The disease is, at an earlier stage, even more curable by encapsulation and cretification of the deposit. Of this I have witnessed several examples. These boxes exhibit indubitable evidence of cured phthisis in four instances; they contain cretified tubercle expectorated by phthisicals in different stages of the disease, and two of them are perfect casts of an air-sac and its alveoli. In the fifth is presented for comparison a cretaceous particle discharged by a gentleman from a crypt of one of his tonsils, causing him much alarm.

Suitable change of climate is, *par excellence*, the remedy for phthisis. A long journey by sea is also of the highest value, and in many instances it has been known to effect a complete cure. Of medicines, cod-liver oil is the best, and of aliments, fats of every kind. Where cod-liver oil cannot be borne (and there are many such cases) I have given arsenic after food in small doses (3 to 5 m.), alone or combined with one of the ferruginous syrups, or with Parrish's compound syrup of phosphates, after food, as suggested by the general condition and the special symptoms. I have been induced to make trial of arsenic, in cases especially characterised by great and rapid wasting, from the remarkable results recorded of "arsenic-eating" in Styria, and I am satisfied it is of great value so given. Rich cream is likewise a good substitute for cod-oil. Dover's powder, given in 5 gr. doses once or twice in the course of the night, is the best remedy for night-sweats.

ART. XIX.—*Herniotomy, chiefly in the County Down Infirmary.*

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IN the following paper I propose giving an account of all the cases in which I have operated for strangulated hernia, with the failures, accidents, and successes, in the order in which they occurred in my practice during the last eighteen years.

This being an operation that any surgeon may be suddenly called on to perform, particularly in a country practice—possibly with little skilled assistance and unpropitious surroundings, and one in which the treatment before operation has a most important bearing on the probabilities of success—I am not without hope that a short account of my cases, with a few remarks in which I shall attempt to convey what I believe they have taught myself, may be of interest to some of the readers of the Journal.

TABLE.

No.	Name	Occupation	Class and Duration of Hernia	Operation	Result	Observations
1	Samuel C., aged 75, Aug., 1859	Farmer	Right oblique inguinal entero-epiplocele; symptoms of strangulation of six or seven days' standing.	Sac opened; bowel being gangrenous, not returned.	D. 36 hours	This operation was undertaken with scarcely any hope of success.
2	Mrs. F., aged 30	None	Left femoral enterocele; three days' irreducible, symptoms not acute.	Sac not opened; after the division of Gimbernat's ligament reduction was easy.	R. about 2 weeks	After-treatment, an opiate shortly after the operation, a chamomile enema three days after. (See remarks below.)
3	Mary M., aged 52	Labourer's wife	Right femoral enterocele; five days' symptoms of strangulation.	Sac opened; bowel very much discoloured; both layers of peritoneum studded with lymph.	D. over 2 days	Opium treatment; no motion from bowels; death from peritonitis.
4	Miss J., aged 50	Farmer's sister	Right femoral enterocele small; three days' symptoms; vomiting excessive.	Sac opened; only part of the calibre of intestine protruded.	R. 5 weeks	This case resulted in an artificial anus, which rapidly closed. (See remarks below.)
5	Jane M., aged 70	Labourer's wife	Left femoral enterocele; symptoms of two days' standing, not very acute.	Sac not opened; hernia returned easily without doing so.	R. 6 weeks	The reason of the delay was the occurrence of anthrax over the crest of the ilium; left the infirmary quite well.
6	John J., aged 70	Labourer	Left oblique inguinal entero-epiplocele; symptoms of either four or five days' standing.	Sac opened; bowel not returned, being gangrenous.	D. under 48 hours	Patient did not rally after operation; peritonitis.
7	Eliza M., aged 56	Servant	Right femoral enterocele; symptoms about forty-eight hours.	Sac not opened; hernia easily returned; operation perfectly bloodless.	R. 12 days	An opiate after operation, no other medicine; bowels moved on fifth day.
8	Mr. S., aged 45	Farmer	Right oblique inguinal enterocele; thirty-six hours' symptoms at most.	Sac not opened; hernia easily returned.	R. quickly	(See below.)
9	Eliza W., aged 69	Servant	Right femoral enterocele; four days' irreducible, not very acute symptoms.	Sac opened; gentle pressure not succeeding after the division of Gimbernat's ligament.	R. 23 days	No trouble in the after-treatment of hernia; a suppurating lymphatic caused delay.

In order to avoid tediousness, I shall beg the reader to assume that in all these cases the usual bath, enemata, &c., were given, and at least a gentle taxis resorted to before operation.

Every case got chloroform, except No. 16; the omission is accounted for in the column of observations.

Where necessary, I have given a more extended account of some of the cases immediately after the tabular statement.

REMARKS:

CASE No. 2.—During the performance of this operation I was assisted (?) by a practitioner of the old school, who kept constantly assuring me that I was ruining the case, that no hernia could be reduced by such an operation—my offence being that I had made only a simple incision instead of a T for a small hernia. This, during my first operation in a private family—and, indeed, my first herniotomy with any chance of success—was hardly help.

CASES 4 and 10.—Although one was a femoral and the other a direct inguinal, these were similar in many respects; in both there was only part of the calibre of the intestine strangulated; both resulted in artificial anus; both recovered without any surgical interference, the artificial opening closing in a few days, and in both there were figured motions per anum while the artificial anus was discharging. I have seen worse-looking intestine than either of these cases presented returned, and no evil ensue. I believe that no amount of caution will prevent the occasional occurrence of this accident. There is, however, a practical point in connexion with these cases of strangulation of only part of the intestine—viz., the finger of the operator should not follow the intestine so far through the ring as to endanger any adhesions that may exist close to its abdominal aspect. I think it at least probable that the safety of my two cases depended on such adhesions.

CASE 8.—Was operated on in his own house at night. I had to administer chloroform myself, and then to operate, as a medical man who was with me would not give chloroform. We had a farm servant-man to hold two dipt candles as our light, but during the operation he fainted, fell on the candles, and left us in total darkness. When light was restored I gave another whiff of chloroform, and completed the operation without opening the sac. On my return to the house, thirty-six hours after the operation, I found the bowels had moved, and the patient sitting at the fire smoking his pipe. His recovery was rapid and perfect.

CASE 14.—In this case two or three enlarged lymphatic glands occupying the hernial region left me entirely dependent on the general symptoms

as to the nature of the case. The operation alone demonstrated a very small hernia behind the glands, which were easily separated from the outside of the sac. I am disposed to think that the swelling of the gland, usually in or very near the ring, must have distended the ring, and so led to the rather uncommon case of femoral hernia in a boy. The glands were more troublesome in the after-treatment than the hernia.

CASE 15.—The medical gentleman who sent this case to the Infirmary thought he had almost completely reduced the hernia three days before her admission, symptoms being two days antecedent to the time of his seeing the case. The patient was a fat, flabby woman; when she came to the Infirmary there was a great deal of swelling round the sac, which could be pushed away by moderate handling to the extent of apparently reducing the tumour to less than half its original size. The inference here is obvious—unless the hernia disappears with a jerk, and unless the symptoms are relieved by reduction, surgery has done no good.

CASE 18.—The history in this case induced me to postpone the operation for a few hours, with, as the event showed, a considerably increased risk to the patient. It was an old hernia which had occasionally been two or three days irreducible without any bad consequences ensuing. Her bowels had moved freely the day before, on the morning of admission, and again after an enema given in the Infirmary. At first there was neither pain nor tenderness in the tumour; there was no vomiting; the abdomen was soft and very little swollen. Under these circumstances, I made several attempts at reduction, the effect of which was to make the tumour painful and tender, to induce nausea, though actual vomiting did not occur; in short, an obstruction was changed into a true strangulation. When the operation was performed I found the intestine of a sienna brown colour, very full, and some spots of lymph in the vicinity of the neck of the sac, and, even when the neck was freely dilated, the reduction was not easy. For three days after the operation there was neither fever nor vomiting, and, though the bowels did not move, I began to hope for a speedy and safe recovery, but subsequently the case became most critical. Occasional vomiting, alternate diarrhoea and constipation, and an almost total incapacity for nourishment, rendered the result to all appearance hopeless. The hypodermic injection of the pharmacopœial solution of the acetate of morphia three and four times a day, in doses sometimes as high as twelve drops, the frequency and amount being regulated by Dr. Joseph Clarke, House Surgeon to the Infirmary, were, I believe, the means of saving the patient, who left the Infirmary perfectly well in about six weeks. I have given a full account of this case, because I believe its history was calculated to mislead, and that, if I had operated three hours sooner, I should have avoided both trouble and risk.

I could well wish I had a smaller mortality to report than appears in the above Table. There were three of the cases in which it might have been almost as well to have let them alone, and one, Case 12, was really a successful operation, but is here reported as it appears on the Infirmary books as a death.

Though in all the fatal cases, except No. 12, the sac was opened, and though No. 12 is the only case in which there was a fatal result after reducing the hernia without opening the sac, I do not think any deduction can be made as to practice on this point, because I never opened a sac except where I could not easily reduce the hernia without doing so; and this I believe sound practice, provided no forcible attempts at reduction are made. The lightest possible adhesions, however recent, or the least inflammatory thickening of the neck of the sac, will prevent a gentle taxis being successful, even when the sac is bare. In any hernia that I felt warranted in attempting the taxis, when the patient was anæstheticised for the operation, I should not hesitate to try and gently empty the sac without opening it. The adoption of this line of practice results in the sac being opened in all the worst cases. In most of the fatal cases there is, however, one element in common—the long interval between the commencement of symptoms of strangulation and the operation. This often arises from ignorance on the part of the patient and the friends. It is, however, a matter of the highest importance that, once the case has been entrusted to professional hands, no time should be lost. There is a far deeper and heavier responsibility in protracting measures, the object of which is to avoid the operation, than in accepting the inevitable at once, and operating before the combined action of time and handling destroy the pliability of the protruded intestine, and render it unfit to resume its functions. The taxis, even with very moderate pressure, will at any time soon cause or increase inflammation of the protrusion and sac, and doubtless does often convert a simple obstruction to the onward progress of the contents of the bowel into a true strangulation; so that the very fact of the surgeon making the necessary attempt at reduction renders it imperative on its failure that the operation shall follow speedily.

I have never delayed an operation or resorted to heavy pressure to effect reduction with benefit, and have had occasion to regret both the time and the pressure; and I have never seen, heard, or read of a case in which there was the least reason to regret having operated early.