to appropriate treatment. In a very large number of cases we have no history of misfortune or monotonous anxiety to account for its origin; and in such we turn to physical conditions, and inquire whether there is not a melancholia which depends on these for its causation. That such should be the case would be no more extraordinary than that mental anxiety and worry should, as they certainly are capable of doing, produce a diarrhoea. Some cases, of course, depend largely upon hereditary predisposition to insanity. Of the fifty-two cases in question there is history of heredity in three only of the thirty-nine associated with bodily diseases; whereas of the thirteen admitted in "good bodily health" no less than eight were distinctly hereditary. In a large proportion of cases, however, we cannot point either to mental or hereditary influences; and in these what is responsible for the mental affection? As I have said, observation has led me to believe, and is daily strengthening the belief, that an imperfect oxygen supply may alone produce a melancholia. How variations in its supply to the cerebrum act in producing a predominance of happy or of miserable types of thought, I will not venture to discuss; but facts seem to suggest that they are intimately connected with such predominance. The events even of everyday life may bear this out. After a day or week of close confinement in an unhealthy chamber, resulting in a low and desponding state of mind, a condition of disgust with things in general, how a walk or ride in pure air outside raises one's spirits. A man under such conditions often comes in feeling, as he says, "a different man." There has been an abundant supply of oxygen, and the exercise has stimulated his heart to increased exertions in driving the oxygen-loaded blood rapidly through his cerebral arteries. The raising of one's "spirits," the generation of happy thoughts as opposed to the miserable, which attend a journey or sojourn in a highly ozonised atmosphere, are surely physiological results; and so also the opposite tendencies of unhygienic conditions to bad temper, irritability, gloomy and miserable states of mind are pathological certainties. Such unhygienic conditions, I hold, we may associate with the various organic diseases I have above referred to and anæmia, as all tending towards the same mental state; and it seems more than likely that they exert their respective influences towards its production through "imperfect oxygen supply" as a common medium.

Worcester.

WHICH IS THE MORE FREQUENT SITUATION IN MALES OF THE INDURATED CHANCRE, INFECTING SORE, OR INITIAL SIGN OF SYPHILIS?

By FREDERICK W. LOWNDES, M.R.C.S.,

SURGEON TO THE LIVERPOOL LOCK HOSPITAL AND CONSULTING SURGEON, SEAMEN'S DISPENSARY.

SOME time ago my colleague, Dr. Bernard, called my attention to the circumstance that the indurated chancres seen by us in our male patients at the hospital and dispensary appeared to be most frequently situated upon the prepuce. Previously to this we had both been under the impression that the more usual seat was in the furrow near the frænum, on the corona glandis, or on the glans, situations where the syphilitic virus might be expected to adhere, especially in cases where the prepuce was long, and where a want of cleanliness was also co-existent. Careful observations in hospital, dispensary, and private practice confirmed Dr. Bernard's statement, and I suggested to him that we should make independent notes of all the cases which came before us until we had observed a number sufficient for statistical purposes. In the course of a few months we had records of 400 cases, made up as follows:—Lock Hospital 163; Seamen's Dispensary, 134; private practice, 103—total, 400. Every care was taken to include none except the true infectious sore. In many cases this was made manifest by the concurrence of secondary eruptions; in others the induration was well marked; while in all there was an incubation period more or less long and the presence of indurated inguinal glands, either in one or both groins. We were ably assisted in the hospital returns by Mr. T. W. Serjeant, the resident superintendent, who carefully recorded our diagnosis of each case in the "case-books." In every

case which was of a doubtful character we deferred recording it until its nature had been fully established.

Before giving the results in detail, I would wish to notice the remarks and statistics of different authors with reference to the locality of chancres. Messrs. Berkeley Hill and Arthur Cooper, in the second edition of "Syphilis and Local Contagious Disorders," say (page 84): "The superficial hard ulcer or erosion is the most common form of initial lesion. A favourite locality for it is the inner surface of the foreskin." At page 87 Mr. Hill says: "Of 150 cases seen by himself at the Lock Hospital in 1861 there were 41 initial lesions of the furrow, 31 of the inner prepuce, 24 of the outer prepuce, 17 of the frænum, 15 at the free border of the prepuce, 12 on the glans penis, and 10 at the urethral meatus." Bumstead and Taylor, in their work "The Pathology and Treatment of Venereal Diseases," say (page 449): "The superficial form of chancre"—i.e., indurated chancre—"is most marked on the internal surface of the prepuce by which it is protected from the air and friction, and kept free from scabs, and it is in this situation that it is most frequently met with." Mr. Barton of Dublin in his lectures on the "Pathology and Treatment of Syphilis," says: "The situation of the sore affects the amount of induration very much; thus on the corona glandis it is very well marked, while if occurring on the prepuce it is frequently very indistinct." But he does not say which situation is the more frequent. Keyes says: "The raw erosion is the most common form of syphilitic chancre. It is found in both sexes on the integument, as well as upon a mucous or semi-mucous surface." The report of the Venereal Committee, 1864, states: "It [i.e., the sore marked by a specific induration] may occupy the inner surface of the prepuce, the fossa, the glans, or the external integument."

The following statistics of Clerc and Fournier are quoted by Professor Van Harlingen in his admirable article on Syphilis in "Ashhurst's International Encyclopædia of Surgery," vol. ii., p. 460:—

Clerc's figures.—Internal surface of the prepuce, 63; balano-preputial fold, 171; orifice of the prepuce, 35; frænum, 14; glans, 12; meatus urinarius, 33; cutaneous surface of penis or prepuce, 58; scrotum, 3; peno-scrotal angle, 5—total, 394.

Fournier's figures.—Glans and prepuce, 314; preputial furrow, 60; multiple, that is showing chancres of the furrow and prepuce, or of the furrow and glans, 11; meatus urinarius, 32; intra-urethral, 17; scrotum, 7; peno-scrotal angle, 4—total, 445.

Our figures.—Prepuce, inner and outer, 166; prepuce, furrow, and corona, 37; body of penis or sheath, 32; prepuce and furrow, 31; furrow, 29; meatus, 15; glans, 13; frænum, 9; corona, 7; furrow and corona, 7; prepuce and glans, 7; sheath and prepuce, 5; prepuce and frænum, 5; furrow and glans, 4; other situations mostly compound, 33—total, 400.

The larger proportion of chancres were thus found to be on the prepuce, and of these the majority were situated on the inner prepuce, comparatively few being on the outer. If in Fournier's statistics the numbers on the glans and prepuce had been given separately, and if Clerc's figures for the "balano-preputial fold" and "orifice of the prepuce" be added to those of the "internal surface of the prepuce," the proportion of chancres upon the latter would probably be as marked as in our cases. The situation will, of course, be determined by circumstances. Many of those seen on the prepuce and furrow, prepuce furrow and corona, prepuce and glans, and prepuce and frænum, were probably at first situated on the inner prepuce, extending to adjacent parts before they were seen by us. The condition, moreover, of the parts must have some influence on the site of initial lesion, an excoriated state being especially favourable for absorbing the syphilitic virus.

While, on the one hand, it would be absurd to attach too much importance to this question as to the exact site of the initial lesion of syphilis, it seems to me that, looking to the past history of this disease, it would be unwise to ignore any well-established fact, or to attempt to say positively of how much or of how little importance it is. Taken in conjunction with the period of incubation which almost invariably precedes the infecting sore, it is somewhat significant that the situation of the latter should more frequently be superficial, and so comparatively rare on the frænum, a place where we might expect the virus to lodge.

Those who have had experience in statistics will know

how difficult it is to take and preserve accurate returns of such details as are here given. I could have wished that they had been even more complete, especially that the numbers for the inner and outer prepuce had been given separately. There are some other points on which it would be interesting, and perhaps profitable, to have accurate records. These are—(1) The relative proportions of single and multiple infecting sores; (2) the comparative frequency or rarity of the absence of induration; (3) the varying periods of incubation in days; and (4) the proportionate frequency of the presence of indurated inguinal glands. It is somewhat remarkable, seeing how greatly syphilitic diseases prevail in these kingdoms, so few English statistics have been compiled, most of them being those of foreign countries. Two possible reasons for this are the paucity in this country of lock hospitals and lock wards, and the immense labour involved in preparing such statistics. To reduce this latter as much as possible I am having printed forms prepared which will enable us to record with ease all the preceding details, as well as the exact site of the initial lesion. I shall probably be able to give these in some future issue of THE LANCET from the returns of a large number of cases. Should any readers of THE LANCET desire to have a specimen of these forms, I shall have much pleasure in forwarding it. We have also observed the site of the infecting sore in females, but the number is not sufficiently large for statistical purposes; these I shall hope also to give in a future article.

Liverpool.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

SAMARITAN FREE HOSPITAL.

(DORSET HOUSE BRANCH.)

CASE OF REMOVAL OF LARGE INTRA-UTERINE FIBROID.

(Under the care of Dr. PERCY BOULTON.)

E. B—, aged thirty-five, was admitted on account of profuse loss of blood at her periods which had rendered her exceedingly anæmic, and latterly, during the whole intra-menstrual interval, she had suffered from a foul-smelling discharge. Being single and the hymen intact, she had never undergone a vaginal examination. Dr. Percy Boulton found the os dilated and the brim of the pelvis completely blocked by a fibroid tumour a little larger than the foetal head at term. A broad anterior attachment was made out, and it was found that the presenting part was decidedly sloughy and causing the foul discharge complained of.

The patient was prepared and the tumour was removed. Owing to the large size of the growth and the smallness of the vaginal outlet, it was necessary to trisect the tumour. The wire of the *écraseur* was placed over it and tightened sufficiently to act as a tourniquet round the thick pedicle, while the other portions were removed with another instrument, the last third being removed by the *écraseur* that was first placed round the pedicle, and in this manner the severe hæmorrhage which was anticipated from so broad a base was prevented.

During the first twelve hours the vagina was packed with wool impregnated with iodoform and eucalyptus, and afterwards the parts were douched several times a day with iodine lotion.

Some slight pelvic cellular inflammation occurred afterwards, from absorption of the discharge through the stump, but the temperature never exceeded 102.4°, and the patient made an excellent recovery and left the hospital convalescent after seven weeks.

As the usual difficulties in removing large tumours were much increased by the small space for manipulation, and a broad pedicle is always an element of danger after the removal of fibroids, the case was regarded as interesting and satisfactory.

WOLVERHAMPTON AND SOUTH STAFFORDSHIRE GENERAL HOSPITAL.

CASE OF STRANGULATED INGUINAL HERNIA; DEATH FROM INTESTINAL HÆMORRHAGE; REMARKS.

(Under the care of Mr. KOUGH.)

FOR the following notes we are indebted to Mr. J. W. Batterham, B.S. Lond., house-surgeon.

George S—, aged thirty, was admitted at 1.30 P.M. on September 5th, 1884. He stated that he had been ruptured all his life, had never worn a truss, and had always been able to reduce his hernia when it came down; that when lifting a mass of iron early on the morning of admission the rupture came down in larger amount than usual, and he had been unable to reduce it. Patient was a spare, delicate-looking man, but had never suffered from any other ailment than his hernia. He was cold and pale with a small, feeble pulse.

Upon examination a scrotal hernia was found on the left side about the size of the patient's head. The tumour was not very tense and was resonant on percussion, but succussion showed it to contain a considerable amount of fluid. Gentle efforts at reduction being ineffectual, the patient was placed in a hot bath for twenty minutes, and then removed to bed with hot bottles to his feet and an icebag on the scrotum. He was left in this condition till 7 P.M. During this time he was extremely restless and complained of great thirst. He vomited a few ounces of bilious matter. At 7 P.M. he was becoming extremely collapsed, and complained of dyspnoea. The hernia was slightly smaller than on admission. At 7.30 P.M. chloroform was administered and the hernia readily reduced. The patient's pulse improved somewhat under the influence of the anæsthetic, from which he soon recovered, but he rapidly reassumed his collapsed condition, and died about 9.30 P.M.

Necropsy, sixty hours after death.—The sac in its empty condition was nine inches long and nine inches in circumference. It appeared to be the sac of an acquired inguinal hernia of the external or indirect variety. The mouth of the sac was large, admitting three fingers. The pelvic cavity was full of blood-stained serum, a little of which was also found in the sac. The last nine feet of the ileum, the cæcum, and ascending colon (in all, about one foot of large bowel) were of a dark-purplish tint, and had evidently formed the recent contents of the sac, though the exact point of strangulation could not be detected. A long meso-cæcum was present. The above-mentioned ten feet of intestine were ligatured and removed. The peritoneal surface was firm and polished. On laying the gut open about a pint and a half of blood escaped. The inner surface of the bowel was of an even darker colour than the outer, and presented throughout large slate-coloured patches of ecchymosis. Peyer's patches and the villi were very well marked, being turged with blood. No ulceration or other sign of disease was detected. The heart was anæmic, but healthy; the lungs were congested and cedematous; the liver congested; other organs were normal. The large venous trunks contained hardly any blood.

Remarks.—The above case presents several unusual features. 1. The large size of the hernia. 2. The great length of the mesocolon and mesocæcum, which allowed the first 12 in. of the large bowel to occupy the sac of a left inguinal hernia. 3. It is difficult to account for the presence in the bowel of so large a quantity of blood. The large size of the opening into the sac, and ease with which the hernia was reduced under chloroform, do not point to a very severe strangulation of the bowel by the neck of the sac. To what then was the intense congestion and subsequent hæmorrhage due? Is it possible that a twisting and stretching of the mesentery may have produced so grave an interference with the circulation? The patient presented the symptoms of internal hæmorrhage, and his death was apparently due to this cause. I am not aware that any case has been reported where death after hernia has occurred in this manner.

CASE OF RUPTURE OF THE LIVER; NECROPSY.

(Under the care of Mr. KOUGH.)

The notes of this case also have been furnished by Mr. J. W. Batterham, B.S. Lond., house-surgeon.

John B—, aged twenty-three, was admitted into the hospital at 2.40 A.M. on Sept. 5th, 1884, having been run over by an empty railway truck (weighing about four tons)