

I did not tell him that the success attending my treatment was worthy of a more exact diagnosis. It is with no sense of pride that I record the case; nevertheless, it might be expedient to adopt this treatment on another similar occasion. With a hyper-sensitive and nervous patient, and a fat or swollen shoulder, it is occasionally impossible to affirm, without the aid of an anæsthetic, that there is no displacement. Traction on the bent elbow, with the heel in the axilla, enables the surgeon to make the necessary examination. Certain am I of this,—that my nervous patient would not have allowed me thoroughly to examine him if I had first said that I thought there was no displacement.

I have observed the same course of events in other cases. For instance, a man has just damaged his ankle, which is now painful, swelled and stiff; a thorough manipulative examination reveals no definite lesion. But immediately after the handling the patient finds the foot so much better in every respect that he talks too lightly of his injury and wishes at once to walk about. Or an elbow, knee, or wrist is stiffened by a wrench. On being thoroughly overhauled, nothing is found absolutely wrong with it; but the patient, though a sufferer during the examination, finds the joint greatly improved by it. The surgeon will rightly refuse to include such a speculative therapeutic measure in his routine practice; but its blind employment by the charlatan is the means of securing many a triumphant success.

Where a limb is stiff from chronic muscular rheumatism, much good may often be done by *massage*, and by sudden movements imparted to it, the stiffness disappearing by magic, whilst no harm can follow the treatment.

Stiffness may follow on a sprain from effusion taking place, not into the synovial membrane of the articulation, but into a sheath in connection with a neighboring tendon. One has often to treat such effusion in the sheaths of the extensors of the thumb and wrist, and also in those of the tendons of the tibial muscles and extensors of the toes. It is, of course, easy to differentiate between an articular and a thenar effusion; the same principles direct the treatment in each case. I have, at the present time, under my care, a wrist which is stiffened from slight effusion into the sheath of the radial extensors; great relief is being afforded by the firm compression and support of a domette roller which is kept constantly wet—*The Practitioner*.

THE TREATMENT OF WHITLOW.

From time immemorial the treatment of whitlow has consisted in the early performance of deep incisions carried down to the bone and prolonged poulticing. This routine treatment is in the main accepted by most surgeons, yet great varieties of opinion are held as to the time when incision should be performed, the locality, and the duration of

poulticing, it being held by many that the necrosis that so often follows this affection is due to the prolonged heat from the poultice as much as to the disease itself. The subject recently has been attracting considerable attention, and Mr. Allingham (*Medical Press*, September 29, 1886) shows that there are several varieties of whitlow, and each of these requires a special mode of treatment. Mr. Allingham described five varieties of whitlow. The first, which he terms phlyzacious pustule, is nothing more than an accumulation of fluid between the epidermis and true skin. Of course, all that is required is to puncture the blister and let out the fluid. In another form, a collection of pus may form under the nail, as a result of a puncture or a breaking down of blood, following a pinch, and so give rise to considerable pain of a throbbing character. In the treatment of this class of the disease, Mr. Allingham recommends the insertion of a hare-lip pin, or some such narrow-bladed instrument, beneath the nail, keeping it quite close, so as not to wound, if possible, the tissue beneath, passing it down to the collection of pus, and then depressing the needle, and then allowing the pus to flow out. This gives instant relief, and prevents the matter from burrowing beneath the nail, and so separating it from its bed. Poulticing and waiting for the pus to work itself to the surface will entail a needless amount of unnecessary suffering upon the patient. Another form of treatment, which may be employed when the collection of pus is situated at the root of the nail, is to cut away the nail from the seat of the inflammation.

Under the term cellular whitlow, Mr. Allingham describes the inflammation of the cellular tissue covering the terminal phalanx, where the bone is free from periosteum. Inflammation of this locality, by producing strangulation of the vessels, cuts off the supply of blood to the part, and as a result causes necrosis of the phalanx. Almost as soon as the first symptoms of this affection develop, as may be recognized by acute pain in the part, with the tip of the finger swollen, tender, tense, and sometimes red, a free incision should be carried directly down to the bone, and necrosis of the terminal phalanx will thus often be prevented. When cases come under observation in which necrosis of the phalanx has already taken place, deformity may be prevented, according to Mr. Allingham, by making an incision along the palmar surface of the finger, removing the necrosed bone, and placing a narrow splint on the back of the finger, allowing it to project half an inch beyond the nail. The nail should then be fastened to the splint by adhesive plaster, so as to prevent it curling up, and it thus may act as a background on which new bone may develop. The fourth form of whitlow described is an inflammation in the sheath of the tendons over the first or second phalanx. It may arise from inflammation spreading from without, or by a purulent inflammation of the synovial sheath of the flexor tendon. The great dangers arising from this form of whitlow are that the tendons may be destroyed,