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pear under the upper sternal fragment and cartilage of first rib. Its left margin is the same as the right for the aorta.

K. *Lungs*.—These could not be inflated satisfactorily (death due to a double pneumonia), so no attempt at securing photographs of them in *inspiration* was made.

The following measurements give the outlines of the anterior margins of the lungs in their partially collapsed state—pleuræ removed.

1. Right: The anterior border appears above in the median line (at the one-and-a-half-inch point), passes downward and to the left of the mid-sternal line until opposite the center of the second interspace (at the two-and-a-half inch point on the mid-sternal line and a quarter of an inch to its left), runs parallel with the median line until (opposite its three-and-three-fourth-inch point) on a level with the center of the third space, when it curves downward and toward the right and is lost running parallel with the upper margin of the sixth costal cartilage.

2. Left: Issues from the upper sternal fragment three eighths of an inch to the left of the mid-sternal line (at the same one-and-a-half-inch point as above), descends, almost touching the right lung, until opposite (the three-and-a-half-inch point on the mid-sternal line) the lower border of the third cartilage, it turns outward toward the left along the upper margin of the fourth costal cartilage until it reaches the left border of the heart, which it follows to near the apex, then turns to the left, following the curve of the sixth costal cartilage (upper margin).

3. Area of heart exposed on expiration: See Sec. G preceding.

(To be concluded.)

## TRAUMATIC DEAFNESS.

By W. H. BATES, M. D.,

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SEVERAL years ago a case of traumatic deafness was treated. Both drum membranes were ruptured by an explosion of dynamite. The tuning-fork test showed symptoms of nerve deafness. Treatment consisted in careful cleansing of the middle ear, politzerization, and the use of general tonics. A successful effort was made to prevent the margins of the perforations from becoming adherent to the promontory. The patient's hearing became more acute than before the injury, possibly from the fact that the cicatrix tightened the drum membrane. A number of other persons injured at the same time by the explosion to about the same degree, not treated, did not recover their hearing. Of the following cases reported, Case VI was the only one to receive treatment, and was the only one which was observed to end in recovery. Cases of traumatic deafness with rupture of the drum membrane need immediate treatment. Methods of treatment which are beneficial in middle-ear disease from catarrhal inflammation are beneficial in traumatic deafness. Politzerization early in the treatment may not benefit, but will improve the hearing after the drum membrane has healed.

The following cases are interesting, as showing the

variety of injury capable of causing deafness. All were in dispensary patients:

CASE I.—J. G., aged eighteen years, was kicked by a horse on the end of his chin. He was unconscious ten minutes. The injury occurred June 22, 1891. The patient was seen the next day. Both drum membranes were ruptured. The left ear bled all night. A clot fills the left external auditory canal. Ears pain on swallowing. Right, watch,  $\frac{2''}{48''}$ ; left, watch heard only on contact.

CASE II.—C. B., aged thirty-five years, fell from a ladder in December, 1891, and struck the back of his head. Sudden deafness, complete in both ears, occurred immediately. Three days later hearing returned partially in the right ear. March 31, 1892, the patient came to the dispensary. Drum membranes of both ears are sunken, pale-yellow in color; the malleus handle is red, prominent, not displaced forward or backward. Tinnitus is complained of in both ears, and it is worse in the right ear, which is the ear with the better hearing. There is an appearance of a cicatrix in the lower portion of both drum membranes (healed traumatic rupture of the membranes). During inflation air rushes through the Eustachian tubes and produces a sound like the sound of a dry tube opening and allowing air to enter. Paralysis of the seventh nerve on the left side, but it is not complete. Right, acoumeter,  $\frac{6''}{100'}$ ; left, acoumeter, 0. After inflation, right, acoumeter,  $\frac{8''}{100'}$ ; left, acoumeter,  $\frac{c}{100}$ .

The case is interesting from the fact that inflation improved the hearing.

CASE III.—R. S., aged forty-seven years, fell down stairs. There was a discharge of blood at the same time from both ears. Collar bone was broken. Tinnitus began at once.

December 12, 1891, six weeks after the injury, presented himself for treatment. Both drum membranes healed with the appearance of a cicatrix in the posterior portion of each drum membrane. The patient complains of dizziness. The tinnitus is still annoying. Ordered tincture of iron, 3 ss., three times a day.

December 22d.—He has less dizziness.

December 29th.—Right, watch,  $\frac{4''}{48''}$ ; left, acoumeter,  $\frac{1''}{100'}$ .

Politzerization improves the hearing of both ears.

CASE IV.—J. L., aged twenty-six years. While loading a truck on August 1, 1892, a barrel fell against his head. He came to the dispensary three days later complaining of deafness. Right drum membrane has a circular perforation below the apex of the malleus handle. There is a slight bloody discharge from the right ear. The left drum membrane is congested; it is not ruptured. Right, acoumeter,  $\frac{2''}{100'}$ ; left, watch,  $\frac{6''}{48''}$ .

CASE V.—W. D., aged sixty-two years, was seen November 1, 1892. During the War of the Rebellion, while standing near the muzzle of a gun at the time of its discharge, he felt a sudden pain in his right ear, which seemed to go through his head to his left ear. The right ear was deaf from that time. He noticed no discharge from either ear. Right, watch heard on pressure against the ear. Left, watch,  $\frac{12''}{48''}$ .

CASE VI.—F. V., aged twenty-two years, while bathing, August 19, 1893, was struck on the left side of his head by the

shoulder of a companion diving from a height of about six feet. The left ear immediately discharged fluid and blood. About an hour after the injury he noticed tinnitus which continued without intermission.

August 22d.—The patient began treatment. Right ear is normal. The left ear hears watch,  $\frac{2''}{48''}$ . The left drum membrane is perforated in the posterior inferior quadrant. There is considerable redness and swelling of the drum membrane. Ordered syringing with warm saturated solution of boric acid.

September 5th.—The drum-membrane perforation has healed. Left, watch,  $\frac{6''}{48''}$ . Politzerization did not improve the hearing.  $\mathcal{R}$  Ung. flav., gr. xx- $\frac{3}{4}$  j, to be applied in the external auditory canal.

September 19th.—Left, watch heard at 3". After politzerization the hearing improved to 5". There is now no tinnitus.

September 23d.—Left, watch,  $\frac{6''}{48''}$ . Politzerization did not improve the hearing.

October 3d.—Left, watch,  $\frac{20''}{48''}$ ; after politzerization the hearing improved to nearly normal. The tinnitus has not returned. Hearing for conversation seems good.

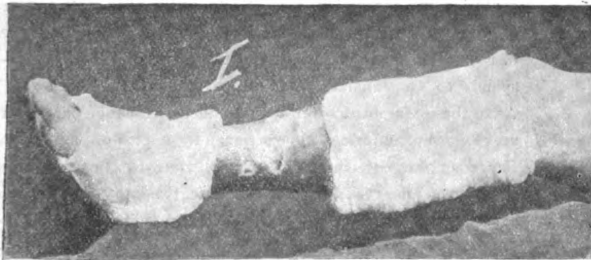
64 EAST FIFTY-EIGHTH STREET.

#### A NEW BANDAGE FOR THE TREATMENT AFTER THIERSCH'S METHOD OF TRANSPLANTATION OF SKIN.\*

By OSCAR J. MAYER, M. D.,

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THE method of transplanting skin first introduced into medicine by Professor Thiersch enjoys such universal employment—possessing as it does advantages recognized on all sides—that it appears hardly necessary to here employ space stating its uses. Not alone can the surgeon with a host of skilled assistants at his side make use of this procedure for a patient's benefit, but as well the ordinary coun-



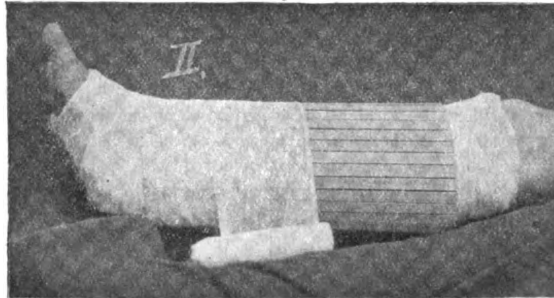
try practitioner, who is thrown entirely on his own resources for assistance.

Only the after-treatment presents some objectionable difficulties, in so far as the oft-necessary change of bandage has as a consequence that pieces already somewhat adher-

\* Read before the Section in Surgery of the First Pan-American Medical Congress.

ent are in the removal either loosened or else wholly torn away.

By means of the dry bandage, which remains five to six days, we—on extensive surfaces, for example—are rewarded, on an average, with the firm adhesion of about sixty per cent. of the transplanted pieces. With the moist band-



age, with or without silk protective, whether using liquor alumini acetatis or an ointment, even with the most painstaking care, on removal of the bandage we find that some pieces are torn away, while others are loosened to such an extent that they go over into necrosis and fall away.

In consequence, I have made an attempt to overcome this difficulty by means of an alteration in the bandage. After the transplantation the bandage is so applied that contact with the wound or surrounding surface is avoided, the wounded surface being bridged over.

As one can readily see from Fig. 1, a pillow of wool, cotton, or like material is placed one above and one below the surface operated upon. If the pillow is now bridged over by a slat of wood or firm pasteboard, and the whole made into a bandage *lege artis* and still further stiffened by a starch bandage, we shall have the wound well covered, yet contact can take place at no point. The bandage can be changed as often as necessary without disturbing the transplanted pieces—a self-evident advantage in this operation.

As, however, on extensive surfaces—for example, in ulcerations on the leg or arm, encircling the whole limb—a broad slat would not be practicable, whereas many narrow ones would present difficulties and require assistance, I have devised an arrangement by which small slats, cut appropriately, are pasted upon a piece of linen parallel and close to each other, so that the whole can be rolled, as can be easily seen from Fig. 2.

As this bandage does not sit firmly over ulcerated surfaces in the region of the elbow joint or of the dorsum of the foot, I have made use of strips of plaster of Paris modeled appropriately and likewise resting on pillows (*vide* Fig. 3). This latter method can be used with great advantage when transplanting is resorted to for covering extensive burns of the chest, back, or other regions of the body.

As a matter of course, the plaster strips must be modeled with due reference to the location for which they may