

REGISTER OF HOSPITAL  
APPOINTMENTS

## MEDICAL REGISTRARS

FROM

Dr. W. J. O'Donovan... June 16th, 1913.  
Dr. R. A. Rowlands... June 8th, 1914.  
Dr. J. G. Chandler... Oct. 20th, 1913.

## SURGICAL REGISTRARS

FROM

Mr. W. S. Perrin... Oct. 20th, 1913.  
Mr. A. B. Lindsay... Feb. 25th, 1916.  
OBSTETRIC—Mr. Gordon Ley Oct. 15th, 1914.

## RESIDENT ACCOUCHEUR

Tenure of appointment: three months

FROM

Mr. M. J. Cronin (Sen.)... Oct. 9th, 1916.  
Mr. W. A. Stewart (Jun.)... Oct. 9th, 1916.

## HOUSE PHYSICIANS

Tenure of appointment: three months

FROM

Mr. T. A. Jones... Oct. 9th, 1916.  
(Dr. Percy Kidd and Dr. Wall).  
Mr. D. J. Valentine... Nov. 14th, 1916.  
(Dr. Hadley and Dr. Lewis Smith).  
Mr. O. C. Carter... Nov. 14th, 1916.  
(Dr. F. J. Smith and Dr. Hutchison).  
Mr. G. Adler... Oct. 10th, 1916.  
Mr. B. Woolf... Oct. 10th, 1916.  
(Dr. Head and Dr. Thompson).

## HOUSE SURGEONS

Tenure of appointment: three months

FROM

Mr. J. W. Hyatt... Nov. 6th, 1916.  
(Mr. J. Hutchinson and Mr. Warren).  
Mr. R. G. Simpson... Nov. 6th, 1916.  
(Mr. T. H. Openshaw and Mr. A. J. Walton).  
Mr. T. W. Robbins (ill)... Oct. 9th, 1916.  
Mr. D. F. Panton... Nov. 21st, 1916.  
(Mr. Furnivall and Mr. Kidd).  
Mr. G. A. Green... Oct. 3rd, 1916.  
(Mr. Sherren and Mr. Howard).  
Mr. H. H. Bailey... Oct. 30th, 1916.  
(Mr. Rigby and Mr. Milne).  
Mr. F. M. Mosely... Nov. 15th, 1916.  
(Mr. Lett and Mr. Souttar).

## To Ophthalmic Department

FROM

Mr. L. D. Cohen... Sept. 15th, 1916.

## To Aural Department

FROM

Miss Sproule... Dec. 11th, 1916.

## RECEIVING ROOM OFFICERS

Tenure of appointment: three months

FROM

Mr. W. H. Forshaw... July 24th, 1916.  
Mr. R. A. Madgwick... Nov. 21st, 1916.  
Capt. G. D. K. Waldron... Dec. 7th, 1916.  
Mr. H. Gwynne-Jones... Dec. 13th-27th, 1916.

## EMERGENCY OFFICERS

Tenure of appointment: three months

FROM

Mr.

## OUT-PATIENT CLINICAL ASSISTANTS

Tenure of appointment: three months—and renewable

FROM

Mr. O. Beddard... Oct. 20th, 1916.  
Mr. J. M. Scott... Oct. 7th, 1916.  
Mr. G. Jones... Oct. 23rd, 1916.

## OUT-PATIENT CLINICAL ASSISTANTS (continued)

## Surgical

FROM

Mr. J. Hill... Oct. 30th, 1916.  
Mr. A. B. Dunmire  
(Special)... Oct. 30th, 1916.

## To Ophthalmic Department

FROM

Mr. Roxburgh  
Mr. J. Eadie... May 21st, 1912.  
(Renewed).

Mr. Lister

Mr. H. R. Jeremy... July 31st, 1914.

## SKIN AND LIGHT DEPARTMENT

FROM

Mr. G. T. Calthorp... Dec. 8th, 1916.

## SENIOR DRESSERS TO OUT-PATIENTS

## PATHOLOGICAL ASSISTANTS

FROM

Mr. R. Donald... Aug. 10th, 1914.

## ASSISTANTS IN INOCULATION DEPARTMENT

## Senior

FROM

Dr. G. T. Western... July 25th, 1905.

## Junior

## CLINICAL ASSISTANTS FOR COUNTY COUNCIL CASES

## To Ophthalmic Department

FROM

Mr. A. D. Davidson... Jan. 24th, 1910.  
Mr. M. L. Hepburn... Jan. 24th, 1910.  
Mr. J. Eadie...

## To Throat and Ear Department

FROM

Mr. W. S. Perrin...  
Mr. A. B. Lindsay...

## To Skin and Light Department

FROM

Mr. W. J. Oliver... Sept. 10th, 1914.

## OUT-PATIENT CLINICAL ASSISTANTS (UNPAID)

## To Ophthalmic Department

FROM

Mr. Roxburgh

Mr. Lister

## Throat and Ear Department.

FROM

Dr. Lack

Mr. Tod.

## ORTHOPÆDIC DEPARTMENT

## Senior

FROM

## Junior

## DENTAL DEPARTMENT

## Anæsthetist

FROM

Mr.

## House-Surgeon

FROM

Mr. W. S. Herman... Mar. 1st, 1916.

Printed for the Proprietors, by H. HORNER, 5, Rupert Street,  
London, E., in the County of Middlesex, Friday, February 2nd, 1917.

## THE LONDON HOSPITAL GAZETTE

No. 194]

MAY, 1917

[ONE SHILLING

## EDITORIAL

Since our last issue there has been no lack of events—many of them of the most supreme importance, many of mere Collegiate interest. To the first category belong such epoch-making events as the Revolution in Russia and the entry into the War of the United States. To the second category belong such changes as the calling-up of all medical men of military age and the prohibition by the War Office of all public mention of the particular units to which Officers and Men belong. This last regulation—which means that we can only give the Regiment in which a man is serving, without specifying the Battalion or the Division—must, we fear, militate not a little against the plan we have had so long in view of making the *Gazette* the medium for informing London men of each other's movements.

Since the beginning of the year, we are glad to say that, so far as we know, our losses have been relatively slight. Captain Huddart, R.A.M.C., died suddenly while on Embarkation duty. Private Copeland, of the Accountant's Office, and Seaman M. J. Oatley, of the Surveyor's Office, have both been killed in action.

Just as we are correcting proofs we hear with deepest regret of the loss of Lieutenant J. G. Will, R.F.C., and of Captain P. H. Burton, R.A.M.C., of both of whom we hope to publish obituaries in our next issue.

Much sympathy has been felt for our old friend Mr. G. P. Mudge on the loss of his only son, who has died from wounds received in action.

Among the wounded we regret to report the following:—Captains W. B. Purchase, R.A.M.C., and E. H. Moore, D.S.O., R.A.M.C.; Lieutenants V. D. Corbett, Middlesex Regiment, and B. Peverell, Durham Light Infantry; Second-Lieutenants F. J. Smith, King's Own Royal Lancasters, J. K. Grayson, Middlesex Regiment, and M. P. Atkinson, Worcester Regiment; and Rifleman A. Bray, of the King's Royal Rifle Corps. Second-Lieutenants B. W. Phillips, R.G.A., and T. E. Wood, Dorset Regiment, and Private V. H. Barker, H.A.C., have been reported sick. To all these we offer our deepest sympathy and send our warmest wishes for a rapid and complete recovery.

Our Honours List has received many notable additions. Surgeon-General N. R. Howse, V.C., has received the K.C.B.; Lieutenant-Colonel T. Openshaw, C.M.G., the C.B.; and Lieutenant-Colonels H. G. Bruce Porter and J. Lynn Thomas, the C.M.G.; Major G. B. Edwards, Captains G. F. Rudkin, F. R. Armitage, D. H. Pennant, and Surgeon H. B. Padwick have received the D.S.O.; Captains R. Burgess, M. B. Baines, W. G. Hartgill, P. H. Rawson, and Lieutenants J. B. Thackeray and A. G. Reid the Military Cross. Our Matron and no less than twenty-two London Hospital Nurses have been decorated with the R.R.C. since our last issue.

It is with special pleasure that we offer our congratulations to Miss Luckes, than whom no one has worked with more disinterestedness or with more energy, despite the fact that she has only recently recovered from a serious illness.

Of foreign decorations, Lieutenant-Colonel H. J. Challis has received the ribbon and cross of the Order of St. John of Jerusalem, Major H. S. Souttar has been made Officer de l'Order de la Couronne by the King of the Belgians, Captain A. Maitland-Jones has received the Croix de Guerre from the President of the French Republic, and Captain H. J. M. Cursetjee the Order of the White Eagle from the King of Serbia.

The following have been specially commended for their services by the Secretary of State for War:—Lieutenant-Colonels T. H. Openshaw, H. E. Bruce Porter, E. Hurry Fenwick, and J. Lynn Thomas; Majors C. Bramhall and C. H. Miller; and Captains W. B. Cosens and F. G. P. Daly, while among those mentioned in Despatches we find the names of Lieutenant-Colonels W. V. Field, H. M. Rigby, E. C. Montgomery Smith, and A. D. P. Hodges, C.M.G.; Captains F. R. Armitage, A. G. Maitland-Jones, J. H. Bayley, K. Biggs, N. F. Graham, J. H. Thomas, T. L. Ingram, H. D. Lane, O. R. McEwen, and J. C. Andrews; Surgeon A. F. R. Woollaston, R.N.; and Miss F. Garnett.

A Roll of Honour, giving the names of those who have fallen in the War, has been recently installed in the Main Hall of the Hospital, on the initiative of Mr. Russell Howard.



Owing to the calling-up of all medical men of military age, we anticipate we shall have many interesting changes to chronicle in our next issue. It is this requisition, together with the mobilisation of all medical students as they reach the age of eighteen which is likely to affect the College more seriously than have any of the previous War Office Regulations.

We hope, however, to weather the storm, although we fear our numbers are going to be sadly reduced from even our present modest total.

To any of our readers who can help by supplying us with matter for our future issues, we express in advance our grateful appreciation. It is no easy task to keep up the standard of our *Gazette* in these days, but many hands make the labour light.

## ON DUPUYTREN'S CONTRACTION OF THE PALMAR FASCIA

### DUPUYTREN'S LIFE AND WORKS.

*A Lecture delivered at the Royal College of Surgeons on February 12th, 1917,*

By J. HUTCHINSON, F.R.C.S.,

Hunterian Professor and Examiner in Surgery to the College.

### THE OPERATIVE TREATMENT.

In long-standing and severe cases of Dupuytren's contraction, certainly all those in which the affected digits are rigidly bent into the palm, the surgeon who trusts to the operations hitherto in vogue may be disappointed. Whether he divides or excises the palmar fascia he cannot straighten the contracted finger by manual force, still less can he trust to this being effected by subsequent splint-pressure, however prolonged.

What is it that prevents extension of the contracted fingers after the fascia has been thoroughly divided or incised? Obviously the skin will not account for this failure, and there are three other possible explanations:—

1. The one most generally assigned is a consecutive contraction of the flexor tendons. These have often been divided in the vain hope that the resistance would then be overcome. But it is easy to prove, without this useless test, that the fault does not lie in the tendons, for full flexion of the wrist or metacarpo-phalangeal joints makes no difference at all. This is conclusive, as thereby we relax thoroughly both flexor profundus and sublimis.

Before Dupuytren discovered the real cause of the contraction, which ever since has borne his name, the view chiefly held was that the flexor tendons were to blame, and it is curious to find traces of this exploded view surviving still. Nothing is, however, more certain than their innocence of any share in producing or keeping up the deformity, except that slight flexion of the fourth and fifth digits at the first inter-phalangeal joint is the normal position of rest. The possible relation of this fact to Dupuytren's contraction is discussed later.

2. Intra-articular adhesions in the metacarpo-phalangeal and inter-phalangeal joints of the contracted fingers might be invoked as the cause of the resistance, especially by those who see a close relation between this condition and gout or rheumatism. The idea of the existence of these adhesions is also favoured by the grave danger of stiffening of the fingers during the splint-treatment ordinarily pursued after operation, a danger which can hardly be impressed too strongly.

It would be difficult to disprove the theory of adhesions in the finger-joints without the aid of the X-rays. But reference to Fig. 4, which may be taken as a typical instance of Dupuytren's contraction, shows a perfectly smooth articular surface in each joint. In the specimens I have obtained by operation (excision of the first inter-phalangeal joint) the joint surfaces were always found to be normal. Both the explanations suggested are therefore seen to be groundless. The true reason is that, owing to the second phalanx being extremely flexed so that its base is pressed against the neck of the first phalanx, and owing to this position being kept up during many months or years, the glenoid ligament in front of this joint as well as the lateral ligaments, become shortened and incapable of extension.

*The only way to overcome this obstacle is to excise the head of the first phalanx.* Briefly the method is as follows:—

1. Through a palmar incision the bands of contracted and thickened fascia are dissected out, including their prolongations in front of the first phalanx (the best form of incision will be discussed later). The palmar wound or wounds are closed with the finest silkworm gut. The finger still remains flexed at the first inter-phalangeal joint.

2. The hand is turned over so that the dorsal surface is uppermost, a semilunar incision is made over the first inter-phalangeal joint, the extensor tendon divided, the head of the first phalanx cleared to its neck, the latter cut across and the head dissected out.

3. The extensor tendon is slightly shortened and its two ends united, preferably with fine kangaroo

tendon or Japanese silk, and the small dorsal incision (which is of course quite separate from the palmar one) is then sewn up. The finger should now become perfectly straight (or nearly so) *without any tension whatever.*

4. No splint is required in the after-treatment, the gauze dressing is a sufficient support, gentle active and passive movements should be resorted to within the first few days. *No digit should be allowed to stiffen.*

I attach equal importance to two points, namely, the excision of the first phalangeal head and the avoidance of the prolonged and irksome splinting usually resorted to. The latter has been responsible, as will be illustrated later, for many stiff fingers and hands following the orthodox operations; and I believe it is to some extent also responsible for the well-known tendency to recurrence of the contraction after them.

The following case illustrates how excellent a result can be obtained by the method advocated without the employment of any splint in the treatment from beginning to end; further, how perfect a new joint is formed at the site of the excision. The patient was a man aged 54. His right little finger was alone affected, and was bent right into the palm. I dissected out the band of palmar fascia thoroughly, but found it impossible to alter the deformity materially. I then excised the head of the first phalanx, shortening the extensor tendon and uniting it by fine kangaroo tendon sutures. The finger came practically straight without tension, aseptic dressings were applied without a splint.

He was back at work very soon, and Figs. 1 and 2 show in a perfectly unbiassed way the result several months later. The upper figure shows his hand in voluntary extension, the little finger is the least bit bent at the two digital joints, but this is no more than is habitual with many people who possess normal hands. In fact, it may be termed a normal position of rest for the little finger.

In flexion it will be noticed (Fig. 2) how good is the movement at the new joint, his grip was *strong in all the fingers.* Practically no sign of the small dorsal scar could be detected, the palmar one was very inconspicuous. Here I would note that in some cases where forcible stretching of the finger has had to be employed by the surgeon during and after his operation the palmar scar becomes thick, disfiguring, and uncomfortable when the patient uses his hand. The well-known pathological law is illustrated that intermittent pressure and irritation of tissues always cause hypertrophy. It is just this hypertrophy that we have to dread and avoid in our treatment of Dupuytren's contraction.

The photograph shows the slight degree of shortening of the digit produced by excision of the first

phalangeal head. The normal relative length of the different digits is variable and of no importance. A slightly shortened but thoroughly useful finger is a very different thing to a stiffened and useless one!

It must not be claimed that a perfect result, functional and cosmetic, can be obtained in every case of Dupuytren's contraction; owing to the extreme length of time which is sometimes allowed to elapse before operative aid is sought. This point is illustrated by the following case:—

A man aged 54 was treated for Dupuytren's contraction of the ring finger, of ten years' duration. (Fig. 3.) Excision of the band of palmar fascia made no difference to the deformity; I then removed the head of the first phalanx, and the finger came straight. But the other two joints of the digit had lost their natural mobility after ten years' rigidity, and though the deformity was removed the result was not perfect.

A few words must be devoted to the history of the various methods of treatment in Dupuytren's contraction. Prior to the publication of the French surgeon's accurate pathological account of the disease in his "Leçons Orales" (Vol. I., 1832), there was no treatment worth mentioning for the condition. Thus Sir Astley Cooper simply referred to it as incurable. Dupuytren, having proved that the palmar fascia was to blame, advocated open transverse division of the fascial bands, the wounds being allowed to heal by granulation. Three cases only are described in his account; they were said to have been cured, but no surgeon at the present time would employ this method or hope for a cure from it.

Then came, with the wide use of tenotomy for club foot, etc., the introduction of the subcutaneous division of the fascia in Dupuytren's contraction. This required many operations and laborious treatment with special splints applied to the fingers. Mr. William Adams's name is to be associated with the subcutaneous method, which is still employed by some surgeons; in slight cases it may meet with success. Following Lord Lister's great discoveries the open excision of the fascial bands naturally came into vogue, and must of necessity continue to form a chief part in the treatment. Such attempts to cure the deforming contraction as the use of X-rays, fibro-lysin, ionization, short-circuiting intestine for imaginary stasis, etc., need not be described here; they are quite useless.

As regards the open excision of the fascia we may admit that in early cases it attains a good result. But in long-standing ones where the contraction is very pronounced, I contend that this method, however carefully performed, leaves a good deal to be desired; it is far from perfect.



1. It is impossible by it alone to straighten the bent finger; indeed, sometimes the degree of flexion remains the same as before, and the surgeon may be driven to amputate the digit. (See Fig. 5.)

2. Following the operation, a prolonged and irksome splint-treatment is always advocated, and in the subjects of Dupuytren's contraction stiffening of the digits and hand is very apt to occur as a result. If any splint be employed it should only be for a few days whilst the wound is healing, and it is best to remove it daily so that the digits concerned should be gently bent.

Let the surgeon remember that *stiffness of the fingers resulting from his treatment may prove a worse evil than their original contraction*. As a rule, the patient only submits to operative measures when the finger is bent strongly into the palm, when the deformity has lasted a long time, and at this stage the question of consecutive changes in the ligaments of the finger-joints becomes as important as the contraction of the fascia.

#### THE PATHOLOGY OF DUPUYTREN'S CONTRACTION.

Strange to say, the current teaching as to the joint most concerned is quite wrong. To quote one of the most recent writers on the subject, "The forced flexion of the finger concerns solely the metacarpal-phalangeal joint. . . . If one tries to extend the first phalanx one makes the cord project forwards which ties it to the hollow of the palm. The second phalanx is equally flexed on the first, the third is in a position intermediate between flexion and extension, but these last two segments allow of easy extension and have preserved all their freedom and integrity of passive motion."<sup>(1)</sup>

As will be shown directly, almost every particular dictum in this account, taken from the best French text-book, is untrue. A German writer<sup>(2)</sup> states more vaguely that in Dupuytren's contraction "the bending commences in the metacarpo-phalangeal joint and later involves the lower ones."

Similar views from English works could be readily quoted; in fact, the universal opinion prevails that as contraction of the palmar fascia would naturally be expected to involve flexion of the metacarpo-phalangeal joint, therefore it alone need be considered. It has not occurred to surgeons to test these views by X-rays photographs. Fig. 4 is taken from an exact tracing of one (made by my friend Dr. Gilbert Scott at the London Hospital). It shows the little finger of each hand of a man in whom Dupuytren's contraction was symmetrical and concerned only the fifth digit. The lowest

inter-phalangeal joint (c) is in full extension, the metacarpo-phalangeal one (A) is slightly bent about 40 degrees, whilst the joint between the first and second phalanges is bent to the utmost possible extent (a full right angle). The base of the second phalanx is seen to be pressed against the neck of the first one, no further flexion could occur. In front of each last phalanx slight bony irregularity will be noticed, and in one finger (D in the upper figure) this outgrowth of bone forms an eminence in front of the second phalangeal shaft. Such outgrowths or irregularities are common in the fingers of working men, and are to be ascribed more to hard use of the tendons than as proving a relation (often wrongly asserted) between Dupuytren's contraction and osteo-arthritis. It will be noticed that in this typical X-ray picture the actual joint surfaces are perfect. It is somewhat difficult to explain why in Dupuytren's contraction it is the first inter-phalangeal joint that is the important one, though it is easy to see why the last one should escape, for the palmar fascia sends no fibres down so low as that. I may suggest that in the normal hand at rest extension is the usual position of the first and last joints, whilst at the second joint (the first inter-phalangeal one) flexion is habitual. Granting that the lowest slips of hypertrophied palmar fascia reach down in front of this latter joint we may conclude that its usual position of flexion becomes readily exaggerated as Dupuytren's contraction commences and progresses.

At any rate, whatever the explanation may be, Maclair's description of the pathology is quite mistaken. It is the first inter-phalangeal joint which is most affected by the contraction, and it is this joint (so far from "preserving its freedom and integrity of movement") which in long-standing cases is found to offer an invincible obstacle to the finger being rectified after the fascia has been divided or excised.

It has, I hope, been conclusively shown that in Dupuytren's contraction the site of greatest flexion is the first inter-phalangeal joint, and it is a remarkable fact that the palmar fascia in its normal state is not described as reaching nearly so low as this. In the long account and numerous illustrations of the palmar fascia given by Testut,<sup>(3)</sup> the lowest point to which the fibres are traced is the base of the first phalanx on its dorsal aspect. Practically the whole fascia ends at the level of the web. In other words, according to Testut the human hand does not possess any fibrous bands going to the fingers which by their hypertrophy and shortening could possibly produce flexion of

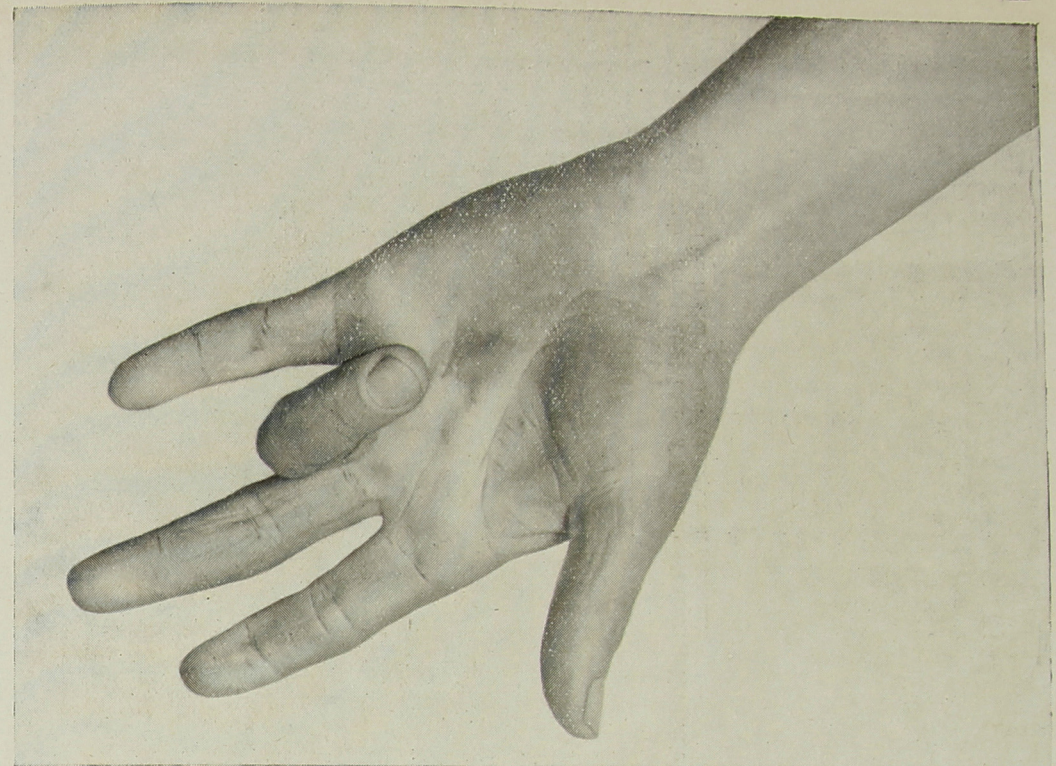
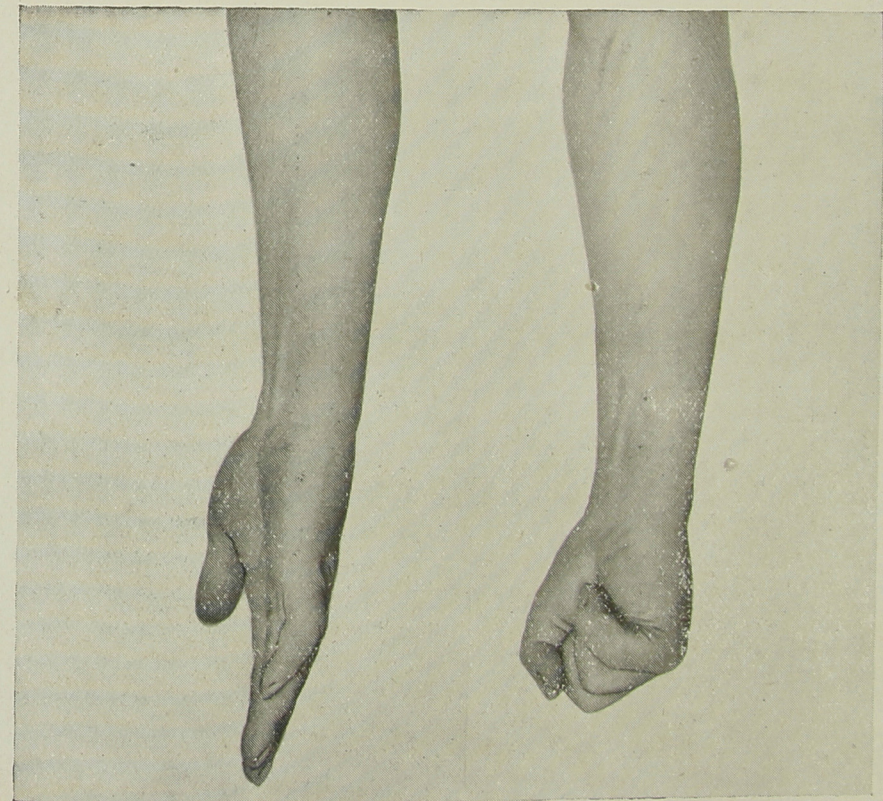


Fig. 3. Contraction of one finger only of 10 years' duration. The flexion is seen to involve first inter-phalangeal joint almost entirely. See text.



Figs. 1 and 2. Case of Dupuytren's contraction of little finger after treatment by excision of palmar fascia and head of first phalanx. The figures show almost perfect range of extension and flexion. No splints were used during the treatment.

<sup>(1)</sup> Maclair, on Dupuytren's contraction. Le Dentu and Delbet's Traité de Chirurgie. Vol. 33, p. 127.

<sup>(2)</sup> Sultan. Specielle Chirurgie. Vol. II., p. 415.

<sup>(3)</sup> Testut and Jacob—Traité d'Anatomie Topographique 1914. Vol. II., p. 827; also Testut—Traité d'Anatomie Humaine, 1899. Vol. I., p. 918.



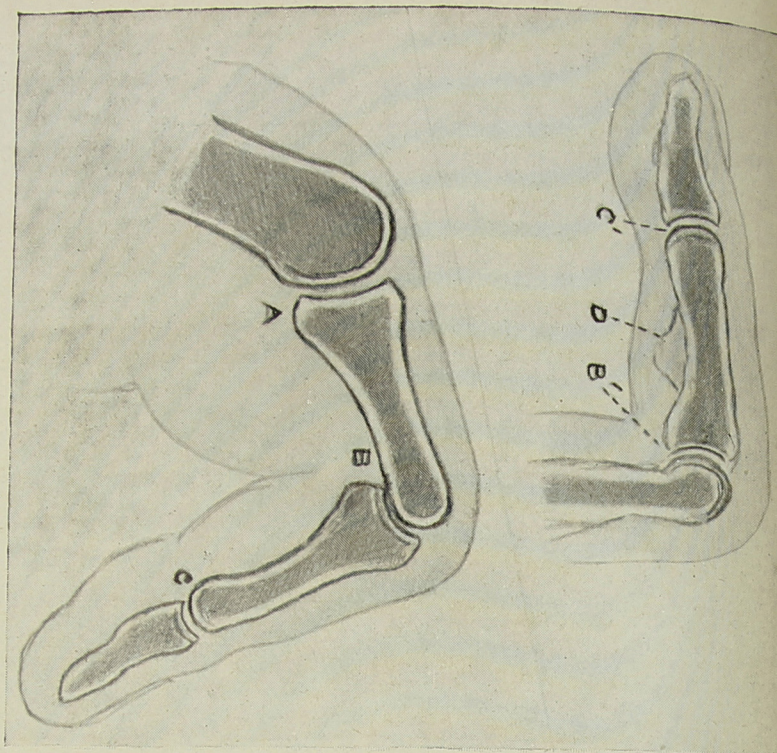


Fig. 4. Radiographs from typical case of Dupuytren's contraction (little finger of each hand). For explanation see text.

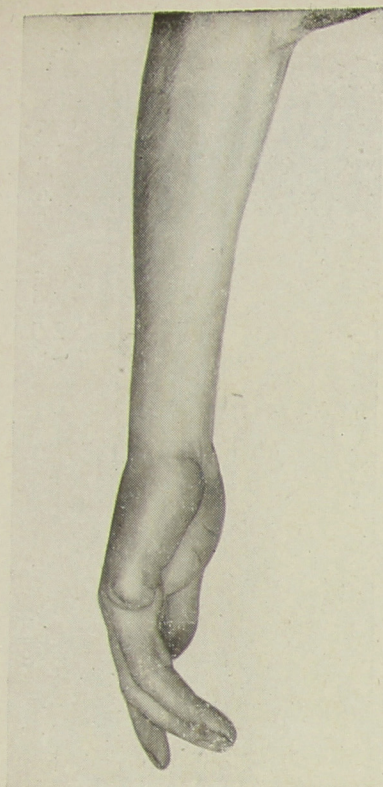


Fig. 5. Indifferent result after treatment by excision of the fascia alone, followed by prolonged splinting. The little finger had been amputated; the others remain stiffened in the position shown.

the first joint. Yet this is without doubt most contracted in this disease. Professors D. J. Cunningham and Merkel in their treatises on anatomy, Poirier and Charpey in their voluminous accounts of the fascia, are equally silent on the subject. The last-named authors note that a few longitudinal fibres may be traced to "the level of the highest furrow across the fingers where they end in the skin." This point is at least an inch above the joint concerned. It is noteworthy that Dupuytren's observations have led anatomists to investigate and describe the palmar fascia with especial care, and that the smallest fasci of it have been followed out.

In an excellent dissection of the palmar fascia in the Royal College of Surgeons Museum some delicate fibrous bands are shown in front of the first phalanx, chiefly attached to its sides, but even if these were hypertrophied and shortened, they could not produce flexion of the second phalanx. Yet clinical experience shows there is actually a firm band of fibrous tissue running down in front of the first inter-phalangeal joint, which is responsible for the chief deformity and which should always be dissected out in the open operation. We must therefore admit that in Dupuytren's contraction the thickening does not limit itself to the normal anatomical bands but that fresh fibrous prolongations are developed. Certainly in the palm the overgrowth of the fascia (and sometimes of the skin) becomes almost a caricature of the normal arrangement.

#### TREATMENT AFTER OPERATION.

The after-treatment usually advocated in a case of Dupuytren's contraction, i.e., that following operation, whether sub-cutaneous or open division, is so serious and irksome that any method which lessens, or, better still, does away with it, deserves a careful trial. The following is the course of treatment after operation which is at present in vogue. A special metal splint which holds all the joints rigid from wrist down to the terminal joints of the affected fingers "must be worn night and day for the first month," then a still longer dorsal splint, to be worn again night and day but removed two or three times daily for massage and passive movements to be practised. With this continuous splinting for ten weeks, it is obvious that a working man for the whole of this time would be unable to use his hand, and at the end of it would doubtless have lost his employment. This is not all, however, for a further term of at least four months the patient should not give up the use of the splint at night. "When there is much stiffness of the joints a course of treatment by superheated air is useful in getting the part supple." One thing is certain, that if such vigorous and prolonged splinting is carried out, the joints are sure

to be stiffened more or less, and no hot-air baths will give back suppleness to them.

In the account from which I have quoted, it is remarked that even if this irksome treatment, which puts out of use the hand for two or three months, is thoroughly carried out, "no permanent cure can be looked for, as the contraction recurs within three or four years, and a second operation is required." This, it is stated, happens after both the multiple division of the fascia and the V.Y. method.<sup>(4)</sup>

Now it may fairly be asked whether even a man of leisure, one not required to earn his bread by manual labour, would care to undergo such a tedious period of crippling of the hand—for such it comes to. For a working man (and most of us have to use our hands extensively) it is positively disastrous, as I have said it generally means that some other man is found to occupy his berth by the time the patient is allowed to give up his splint. Nor can a working man be expected to apply the splint every night for a period of six months. It may be said by the advocates of the treatment given above that the whole hand is not confined, only the fingers operated on. But a splint which fixes these and the wrist-joint *does* put the hand *hors de combat* so far as any working use is concerned. Let any surgeon try wearing such a splint for a week—much less for two months—and he will realise what an infliction and a disability it amounts to. I wish to bring out clearly that by the method now advocated this prolonged splint-treatment is done away with, after the operation wounds have healed (a week should suffice) no splint whatever is required, the patient should be encouraged to flex and extend all the joints of all the fingers, and should certainly be back at work within a few weeks of the date of operation. As to the risk of recurrence, my experience of the method is not long enough to allow me to be dogmatic, but my conviction is that the reliance on splints to stretch the fingers and complete the case is not only fallacious but it apt to increase the formation of fibrous tissues in front of the digits, *certainly it risks stiffening of joints and adhesions of tendons to their sheaths*. And once this stiffening has been produced, as I have seen several unfortunate examples, no known treatment will effect any material improvement in it. To sum up the question—loss of suppleness in the fingers due to the surgeon's use of splints may be a greater drawback to the patient than the original contraction. In the after-treatment of a case of Dupuytren's contraction, splints should be dispensed with after the first few days, if they are used at all. This desirable end can be secured

<sup>(4)</sup> The quotations are from Cheyne and Burghard's *Surgical Treatment*, revised by Messrs. Legg and Edmunds. Similar stringent directions as to the after-treatment will be found in other books.



Fig. 6. Crippling of both hands from multiple osteo-arthritis, etc., due to prolonged splint treatment after operation (excision of palmar fascia). All the digits were rigid and bent. See text.



if to the open excision of the fascial bands is added resection of the head of the first phalanx with its resulting removal of the tendency to flexion of the digit.

A fair analogy is afforded by the comparison between the modern and the old treatment of "congenital" torticollis. When surgeons were content with subcutaneous division of the sternomastoid (perhaps only of the sternal origin of the muscle) the tendency to contraction was never wholly removed, the patient's neck had to be fixed in an irksome apparatus, subsequent treatment by stretching exercises had to be employed, and the result was rarely if ever perfect. On the other hand, if the open operation is carried out, if not only both heads of the muscle be divided but also its contracted fascial sheath thoroughly and carefully, all apparatus may be dispensed with, and there is no tendency to further contraction. Of this I have had many instances. It will probably prove that the removal of all tension at the time of operation on Dupuytren's contraction and the subsequent avoidance of splint-treatment will have equally lasting effect.

It may seem invidious to bring forward examples of failure of treatment by other surgeons, but the view is still held that all cases (mild or severe) of Dupuytren's contraction can be treated successfully by the prevailing methods—either of subcutaneous division or of open excision of the fascial bands. It is my contention *that they cannot*, and my wish to introduce a new and real improvement. Fig. 5 illustrates the result in a case operated on by a first-rate surgeon only a few years ago. It is clear that after open excision of the palmar fascia he found it impossible to improve the position of the little finger, which was then amputated. The fascia was then dissected away from the third and fourth digits, which were subsequently treated on a splint to further the straightening. From this splinting a good deal of stiffening has resulted, and the fingers cannot be straightened any more than is shown in the Fig. They can be bent a little, especially at the metacarpo-phalangeal joints, but the grip of the hand does not include these fingers; it is poor at the best and limited to the thumb and index finger.

The next case illustrates still more forcibly my contention. *Arthritis and contraction of nearly all joints of both hands following the treatment of Dupuytren's contraction of the two inner fingers.*

C.T., aged 57, a temperate and healthy man, who showed no evidence of either gout or rheumatic tendencies elsewhere, came under treatment for Dupuytren's contraction of the ring and little fingers of both hands, of seven years' duration. The other fingers and thumb were perfectly supple.

He had two operations performed—first on one hand, then on the other—the contracted hands being dissected out by linear anterior incision. These operations were done by different surgeons, and the after-treatment carefully carried out, especially as regards making the patient wear a palmar splint at night-time. This latter procedure he kept up for eighteen months, when I saw him for the first time. Both hands were then stiffened as regards all the fingers and the thumbs, some of them completely rigid and contracted. On one hand the little and ring finger had again bent in to an extreme degree, though no fresh bands of palmar fascia could be felt. (See Fig. 6.) There was undoubted evidence of osteo-arthritis of various digital joints, especially of the first inter-phalangeal ones, and from the rigidity there must have been intra- as well as extra-articular adhesions. Massage, baths, etc., had been most thoroughly employed, though without benefit, and it was difficult to see what more could be done to improve the rigidity and osteo-arthritis. The condition would have been much better had no operation ever have been done, as his hands were gravely crippled in all the digits, nor was there any prospect of improvement.

*Permanent rigidity of the whole hand left after operative treatment of Dupuytren's contraction of one finger.*

This was almost identical with the former case, though fortunately only one hand was involved. The surgeon had operated on the contracted fascia of one finger; owing to too careful and prolonged use of splints not only were all the fingers left crippled by ankylosis but the wrist-joint became permanently rigid.

It is such disastrous results as the above, coupled with the difficulty they have found in overcoming the original deformity by the usually advocated methods that have led some surgeons to avoid operating on Dupuytren's contraction.

The examples adduced must be enough to bring home the dangers of splint-treatment after the operation; a few words remain to be said about the incisions employed in dealing with the palmar fascia. The VY method in either of its forms, whether the angular reflected flap is made of skin only or of skin and fascia together, is not a good one. It involves too much scarring of the palm, the prolongation of the fascia to the second phalanx (which we have seen is all important) cannot be dealt with by this method. In plastic surgery elsewhere (for example, in dealing with ectropion of the eyelids) the VY method is a failure. I have never known it successful in Dupuytren's contraction.

Again, it is not satisfactory to remove much skin from in front of the bent fingers and to trust to skin-grafts. Mr. W. H. A. Jacobson<sup>(5)</sup> well pointed out their drawbacks. The wide excision of skin and fascia, followed by transplantation of a flap from the side of the chest (Paul Berger's method<sup>(6)</sup>) has nothing whatever to recommend it. Among other faults it fails entirely to deal with the contraction of the first inter-phalangeal joint. It is strange to find this method recommended above all others in the latest French work.

Seeing that we entirely reject the wide excision of palmar skin as well as the VY method of a shifting flap, what is the best form of incision to employ? With the proviso that all scars in the palm may prove a slight drawback and should be made as short as is consistent with the thorough dissection of the contracted bands; further, that it is useless to lay down exact lines of incision for differing cases, the following points are worthy of consideration:—

1. The main incision must be linear and vertical, over or closely parallel to the ridges of palmar fascia. Small transverse incisions at the front of the web may be needed, and any prolongation of the fascia in front of the first phalanx must be followed down and removed.

2. In the case of the middle or ring finger it is impossible to avoid placing the incision towards the mid-palm. In the case of the little finger alone, the incision may be made rather to the ulnar side of the hand, where the skin is more supple and less subject to pressure.

In closing the wounds, the finest silkworm gut (ophthalmic) should be used. It is rarely necessary to leave any raw area to granulate up, especially if the head of the first phalanx has been excised and tension in the front of the finger thus removed.

Should a small plastic operation be required, a tongue-shaped flap *with its base upwards* might be taken from the side of the digit concerned and shifted over so as to lie transversely. I have repeatedly used this method in cases of ectropion with good results, but in Dupuytren's contraction it can be rarely necessary. As such a flap contains the whole thickness of the skin and its blood supply, and is fixed in place by two or three fine sutures, it is much better than the epithelial grafts advocated in the text-books.

#### ON DUPUYTREN'S LIFE AND WORKS.

*Guillaume Dupuytren*, the son of a poor avocat (or barrister-solicitor) in the small town of Pièrre-

<sup>(5)</sup> Jacobson's Operations of Surgery. 1907 Edition. Vol. I., p. 30.

<sup>(6)</sup> Paul Berger. Acad. de méd. April 20, 1892.

Buffière, was born on October 5th, 1777. He died in Paris on February 5th, 1835, at the age of fifty-seven. Dupuytren was therefore a contemporary of the two great warriors Napoleon and of Wellington, being eight years junior to them, and his birth almost coincided with that of the three immortal masters of Art—Beethoven, Turner, and Hokusai.

Sir Astley Cooper was his contemporary and friend, but was his senior by nine years.

There are many biographical reviews of Dupuytren in French, but nothing like a complete account of his life or works. In English there is hardly anything of value, though the new Sydenham Society gave us his *Leçons Orales* in an admirable translation. Of the French notices of Dupuytren several were written in a very critical or hostile spirit, and even as to the facts and dates of his life contradictory accounts are frequently met with.

I hope later to publish more fully a biography of the man who was certainly the most famous, if not the greatest of all French surgeons; on the present occasion a brief notice will have to suffice.

In 1789, the first year of the French Revolution, a certain Captain Keffer, when passing through Pièrre-Buffière with his regiment, was so taken with the young Dupuytren that he offered to have him educated in Paris, an offer gladly accepted by the parents. The next four years were spent in the *Collège de la Marche*, of which M. Keffer, the captain's brother, was the principal. Dupuytren's studies were brought to an abrupt end at the age of sixteen by the closure of the Paris schools, and in 1793 he journeyed home on foot—two hundred miles. A few months later, his father having decided in favour of the profession of medicine Dupuytren returned to Paris. His student days were passed under the greatest difficulties, owing to extreme poverty. His relations would not, or could not, help him, and in a state of complete destitution he would have gone under but for the succour of an illiterate water-carrier from Auvergne, named Jean Sebastian. This poor but saint-like man provided lodging and food for Dupuytren (who had for several weeks subsisted on bread alone), he gave him money for the necessary fees and books, and was ultimately rewarded by Dupuytren's appointment (at the age of eighteen) to be Prosector of Anatomy at the *Ecole de Santé*. This post was paid, however poorly, and by teaching anatomy and surgery (!) the young student eked out a living. Unfortunately his benefactor died, in Dupuytren's arms, at the very time when the latter was about to pay back some of the priceless help he had received.

He had taken his degree as Doctor of Surgery before he was twenty, and five years later we find him "chef des travaux anatomiques" and, what



was of far more importance, second surgeon (a new appointment) at the Hôtel Dieu. Both appointments were given after public competition (Concours). M. Pelletan was the chief surgeon at the Hôtel Dieu, and it must be owned that Dupuytren proved an unpleasant colleague. It is evident from his writings that he had a low opinion of Pelletan's surgical ability, if not a strong personal animosity towards him, and in 1808 he succeeded in compelling him to resign. Thus at the age of thirty Dupuytren stepped into the post of surgeon to the Hôtel Dieu. For the next twenty years he had sole control of the surgical wards in the only large hospital in Paris. In this unique position, with the care of some 500 beds, he accomplished an amount of strenuous work which can rarely, if ever, have been surpassed. He did everything; operated on all cases alike in general surgery, ophthalmic work, gynaecology, and other special branches. He lectured to classes which sometimes numbered five hundred, he conducted an outpatient clinic, made surgical post-mortems, visited the wards and performed the dressings himself. His hospital visit began every day at 5 a.m., summer and winter he rarely missed a day, he left the Hôtel Dieu only at 1 p.m., and habitually made an evening round of the wards. With all this prodigious hospital work he carried on a private practice which enabled him to save the great fortune of 150,000 pounds. His reputation as a consultant, an operator, and a teacher was European. His only rival in these respects was Sir Astley Cooper.

Dupuytren must have witnessed the stirring events of the Revolution in Paris. Marat lived and was assassinated by Charlotte Corday in the Rue de l'Ecole de Médecine, his club—the scene of his and Danton's frenzied orations—stood at the end of this street, and the hall itself became ultimately the Dupuytren Museum. This is the only part of the old Convent of the Cordeliers which has survived to the present time.

When the allied troops were taking Paris in 1814, Dupuytren showed personal bravery at the head of an impromptu ambulance-party which he organized from his internes of the Hôtel Dieu and led out to La Villette.

During the occupation of Paris, Dupuytren, then and until his death, residing in a house on the right bank of the Seine opposite to the Louvre, had quartered on him a young Russian ensign named Kazakov, who has left an account of his host which is full of interest. This Russian officer survived until 1883; his narrative only came to light a few years ago, and I discovered it by accident. Kazakov describes Dupuytren as having been a kindly but tyrannical host, living in simple style (although he then enjoyed a large practice and income) with

his wife and only daughter. It may be noted that Madame Dupuytren seems to have left him later; there was some scandal. It was his ambition to make his daughter a great heiress, and with the exception of a moderate legacy to found a Chair of Pathological Anatomy, all Dupuytren's wealth passed at his death to her.

Alike under Napoleon, Louis XVIII, Charles X, and Louis Philippe, Dupuytren's star never failed him. His being a freethinker in religion did not hinder his Court appointment as surgeon to bigoted Catholic monarchs. When the Duc de Berri was assassinated at the Opera, Dupuytren was called to attend him; he subsequently published an often-quoted account of the death scene.

This was written partly to defend himself from hostile critics and professional enemies, who never failed Dupuytren throughout his whole career. The Duc de Berri had been stabbed in the chest, and for some reason Dupuytren thought it right to enlarge the wound.

The dramatic scene at the Opera, when the Duke's wife met and acknowledged for the first time two illegitimate daughters of her husband, has been pictured and engraved. Amongst the crowd grouped round the dying Prince, Dupuytren's portrait may be recognized. This is the only one of all the State episodes in Dupuytren's experience of which he has left a record. He was, in fact, through life absorbed in his professional work; he had no other interests, no politics, no religion, and no friend except his daughter. A stern, melancholy, ambitious, and bitter man; it is difficult to idealize Dupuytren except as a martyr to his work.

When urged to have assistance at his hospital, or to take some holiday or rest, his reply would be: "There is no rest but the grave."

An attack of partial hemiplegia during the delivery of a clinical lecture warned him of the inevitable breakdown which must follow such perpetual toil as his, two assistant-surgeons were practically forced upon him. A journey to Italy for the benefit of his health was of no avail. He returned to Paris and resumed his arduous work; a chill contracted during his hospital work resulted in pleuritic effusion, of which he died.

It is a mistake to assume that the Dupuytren Museum was founded or endowed by him; it owes nothing but its name and a few specimens to Dupuytren. In this respect our Hunterian Museum, which was in being long before Paris had any adequate pathological collection, is a marked contrast, as John Hunter gave everything to it. In size and importance our museum far surpasses its French rival; there is really no comparison between them.

#### SURGICAL WRITINGS AND TEACHING.

Dupuytren's surgical teaching is contained in the *Leçons Orales* and the second edition of Sabatier's *Operative Surgery*.

In both cases his pupils, aided and directed by Dupuytren, reported his lectures and arranged his observations. The *Leçons Orales* deals with a great number of subjects in a somewhat disjointed manner; the other work is more systematic. Both contain copious narratives of cases and pathological records spread over several thousands of pages.

It is strange that Dupuytren neglected the aid of all illustrations, whilst Sir Astley Cooper employed them so freely and so well that it is still a pleasure to consult his works. Had Dupuytren followed his rival's example his works would not have fallen into such oblivion. Dupuytren lectured to immense audiences, but there is little reason to consider him an eloquent orator, and his writing lack the attraction and the style of Sir James Paget or Sir Frederick Treves. In spite of his unique position, in sole control during a generation of the one great surgical clinic in Paris, it can hardly be claimed for Dupuytren that he made great discoveries in surgery. Nevertheless we owe to him many valuable observations and real advances in our science. He first demonstrated the nature of yellow elastic and erectile tissues. He proved on animals that excision of the spleen could be safely carried out.

He showed that iliac abscess on the right side was frequently due to perforation of the vermiform appendix, that chronic enlargement of the testis was often caused by syphilis and was curable by mercury given internally. Dupuytren's pill for syphilis, containing bichloride of mercury, is still advised in France as an addition to the treatment by Galyl. He wrote copiously on fractures of the long bones, and greatly improved their treatment, especially those of the femoral neck and lower end of the fibula. His treatment of artificial anus survived until recent years; he was the first surgeon to excise a carcinomatous cervix uteri, and the first to describe congenital dislocation of the hip. Dupuytren was specially interested in the treatment of both lacrymal fistula and cataract; the former he improved, but he adopted the operation of "couching" with his special needle as the routine operation for cataract. In this he was certainly wrong, and sinned against the light of his time in more than one sense.

With regard to the surgery of the blood-vessels Dupuytren records many interesting and bold operations, following in part those of Abernethy and Cooper. He devised a whole series of surgical instruments, and did invaluable service in reforming the treatment of urethral stricture by the introduction of gradual dilatation by flexible bougies.

Of all his work in surgery perhaps the most original was that on the contraction of the palmar fascia, which has immortalized his name. Whether Sir Astley Cooper first suggested the right explanation of this condition (as asserted by one French writer) or not, is quite immaterial. But it may remind us of the fact that Dupuytren was a friend of Cooper's, that his writings are full of references to his works and those of other English surgeons. He had a special admiration for Sir William Lawrence's writings, and to English visitors in Paris he opened his mind more fully than to any others.

#### CONCLUSION.

The Duke of Wellington repeatedly affirmed (about the year 1840) in words that deserve to be recalled: "It is an old and very strong conviction of mine that in matters of peace *we can do nothing except in co-operation with France.*"

In medicine and surgery the two nations have learnt much from each other; a closer understanding must result in further gain. I will allude to two points only brought out by the study of Dupuytren's life and time. The first is the system of election to hospital appointments. From the period of the Revolution to the present one the French have elected their hospital surgeons by public competitive examination—the *Concours*. This examination is exactly like that for the Final Fellowship, but is held in public. In England until quite recently the selection at some hospitals was made through canvassing the votes of a heterogeneous mass of Governors! It would need the caustic pen of a Charles Dickens to describe the iniquity, the expense, the absurdity of such a system. Fortunately it is now extinct, or very nearly so. The present method of selection varies somewhat at different hospitals; it has many defects, but the best candidates are elected by it in a fair proportion of cases. Could we improve matters by adopting the *Concours*? Probably we should, but the change is not one likely to be made.

The other point is of far greater importance. In France for over a hundred years the hospitals have derived much of their income from a tax (8 to 10 per cent.) on the gross receipts of all theatres, music-halls, and other places of entertainment. The year before this War, in Paris, the income from this source was no less than 250,000 pounds. In London a similar tax would produce an annual revenue of at least half a million. How long will it take us to follow the admirable example set in this respect by the French? The flow of private benevolence need not be checked by it, nor endowments, nor help given by Government to universities or medical colleges. We want the money badly. The hospitals, apart from their maintenance, need more convalescent homes; they ought to be able to



pay their nursing staffs in a more adequate manner. In Paris all who work in the hospitals or who teach medical students, from the internes to the professors, receive some salary; many of the teachers are well paid. In London medical education, research work, clinical teaching are alike hampered and starved through want of funds. The teachers of pure science, such as those of anatomy, physiology, bacteriology, etc., may perhaps earn a living, but never a sufficient recompense. The clinical teachers, who train our students in the most important part of their career, with rare exceptions receive no pay at all!

Again, in Paris every year many valuable money prizes are given for original research and essays in medicine and surgery. In London, the richest capital in the world, there is only one such reward annually given for original work on a surgical subject, the Jacksonian Prize of the College of Surgeons. Its net value is 13 or 14 pounds. The drawings alone which accompany the essay may well have cost the successful competitor a hundred!

Surely we have much yet to learn from France.

In the first part of this lecture I trust that a real addition to our knowledge of the pathology and treatment of Dupuytren's contraction has been established. To devise and introduce some improvement, to render more easy and effectual our treatment of a disabling deformity, is in itself a source of personal pleasure. That pleasure is much enhanced by the knowledge that a tribute has at the same time been paid from this theatre to the memory of the distinguished French surgeon whose life and works we have been considering, and to the great nation with whom we are henceforth indissolubly allied.

### "THE STRIKE IS OVER, BUT THE REVOLUTION CONTINUES..."

"Since the soldiers and the Social Democratic Party were responsible for the success of the Revolution they naturally bound themselves into one organisation, now known to the workmen's and soldiers' delegates."

The Times' Petrograd Correspondent.  
March 27th, 1917.

The "Conspiracy of Silence" is broken, and the bewildered Western Democracies are seeking for an explanation of the true significance of an unexpected, and to some, perhaps, an unwelcome, upheaval. It is dangerous to prophesy and it is difficult to gauge the relative importance of the

factors the intermingled play of which resulted in the Revolution. Information is not only scanty, but it is obviously tainted by the tendencies of the correspondents' informers and of the correspondents' newspapers. Further, the first impulse was to discover the effect on the continuation of the War. The first despatches were uniformly reassuring. It was said to be a "crushing blow" for pro-Germanism. And yet the way for a true understanding will not be clear unless and until it is realised that the War was but a secondary consideration for the real promoters of the Revolution. A month before the Revolution, Mr. Kerensky, present Minister of Justice, exclaimed in the Duma: "... The greatest mistake is to look everywhere for traitors, German agents, individual Stürmers under the legend of dark forces and German influence. Among us is a far more dangerous foe than German influence, than the treachery of individuals, and that is *the system*."

It is *the system* which all that is best in Russia were battering against for generations. The early revolutionists of the epoch of Alexander II. tried to abolish *the system* by doing away with its embodiment in the person of the Monarch, or of some of his officials more prominently representative of *the system*. The terror provoked a counter-terror. The revolutionists decided to enlist the interest and assistance of the people ("narodnichestvo"). They failed: Russia was hardly an industrial country at the time, and middle-class Liberalism was still a weak plant. The wonderful development of industries, the unbounded energy of modern Russia have brought into her life two new factors: the town proletariat and the enlightened, the uncommonly well-informed and scholarly university and professional classes, who have gained experience in self-government by participation in the Zemstvos. Both these groups wanted to see Russia a civilised country; both of them were, as yet, denied elementary rights; neither of them dreamt of being even partly admitted to power. A natural bond united the two: they were equally persecuted and had to use equal weapons of defence and attack. The proletariat was finally organised into two groups: the orthodox social-democrats and the socialist-revolutionaries. The intellectual classes were joined into "the League for the Emancipation of the People." M. P. Struve, "the man behind the scene" who was during the last few years unofficial adviser to M. Sazonoff, established his headquarters at Stuttgart, and thence by ingenious means circulated throughout Russia a bulletin under the title "Emancipation." The brutal denial of a right of asylum by the German Government must have unconsciously weighed in Mr. Struve's mind when he was shaping with Sazonoff the new Imperialistic

policy of Russia. The present intellectual exponent of Russia's extreme war aims, M. Miliukoff, had likewise to leave Russia and spend bitter years of exile in America and Western Europe. It is barely more than a decade since both these men met in secret conference in Paris representatives of all the violent revolutionary and separatist groups of all Russia, and of nations under the Russian oppression, to discuss and to prepare the overthrow of *the system*. The overthrow, they realised, must be a common work; not only that, but they recognised that whatever their intellectual accomplishments as individuals might be, the overthrow had to be accomplished by the hands, and indeed by the bodies, of the masses. These last were influenced by the Social-democrats and by the Socialist-revolutionaries, the former directing them to seek salvation by class organisation based upon an orthodox Socialist programme, the latter advising militant methods based upon more general Socialist principles. The present conditions of Society make it obvious that masses cannot be put into motion without an economic programme. The Social-democratic camp relied, and still relies, on a minority of the nation: the workmen of great industries, railways and public services. The Socialists-revolutionaries' camp had, and still has, a more ambitious scheme of leading the peasant majority of the nation on an agrarian programme. There were, practically speaking, no other active political parties in Russia proper until the first Revolution in 1905, and even these parties were of the nature of Secret Societies. One great prize of this Revolution was the Duma. Russia, for the first time, had a Public Assembly for open political discussions. But whereas the former "league for the emancipation of the people," now re-named "Constitutional Democratic Party," or "Ca-dets" in abbreviation, had no further need for conspiracy, their former political allies, the Socialists of all camps, had still to work in secret since the ordinary methods of economic struggle—by reason of the exercise of which they retained their hold on the masses—were still punishable as criminal offences, and the mere membership of a Socialist party was punishable by penal servitude. In the Duma, new political formations appeared in competition with the Cadets, who in parliamentary life took up at first an attitude of Radical Liberalism. The more moderate elements came together on the basis of the constitutional manifesto of October, 1905, under the name of "Octobrists." The previously non-descript groups of bureaucratic, agrarian, and conservative elements became politically articulate. The peasantry found its political expression in "Labour" groups which, though they were under the moral guidance of Socialist-revolutionaries, yet showed a more and more pronounced tendency towards a popular democratic rather than towards a

violent militant policy. The successive manipulations whereby the franchise became more and more restricted weakened the position of the Cadets, and still more that of the parties of the Left. Successive Dumas became more and more "Octobrists" in tone. Simultaneously the hope of overthrowing *the system* was vanishing. The issue became: constitutional versus revolutionary reform. The Cadets declared for the former, partly from a timid appreciation of the situation and partly from fear of the Octobrists gaining a dominant position. The choice having been once made, the Cadets began to work for responsible government, hoping to achieve it by diluting bureaucratic governments with "parliamentary blood." But becoming candidates for office, they began to behave by imperceptible stages like Ministers "*in spe*." So much so, in fact, that the last years witnessed the formation of a new political party of Progressists more Radical than the Cadets, who thus evolved into a Centre Party, flanked by Octobrists on the Right and Progressists on the Left, with an Extreme Left consisting of various Socialist groups and an Extreme Right, part of which was avowedly against the very existence of the Duma. Political readjustments are, after all, the expression of interests. Translated into plain words, the Cadets in the altered circumstances sought support outside the University circles in the rapidly growing circles of captains of industry, while the Octobrists were more representative of the landed interests. Those two interests, it is true, were greatly handicapped in peace time by the utterly obsolete *system*. Yet they could hardly have contemplated with joy the return of the struggle of 1905, since the first Revolution had shown that the two indispensable weapons were general industrial and railway as well as agrarian strikes. It had taught more: that the chances of success were hopeless unless the army was with the people. The army, again, consisted of officers and men. The officers might be gained over for a palace revolution or a coup d'état, but this would hardly eradicate *the system*.... Thus, the men remained. They could be appealed to only by the Socialists, who alone could hold out to them a programme of economic emancipation. The intensive work carried out in the army in 1905 missed fire mainly because the army on a peace footing consisted of long-term conscripts. The long years of darkness after the first Revolution broke into two the Social-democratic camp: the majority declared for an unflinching struggle for the overthrow of *the system*, and refused to participate in the Duma elections. In doctrine it stood for the idea of bringing about a Social revolution. It did not recommend, but it neither repudiated, terroristic tactics. The minority were for utilising the Duma tribune for propaganda purposes, and generally



for storming and entrenching any position open to attack. They dismissed terrorism, and in doctrine approached the "revisionist" tendency of International Socialism. Both camps, though losing in cohesion, gained greatly in power through the accession of legions of the agrarian proletariat in consequence of the famous land reform of the great Russian reactionary statesman the late M. Stolypin, who broke up the ancient village commune system. Tens of thousands of peasants became landless, and went to swell the ranks of the industrial proletariat. Thus the powder was slowly accumulating in the magazine. It began to smoulder in the early summer of 1914, when the War broke out. August, 1914, saw Russia war mad. The amazed world witnessed the spectacle of all Russia making common cause with *the system* against the external enemy. Prospects of far-reaching reform seemed to have hypnotised even part of the Socialists' camp. And yet internal progress in Russia has been usually realised only after disasters in the field. After the early defeats of Alexander I., the famous reforms of Speransky were sketched out. Alexander's ultimate victories over Napoleon were quickly followed by the reactionary period of Araktchaieff. Likewise the triumphs gained by Nicholas I. over Turkey and Poland opened an era of prolonged and merciless reaction. The disasters of the Crimea and Manchuria were succeeded by the social reforms of Alexander II. and political concessions of Nicholas II. Russian Social-democrats who, remaining true to their ideals, resisted the War psychosis, stood by the repeated lessons of history and boldly declared that only a defeat in the field would finally undermine *the system*. The Russian fancy for labels found for them the designation of "defeatists" (porajentisy).

*The system* was hoping for victory, but primarily for a victory for itself. Unless this is realised, the kaleidoscopic ministerial changes in Russia during the War cannot be understood. Indeed, what connection with the War had the fact that the Holy Synod, which was presided over for thirty long years by the late notorious Pobiedonosceff, has had four chiefs during the last two years? Or that the Ministry of Justice had three, of Agriculture four, and the Home Office six since 1914? Some influence the War has had. Although the changes have always resulted in placing reactionaries in the office, yet men of a more liberal "nuance" were appointed, after each more manifest defeat in the field—(e.g., Prince Tcherbatoff, Mr. Samarin, General Polivanoff).

But the art of governing in Russia consisted in avoiding the placing of emphasis on the modifications in any determined sense. Thus, e.g., no sooner had the German offensive of 1915 come to a

stop than the colourless Progressists previously admitted to power were dismissed again. Occasionally trustworthy supporters of *the system* shared the same fate. These equilibristic tactics found their full expression when the moderate Mr. Krivoshein and the reactionary Mr. Ruhloff were simultaneously sent away, the one the least capable and the other the most skilful member of the Government. Or again—during the brilliant dash of Brusiloff's offensive, M. Sazonoff fell, for though he was not seriously suspected of Liberalism, yet he was too favourably looked upon by the Progressist block in the Duma, etc., etc. Indeed, the all-powerful circle which went by the name of "spheres" were equally apt to profit from the competition of persons as that of tendencies by opposing one against the other in the whirlpool of Cabinets.

It was, in fact, a supreme art of neutralisations, vacillations, fictitious moves forwards and backwards wilfully and consistently intended to result always in "as you were." The fluctuations in the personnel of the membership of the Government were but a sign of, and a means for, ensuring the immutability of *the system*.

It became clear early in 1915 that *the system* was incapable of waging war, the conduct of which must rest on a rigidly organised nation. The proffered, and indeed splendidly organised aid of the Zemstvos could not be openly rejected. But hindrances were continuously placed in its way from fear that a close contact of the voluntary workers of the Zemstvos with the army could "contaminate" the latter. And "contaminate" it did, as the events have shown. . . .

Obviously, then, if the Governmental tactics were to be destroyed, the unanimity of the early stages of the War had to be abandoned and the Government had to be attacked in the Duma. A "Progressist" block was accordingly formed in the Duma. It consisted of Octobrists, Cadets, and Progressists, together with some elements of the Left, and it found support even in individual members of the Right, with the Cadets as its leading spirit. The block was based on a compromise between its constituent parties; it sought support in the public opinion of Russia by advancing Imperialistic watchwords (Constantinople) and in that of the Allies by proclaiming absolute solidarity and "war-to-a-finish." The block wanted to take advantage of the menace of the War in order to climb into power by means of parliamentary Western European methods, i.e., they wanted precisely what *the system* was bent on avoiding at all costs. But their chances of success were always doubtful. They could in reality count neither on themselves being torn by internal jealousies with the Cadets

and the Octobrists at loggerheads, nor on the masses more than ever determined to overthrow *the system*, and intensely suspicious of any compromise with it, nor finally, on any active foreign support.

The general war situation, the gravity of the food crisis, the financial and industrial straits of the country, and finally the obvious attempts of *the system* to bring about a favourable peace with Germany and thus to gain final victory for itself, were rapidly leading to a climax. The climax came—the "Block" vanished into nothingness. The "masses"—civilian and military—won the day, and though the Cadets gained office, the real power of Russia became concentrated in the Executive Council of Workmen's and Soldiers' Delegates.

The Cadets who in January aspired to become His Imperial Majesty's Parliamentary Duma Government, knew how to adapt themselves to the true spirit of the Revolution. The evolution was indeed marvellous: on March 17 it was reported that M. Miliukoff was negotiating the abdication of Nicholas II. in favour of his son, and on March 27 that the Central Committee of the Constitutional Democratic Party pronounced in favour of a Republic. . . .

The Revolution was prepared by strikes—the strikes have been very wisely called off—but the Revolution continues. . . .

## SOME BRITISH ARMY SURGEONS OF THE PAST

By S. D. CLIPPINGDALE, M.D., F.R.C.S.

When we read of the heroism of our gallant colleagues at the Front in the present War, we—or, rather, those of us who are of a reflective disposition—are prone to wonder what has been the fortune and fate of their predecessors in the battlefields of bygone times.

With the concurrence of our Editor, therefore, and with the hope that it may interest them in their moments of leisure, the following brief notes of some early British Army Surgeons is offered to the readers of the *London Hospital Gazette*:—

*Ralph de Bellomont (temp. Henry II.).*

The first Army doctor of which we have any account is Ralph de Bellomont, or Beaumont. He is described as the "King's Physician." In 1170 the King was at sea and de Bellomont was with him. The Fleet consisted of forty vessels. One of these vessels foundered, and de Bellomont, who was on board, met unhappily with a watery grave.

*Master Haman and Master Richard Haman (ibid.).*

In 1185, Henry II. was at Dover apparently upon his last, and fatal visit to France. It is stated that he was accompanied by Master Haman and Master Richard Haman, probably father and son, who are described as the "King's Physicians." Nothing, however, is known of them.

*Marchadeus (temp. Richard I.).*

Richard I., it will be remembered, was killed in 1199 at the siege of the Castle of Chalus-Chabrol, in France. A French soldier, named Bertram de Gurdun, wounded the King in the right shoulder with a javelin. The surgeon who attended the King was a Captain Marchadeus. He seems to have been an incompetent practitioner, for he is described in the Latin Chronicle of Roger de Hovenden as "illa carnifax." Marchadeus, in removing the arrow, left the head behind. This he subsequently removed by a circular incision around it. Blood-poisoning, however, ensued, and the King died upon the thirteenth day.

Notwithstanding his wound, the King bravely continued his assault upon the Castle, and succeeded in taking it the day before he died.

Marchadeus, for his incompetency, was killed two days after the King's death.

*Thomas of Wexham and Henry de Saxby (temp. Henry III.).*

Thomas of Wexham is described as the "King's Surgeon" and Henry de Saxby as the "King's Sergeant-Surgeon. Mr. Darcy Power, who is perhaps the greatest authority, thinks Henry de Saxby was the first of the Sergeant-Surgeons. The present Sergeant-Surgeon, as we all know, is that illustrious "Londoner," Sir Frederic Treves.

Both de Wexham and de Saxby accompanied the King to Gascony. Upon their return to this country, de Saxby was granted a pension of £10 a year and Wexham received a patent enabling him to mint coins of the Realm. If this meant that Wexham could mint coins for his own use, one can only remark that it was an exceedingly convenient way for an impecunious monarch to reward a valued officer.

*Master Philip (temp. Edward I.).*

Edward I., at the Battle of Acre, narrowly escaped death from an assassin's dagger. Who attended him upon this occasion is uncertain; but the Patent Rolls for July 1st, 1285, contain this entry: "Pardon to Master Phillip, the King's Surgeon, for taking two bucks in the Forest of Whytlecombe."