FERGUSSON'S
PRACTICAL
SURGERY

W M Cathbert
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A SYSTEM

OF

PRACTICAL SURGERY.

BY

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in which they are held. There are subjects treated of in this volume, however, which none of these gentlemen have noticed, and the author is sufficiently sanguine to entertain the idea, that his work may, in some degree, assume that relative position in British Surgery, which the classical volumes of Velpeau and Malgaigne occupy on the Continent.

It is hoped that the present edition will maintain a popularity equal to that of its predecessor. Considerable additions have been made, and advantage has been taken of the suggestions of the reviewers to alter and amend whatever seemed faulty or defective. There will yet appear, however, much wanting towards perfection, especially in the estimation of those who look for something pertaining to all surgery under the title "System."

The author holds the opinion that a complete "System of Surgery" should embrace all branches of professional knowledge: each department has its separate authors and teachers, and it has been his aim, in accordance with these views, to confine himself to that of "Practical Surgery." With many imperfections of which he is himself conscious, and probably many more which have been overlooked, he ventures to hope that the good, if any, may be put against the bad, and that the result will be, that he has contributed, in some measure, to the advancement of a profession to which he has been devotedly attached for more than twenty years.

The illustrations will, doubtless, in every respect sustain the high character which the Messrs. Bagg have already secured for their beautiful and useful art. For most of the designs the author is himself responsible, and for others he has been indebted to the diagrams left, for the use of the chair which he has the honour to occupy, by his predecessors Mr. Green and Mr. Arnott.

To many friends he has to offer thanks for valuable communications and assistance, among whom he may mention Sir George Ballingall, Mr. Lizars, Mr. Watson, Mr. A. Millar, Dr. Handyside, Mr. Goodsir, Mr. Norman, Dr. Machardy, Mr. Elliot, Dr. Wishart, his former pupils Dr. Dods (Connaught Rangers), Dr. George Williamson (Fort Pitt), Dr. Richard Mackenzie, Dr. Henry Reid, and in an especial manner to his present assistant, Mr. Robert Storks, whose services have greatly contributed to lessen the labours attendant on the author's task.

Dover Street, Piccadilly,
1st January, 1846.

CONTENTS.

PART I.

INTRODUCTION. THE ELEMENTS OF PRACTICAL SURGERY.

PART II.

OF THE SUPERIOR EXTREMITY.

PART III.

OF THE INFERIOR EXTREMITY.

PART IV.

OF THE HEAD AND NECK.

PART V.

OF THE CHEST, ABDOMEN, AND PELVIS.

LIST OF WOOD-CUTS.

tibia being thrown to the outer side of the tarsus. In this case the malleolus internus will, in almost all instances, be broken; and in all probability the fibula will have suffered in the same way. The sketch below (fig. 141) gives a kind of diagram of such a case, although, were the parts so much displaced as is here represented, there would doubtless be wounds in the integuments, through which some of the fragments would project.

The most common kind of dislocation at the ankle, viz., that wherein the foot is thrown outwards, whilst the bones of the leg glide inwards, is represented in fig. 142, in which, for the sake of distinctness, the

Fig. 141.

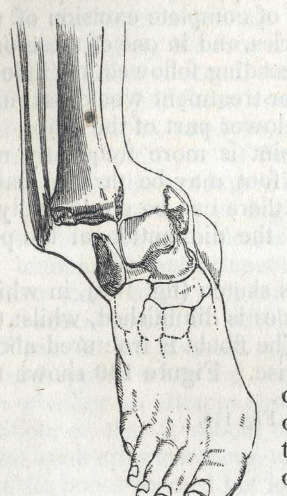
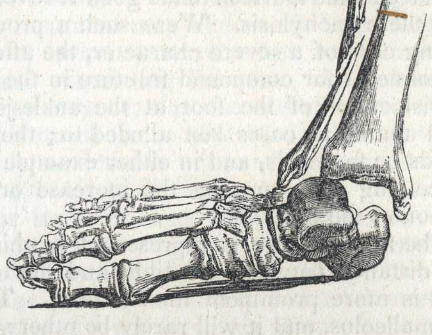


Fig. 142.



distortion is made to appear more conspicuous, and the separation greater, perhaps, than might be in reality: here it will be observed that the fibula is broken higher up than in the preceding figures; such an injury invariably happens in cases of this description (indeed, it is not unusual to speak of the case more as one of fracture than of dislocation, however palpable the latter may be), and the malleolus internus is almost certain to be separated from the tibia.

In the drawing it is represented as being still attached to the bone, though there is a slight fissure, but in reality it would probably be retained in its natural position below by the deltoid ligament.

The common principles of surgery will indicate the necessary proceedings in all these lateral dislocations at the ankle. Gradual extension, the foot being held at a right angle with the leg, with gentle movements at the joint, will enable the surgeon to effect reduction; and the ordinary precautions to avert or subdue high inflammation being carefully attended to, the parts will, after due time, in a great measure recover their original power of resisting the varied and complicated influences under which the ankle-joint is exposed to injuries of the most serious description; but I shall not dwell longer upon these cases at present, as it will be necessary again to allude to them in the chapter on fractures, to which I must refer the reader for further information.

Even in most instances of compound dislocation this fortunate result may be looked for, though in occasional examples of the kind the destruction of parts seems so great, and other circumstances are so unfavourable, that amputation appears the safest measure for the patient.

The vast mass of evidence collected by Sir Astley Cooper seems to settle the line of practice to be followed in by far the greater number of injuries of the ankle-joint; whether the case be one of simple or of compound dislocation, or the latter, complicated with extensive wound of the skin, contusion, and laceration of the other soft parts, and even severe fracture of the bones in the vicinity, the surgeon is fully entitled to give the patient a chance of having his foot preserved. The pulleys may be applied to facilitate reduction, where much difficulty is experienced; loose portions of bone must be picked away; projections may be cut off with the saw or pliers, or the aperture in the skin may be enlarged with the knife; in short, any reasonable expedient may be resorted to in order to save the foot, which, whatever be its after condition, will in general be preferred, by most patients, to any artificial substitute.

In the example here represented (fig. 143), it was deemed expedient to remove the foot, in consequence of the apparent extent of injury to

Fig. 143.

the soft parts in front of the joint; but the practice may seem very questionable, when, in the evidence above referred to, it is proved, in some of the cases, that the patients actually stood and walked on the protruded end of the tibia, and yet most satisfactory recoveries followed. The operation in this instance was a primary one, and did not succeed. Whether the patient would have had a better chance for life with his foot on, or by waiting till the period for secondary amputation, it is impossible to say, but it would appear that under any circumstances amputation in cases of the kind are far from being successful. It has been stated by Mr. Syme, (Edinburgh Monthly Medical Journal, August 1844,) that out of thirteen operations of the kind performed in the Royal Infirmary of Edinburgh, only two of the patients recovered,—an amount of mortality which may well incline the surgeon to act upon the doctrines inculcated by Sir Astley Cooper. I fear, however, that in the attempts which have been made to save