly worthless in a surgical point of view, are nought but licensed necropolae. Whilst I acknowledge that in a salubrious medium the method of Dr. Azam is very acceptable, still I firmly believe that under adverse general conditions it will prove a failure; and, notwithstanding the disadvantage of the cotton-wool dressing—that is to say, a slow recovery—I will for the present continue to adopt it in my wards, as length of time cannot rival the safety of our patients."

Dr. Le Dentu, agrégé of the Paris Faculté, supported Prof. Verneuil's views. If he saw good results follow the use of the cotton-wool dressing in insalubrious hospitals, applied under favourable circumstances it gave admirable results. Thirty-five amputations of the leg, performed *au Cruesot*, and dressed with cotton-wool, gave 35 recoveries.

Professor Courty, of Montpellier, dreads the hermetical closing of the wound. He does not employ the cotton-wool dressing. He once obtained union by first intention after amputation of the thigh, but he agrees with the former speakers that such a result is both rare and uncertain. His great care is to give perfect rest to the wound, and for this purpose he places the whole limb in one of Bonnet's long hollow splints.

ON THE TREATMENT OF ONYCHIA MALIGNA.

In a paper read in surgical section at the annual meeting of the British Medical Association (*British Medical Journal*, August 30), Mr. MacCormac called attention to the treatment of onychia maligna by the application of nitrate of lead. The disease is rather common in Belfast; it affects principally the girls employed in flax-spinning mills. During the ten years, from June 1863 to June 1873, there were 217 cases of this malady among the patients of the Belfast General Hospital, being 2.2 per cent. of the total surgical out-patient cases; 115 occurred in the girls between the ages of ten and fifteen, and 63 between the ages of fifteen and twenty. One hundred and eighty-four were mill-workers. In his experience, Mr. MacCormac had found local applications and evulsion productive of only temporary benefit. The only efficient treatment was the complete excision of the secreting stratum at the root of the nail; a severe operation, and one which requires local or general anaesthesia. Lately, the author had read a monograph by Dr. Vanzetti of Padua, advocating the plan, proposed originally by Dr. Moerloose, of Ghent, of applying powdered nitrate of lead to the ulcerated surface. Mr. MacCormac had had no opportunity of testing this remedy among the patients at St. Thomas's Hospital; but, at his instance, it had been used by Dr. Scott in fifteen cases in the Belfast hospital, with most satisfactory results. According to Dr. Scott, from fourteen days to a month were required for a complete cure. All

pain ceased from one to three days after the first application; and the swollen irritable margin of the ulcer gradually disappeared, leaving a healthy granulating sore.

NEW METHOD OF HEALING ULCERS.

Dr. Nussbaum, in the *Wien Med. Presse*, claims to have successfully treated upwards of sixty cases of chronic, extensive, and otherwise intractable cases of leg-ulcers by the following simple procedure. The patient is at first narcotized, and then around the ulcer of the leg or foot, a finger's breadth from its margin, an incision extending down to the fasciæ is made. Numerous blood-vessels are divided, and a severe hæmorrhage ensues, unless a fine pledget of lint be packed into the cut and the entire ulcer strongly compressed. The packing with lint is also necessary to prevent union of the cut edges by the following day. Upon the second day the bandage and lint are removed. From then until a cure is effected a simple water-dressing is applied. The author states that an astonishing change can be seen even in the first twenty-four hours. The ulcer which yesterday threw off quarts of thin, offensive, ichorous pus furnishes to-day not more than a table-spoonful of thick, non-offensive, healthy pus. The old ulcer becomes rapidly smaller, healing from the margin toward the centre, and is healed in a short time; but the cut is changed into a broad circular sore, which also speedily cicatrizes. The great diminution of the secretion and other favourable changes occurring in the ulcer find an explanation from the fact that the circumcision has divided dozens of large, abnormally-widened blood-vessels. Time is thus given for the lessened nutritive material, which previously was carried off by the excessive secretion, to be transformed into cells and connective tissue; in other words, granulations are formed, which fill up and heal the deep ulcer. Without claiming this as a radical method, the author assures us that the cure is much more rapid, and the cicatrix becomes more elastic and resisting, than in the ordinary means applied, which usually require so much time that the patients depart with half-cured ulcers, soon to find themselves in their previous deplorable condition. — *Phila. Med. Times*.

A NEW URETHROTOME FOR INCISING VERY NARROW STRICTURES.

Mr. Berkeley Hill describes (*British Medical Journal*) an instrument, constructed by Coxeter, consisting of a slender sound, less in diameter than No. 2 catheter, grooved along its stem. The groove, deep for six inches of its length, gradually becomes shallow, so as to turn out a knife attached to a rod passed along the groove. By this means a cutting edge is made to project for half an inch or less, if necessary, against the floor of the urethra. By drawing the whole instrument forwards, the keen edge is brought against the stricture and cuts it through from behind forwards; the knife then returns to the groove, and the instrument can be harmlessly removed from the urethra. A subsidiary adaptation of the instrument renders it capable of being guided through extremely narrow strictures, and also of showing exactly the position and extent of the contraction to be overcome.