NOTE.—Since writing the above, I have noticed, in the JOURNAL of February 7th, a letter from Dr. F. Simms on the internal use of permanganate of potash. In regard to the statement that this drug, "administered in tablets of the strength of one grain, gives rise at once to ulceration of the parts it comes in contact with," I have had no experience of any such effects; nor have I ever found any symptoms of gastric or intestinal irritation produced even after three to six grains have been taken daily for weeks. But I have never used the drug in tablets, but in pills. That the latter, if properly made, should pass unchanged through the length of the intestinal canal, must be, it seems to me, a very rare occurrence.

Kaolin ointment, it may be mentioned, is the best excipient for making the pills; and saccharine ingredients should be carefully avoided, as being liable to cause decomposition, and even spontaneous combustion. Possibly this may be the secret of the caustic action produced by the tablets.

## AN OPERATION FOR DISPLACED SEMILUNAR CARTILAGE.

By THOMAS ANNANDALE, F.R.S.E.,
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THE pathology of the condition called by that wise old surgeon Hey, of Leeds, "internal derangement of the knee-joint;" by Sir Astley Cooper, "partial luxation of the thigh-bone from the semilunar cartilages," and which is now by some authors termed dislocation or displacement of the semilunar cartilages, has not yet been thoroughly worked out, as few opportunities occur for the dissection of a joint so affected. It is, however, a clinical fact that one of the semilunar cartilages, usually the internal one, does occasionally become loosened from its attachments; and, in consequence, this body is liable to be displaced either forwards or backwards, and so to interfere with the proper movements of the knee-joint.

Two classes of this displacement are met with; one in which the condition takes place suddenly, as a result of a twist or wrench of the knee; and the other in which the displacement is not so sudden, but appears to depend upon a gradual stretching of the attachments of the cartilage, owing to some effusion into the joints, or owing to some continued strain upon the joint, as is illustrated in connection with certain occupations.

When the displacement has once occurred in either case, it is liable to occur again; but from my experience, I judge that in cases, the result of a sudden rupture of the ligamentous attachments, which are promptly and carefully treated, the displacement is less likely to recur than in the more chronic ones.

If the condition be not permanently relieved, the displacement of the cartilage takes place more or less frequently in different cases; and sometimes in connection with the slightest movements of the joint.

The symptoms of this accident, as is well known, also vary in degree in different cases. The movements of the joints may be merely stiffened in one direction, or the joint itself may be firmly locked, and remain so until manipulation returns the displaced cartilage. Two patients have come to me from considerable distances suffering from this condition, and in both the knee-joint had been firmly locked in a flexed position for many hours. Manipulation easily replaced the cartilage, and the movements of the joint were at once re-established.

In all cases of this affection, some effusion into the joint follows the displacement.

The ordinary treatment of a displaced semilunar cartilage is to reduce it by flexion, extension, and manipulation; to apply a splint or elastic bandage, in order to keep the joint at rest, and prevent the displacement from recurring; and, if effusion be present, to employ the usual remedies to promote its absorption. When the accident is recent, I would strongly urge the importance of keeping the affected joint absolutely at rest for two or three weeks, so as to promote the union of the ruptured attachments.

This affection may become so troublesome, owing to the constant recurrence of the displacement, that a patient's occupation and comfort are seriously interfered with; and I relate the following example of such a condition in order to illustrate a new method of procedure which I successfully adopted in connection with it. The excellent result obtained in this case encourages me to express the opinion that this, or some similar proceeding, may now become an established means of treatment, when the more simple methods fail to give relief, and to obtain for the patient an useful limb.

CASE.—Thomas M., aged 30, miner, was sent to me from the north of England, on November 1st, 1883, with the following history. About ten months before his admission, he was working in a kneeling position, when he felt something give way in his right knee. He suffered sharp pain, but continued at his work for a few hours. Great swelling of the joint followed, and the pain became much aggravated, so that he could not return to his work, and he had not since worked at his occupation. The condition was treated by rest, blistering, the application of iodine, and various liniments, with the result of reducing the swelling; but the pain still continued, and the movements of the joint were interfered with by something "slipping" in the knee.

On admission, the joint was slightly swollen, and there was a small amount of effusion into its cavity. The patient complained of acute pain in certain movements of the joint, which frequently became locked in the flexed position. He was able, by a little manipulation, to unlock the joint, but the frequency of this symptom made him quite unfit to follow his employment as a miner. On careful examination of the joint, there was a well marked hollow over the anterior border and position of the internal semilunar cartilage. This hollow was most marked when the knee was flexed. Having decided that the case was one of displaced semilunar cartilage, and one not likely to be cured by any ordinary treatment, I, on November 16th, performed this operation. An incision was made along the upper and inner border of the tibia, parallel with the anterior margin of the internal semilunar cartilage, and the few superficial vessels having been secured, the joint was opened. It was then seen that this semilunar cartilage was completely separated from its anterior attachments, and was displaced backwards about half an inch. The anterior edge of this cartilage was now seized by a pair of artery catch forceps, and it was drawn forwards into its natural position, and held there until three stitches of chromic catgut were passed through it and through the fascia and periosteum covering the margin of the tibia. The forceps were then withdrawn, the cartilage remaining securely stitched in position. The wound in the synovial membrane and soft textures having been closed with catgut stitches, a splint and plaster-of-Paris bandage were applied, so as to keep the joint at rest. The progress of the patient, after the operation, was perfect, the temperature never rising above 99° Fahr. Seven weeks after the operation, the splint and bandages were removed, and gentle movements of the joint practised.

On January 25th, 1884, the patient was dismissed cured, the movements of the joint being good, and the limb steadily gaining strength. In April of the same year, the patient returned to show the result. He was then seen and examined by many of our distinguished guests at the tercentenary, who all expressed the opinion that the result was everything that could be desired. He had perfect movement in the joint, and had never had the slightest stiffness or locking of the joint since he commenced to go about after the operation.

## HOW TO PREVENT SEPTICÆMIA IN CASES OF MORBIDLY ADHERENT PLACENTA.

By KEITH NORMAN MACDONALD, F.R.C.P.Edin., L.R.C.P.Lond., Cupar, Fife.

WITH the exception of *post partum* hæmorrhage, adherent placenta is one of the most troublesome after-consequences of the lying-in state. It is, moreover, much dreaded by many practitioners, owing to the probability of septic matter finding its way into the circulation, but that an ordinary case need not give rise to any extraordinary alarm, the following history well illustrates.

Mrs. S., aged 38, six years married, and mother of one child, five years having elapsed since her last confinement, which was a forceps case, with partial placental adhesion, was taken in labour at midnight of December 29th, 1884. The pains were moderate and regular; and I was sent for at 7 A.M. in the morning. The case was apparently natural; the second stage was rather prolonged, owing to the head resting for more than an hour on the perinæum, but was completed at nine o'clock, two hours after my arrival at the house, there being nothing unusual about it, except that the child, a female, appeared feeble, and the cord was unusually small.

During twenty minutes she retched several times, though firm compression was applied externally: she said that she had done so during the entire period of her pregnancy, and also had a "pain in her side." After this interval, I tried to remove the placenta,