mind, who use much mental exertion at night, such as students cramming for examination, &c.

3. Incapacity to complete the generative act from mental agitation. This happens to new-married men from modest respect, and to the unmarried from consciousness of sin, and disgust towards the female. The same mental agitation produces simultaneously indigestion and a deposit of lithates in the urine, which is then supposed to be semen.

4. Nocturnal pollutions, arising solely from the habit of oversleeping; but rarely affecting the health, except secondarily through the mind.

5. Slight epileptic fits.

6. Simple delusions, grounded on no symptom, but taking this form on account of the secret publicity given to the gross exaggerations and falsehoods contained in the books I have alluded to.

7. The fallacies which harass these poor people are often the more deeply ingrained by the consciousness of dirty habits in their boyhood, though probably those habits have been long left off, and have never been practised to the extent of injuring the health. But sometimes you will find patients complaining of "spermatorrhoea," half with the idea of deceiving, and half as a euphemistic way of telling you that they are still addicted to self-pollution.

These are the most common of the cases you will see. When you first enter upon practice, their extreme frequency, combined with the entire absence of the complaint supposed to exist, is a great surprise to you. But I trust no pupil of St. Mary's Hospital will ever be led to sacrifice the interests of truth by pandering to the unhappy error of the patient. He may make his purse heavy, but his conscience will be weighted in double proportion, and sooner or later he will most surely be found out and held up to the scorn of his brethren.

Strange to say, education does not at all guard people against these fallacies. Within the last three months I have had under my care a young medical man in active practice, an experimental physiologist, and an observant civilian in the Indian service, with imaginary spermatorrhoea. Two of them were anxious to marry, and were refraining from causeless fear. You will be obliged to have your wits about you, to argue and to reason instead of pooh-poohing, and it will give you much intellectual exertion to convince your patient that he is not ill. But it must be done or tried at, or else you will deserve to be kicked out of the profession, and will run a fair chance of getting your deserts.

UNUSUAL COMPLICATIONS

OF AN

OBLIQUE CONGENITAL INGUINAL HERNIA

(IN A PATIENT TWENTY-SEVEN YEARS OF AGE), PROBABLY
THE RESULT OF A FREAK OF DEVELOPMENT.

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I FEEL it my duty to place on record the following interesting case, together with an expression of regret that the important deviation from nature which it presented should not have fallen under the observation of one more competent to explain the deductions, embryological, pathological, and practical, which ought to be drawn from it.

On the 16th of April, 1861, at two A.M., I was summoned by Dr. Houghton, the assistant-surgeon to the Clay-cross Works, to a patient suffering from strangulated oblique inguinal hernia, whom I found drunk, collapsed, pulseless, and vomiting, apparently in great pain, and very unruly. On examination, I discovered a firm, oval tumour, the size of a hen's egg, in the left groin, and considerable fulness along the course of the inguinal canal. I entertained doubts as to the character of the tumour, but the patient not being in a position to give me its history, and the bystanders knowing nothing more than "that it had been down once before, and had been put back without cutting," I did not feel justified in leaving my drunken patient with such a suspicious tumour in his groin.

Dr. Houghton at once administered chloroform, and it acted as a direct stimulant to the nervous system and to the heart's action, as, indeed, I believe it almost invariably does in collapse the result of injury. The patient having been brought fully under the influence of the chloroform, I applied the taxis, but without success, and then proceeded with the usual operation

for the relief of oblique inguinal hernia. I found it necessary to divide some constrictions at the internal abdominal ring, after which a portion of the tumour was returned into the abdomen with an unmistakable gurgle. A tumour, however, still remained in the groin, between the scrotum and the external abdominal ring. I re-introduced my finger into the inguinal canal, and found only the spermatic cord, and that the communication with the abdomen was quite patent. Now came the question—What is this tumour? Not an undescended testis, for there are two in the scrotum. Is it, then, a hydrocele of the cord? I applied the knife, divided a fibrous membrane, and then there exuded a number of fine, vermiform, yellowish filaments, each accompanied by a congested vein; and on squeezing the testicle (?) in the scrotum, these filaments and veins protruded all the more from the cut in the inguinal tumour. I now felt certain that I had cut into a portion of the testis, and believed that the inguinal tumour was the globus major of the epididymis, enlarged by disease, and that the vascular filaments were *coni vasculosi*. The gut being fairly returned, however, I felt only a temporary pang at having wounded the testis, and was content to labour for a few days under the imputation of having operated on a testicle in mistake for a hernia.

Eight hours subsequent to the operation, I obtained the following history from the patient:—He has always had *two* testicles in the scrotum, and has remarked that the left one (corresponding to the groin operated on) has always been a little smaller than the other. Never observed a tumour in his groin, except on one occasion, when "it came down" while he was lifting a weight. It was returned by my late assistant, Mr. Carter; and he had leeches applied to his abdomen, and took pills and medicine. On the present occasion, he remembers sneezing, then "feeling something give way in his groin," which caused such great pain that he fell to the ground. "Drunk and incapable," there he lay until found by his friends, at two A.M.

The history was simply that of a hernia of the gut. Had I then erred as to the tumour left in the groin? Had I left a lump of omentum there? I felt certain that I had not erred, and that my patient's history was not correct. Both Dr. Houghton and myself had passed our fingers into the abdomen; both had felt that the inguinal canal contained nothing but the spermatic cord; both had seen the spermatic ducts (?) ooze through the cut in the inguinal tumour when the testis (?) in the scrotum was squeezed; both of us had felt the tumour, and traced the spermatic cord passing into it. How could we be mistaken? The sequel will show how far we were correct in our diagnosis.

Nine P.M.: Swelling and intense tenderness of the testicle (?) in the half of the scrotum corresponding to the groin operated upon; pain and tenderness along the inguinal canal and over the lower part of the abdomen; anxious expression; pulse 120, small and wiry; great nausea and faintness; slight bilious vomiting; no action of the bowels. I diagnosed *orchitis*, consequent on the puncture of the portion of testis (?) in the groin; and peritonitis, the result of the strangulation of the bowel and of the operation; and I saw in this orchitis (?) a confirmation of my opinion as to the nature of the inguinal tumour. Ordered, twenty leeches to the tender parts; calomel and opium every two hours; and the effervescing citrate of potash with prussic acid.

17th.—The peritonitis has become more general, but the scrotal tenderness is much less marked. Ordered, a repetition of twenty leeches, and to continue with the calomel and opium. Flatus has passed freely per rectum, but no stool. Vomiting continues, but the ejecta have not the slightest suspicious appearance or smell.

18th.—Dr. Booth, of Chesterfield, kindly met me in consultation, and to him I stated every particular relative to the history, the operation, and the subsequent treatment of the case: the main points of my statement being, that a knuckle of intestine had been returned, completely and satisfactorily, but *no sac opened*, and I believed there was none; that the remaining inguinal tumour was *part of*, if not *the* testis; and that I had satisfied myself of this by opening it. I asked whether the symptoms called for any further operative interference. Dr. Booth replied that *the testicle was certainly in the scrotum*; but that he would not hold himself responsible for what was in the groin. Believing my statement as to the complete return of any abdominal protrusion that might have been present, he did not consider the existing symptoms more urgent than frequently occurred after the operation for hernia, and he should not advise an operation, but should rely on calomel and opium, fomentations, &c.

19th.—Ten A.M.: Has passed a tolerable night, and is improved in every respect. The abdominal and scrotal tenderness has almost entirely disappeared; the wound in the groin is sloughy and painful. I administered a copious enema of warm water. It returned, in about half an hour, slightly discoloured and smelling very offensively.—Ten P.M.: Vomiting has been very urgent for the last two hours, and the ejecta have a fecal appearance.

20th.—Vomiting decidedly fecal and very copious. Bowels not moved. Complaints of great pain about the umbilicus and left groin. The patient insists that "there is an obstruction," and prays that it may be removed.

I now began to feel that a second operation was imperatively demanded, and that in all probability we should find a knuckle of intestine had again been forced into the inguinal canal (rendered unusually patent by the recent operation) during the act of vomiting, no pad having been applied in consequence of the tumour left in the groin.

21st.—Two P.M.: In the presence of Dr. Booth, Dr. Houghton, Mr. G. O. Siddall, and two medical students, I turned up the flaps made at the previous operation, and exposed a tumour, of the size of an egg, thickly coated with recent lymph. After scraping off some of this lymph we found the tumour to consist of two distinct parts, the upper portion being a knuckle of inflamed intestine, and the lower the testis (?). The intestine was flaccid, and overlapped the upper portion of the other tumour. I enlarged the incisions made on the previous occasion, so as to expose the whole of the inguinal canal, and found that by simply breaking down the recent lymph which connected the bowel with the canal and the internal ring, I could readily pass my finger into the abdomen. Observing this, together with the flaccidity of the bowel, I felt that the hernia was retained in the canal by the inflammatory products rather than *strangled at its neck*. Partly with my finger, partly with an edgeless knife, I broke through the remaining adhesions, and then returned the bowel with the greatest facility. The gentlemen present now examined, with their fingers, the tumour left in the groin and the one in the scrotum, but without satisfying themselves as to which was really the testis. The prevailing opinion was that the *testis was in the scrotum*. Each tumour felt as though a "cord" passed into it. The examination was merely tactile, the inguinal canal having been ascertained to contain nothing but the spermatic cord, and the communication with the abdomen to be quite free. The vomiting and sense of "obstruction" were relieved by the operation; but the patient died thirty-six hours afterwards in a state of collapse, no hiccup having occurred, and the bowels not having acted.

Autopsy.—I regret that a thorough post-mortem investigation was not permitted, and that I was compelled to pledge my word that none other than the parts previously operated on should be examined, and that these should not be removed from the body. Dr. Booth assisted at the examination. To the eye and to the touch there appeared to be three testicles, two in the scrotum and one retained in the left groin. The inguinal canal and groin were now laid open. The proper inguinal canal contained, apparently, merely the cord, and was lined with a layer of recent lymph. In the groin was a tumour coated with lymph, which lymph was found to conceal a thin layer of bloodvessels and (what looked like) nerves, connected by a very fine membrane. This layer passed into the scrotum. The tumour proved to be an undescended testis, with its epididymis and cord. So far, then, with the exception of this nervo-vascular (?) membrane, the relation of parts was such as would ordinarily exist in a case of congenital inguinal hernia prior to the descent of the testis into the scrotum, and prior to the occlusion of the processus vaginalis from the general peritoneal cavity. The testis and epididymis were quite healthy, and neither of them wounded. No doubt "the fibrous membrane" covering the testis, which I divided on the occasion of the first operation, was the peritoneum, or, to speak strictly, the processus vaginalis, thickened as a hernial sac becomes thickened when long exposed; and the filaments which I evacuated, and mistook for "coni vasculosi," were a portion of the nervo-vascular (?) membrane which I have alluded to. I explain the reason of my not exposing the testis thoroughly at either of the operations thus:—The incision through the skin was a long one (and subsequently enlarged by a shorter one made at an acute angle). The deeper incisions were confined to the *upper portion of the wound*, and the intestine was reached without opening any sac of which I was cognizant. This, of course, is usual in congenital hernia. Having returned the gut thoroughly, the testis felt (through the remaining undivided layers of tissue) like a distinct tumour, as indeed it was, and

I did not feel justified in doing more than making such a puncture or (if necessary) incision as should satisfy me as to its nature. I felt satisfied that the filaments which exuded on making this puncture were "coni vasculosi," and so made no further dissection. I was wrong, and no doubt my explanation may not be considered satisfactory. I rest satisfied with having done my duty to the best of my ability. It is impossible to place "old heads upon young shoulders" with any prospect of forming a successful combination. The testis was now removed from its position. Behind it we found a corrugated, crumpled-up, thick substance, coated with fibrine. The canal became contracted immediately below the testis, so as to form a neck, through which the substance just named passed, as also the film from the front surface of the testis. The finger could be passed through this contracted portion of the inguinal canal into the scrotum, and here the canal expanded into a globular cavity, which was filled with some membranous substance, which we presently examined. We laid open the scrotum, and exposed a glistening, oval, fibrous body, about the size, and having really somewhat the appearance, of a testicle. It had a neck too, which during life, and even on tactile examination after death, passed very well for a spermatic cord. We opened this curious body, and found it to be a strong fibrous envelope, about the eighth of an inch in thickness, lined with recent lymph, and containing a globular something, also coated with lymph. This indefinite something we found to be an undeveloped, highly vascular portion of omentum, crumpled up like a veil into a roundish mass, with a process or neck passing from it through the contracted portion of the capsule; the main portion then passing behind the testis, and becoming firmly attached to the spermatic cord and to the posterior wall of the inguinal canal, whilst a thin film passed in front of the testis, and contributed to form the "coni vasculosi," which I evacuated at my first operation. The fibrous envelope became much thinner at its neck, and gradually lost itself in the lining of the inguinal canal.

Remarks.—I take it that in this case the communication between the general peritoneal cavity and the processus vaginalis lining the inguinal canal and scrotum had never been closed; that a portion of omentum passed during foetal life into this vaginal process prior to the descent of the testis; that the fibrous envelope consisted of peritoneum, fascia transversalis, and intercolumar fascia, blended together and developed into a strong covering for the protection of the exposed portion of the peritoneal cavity and of the misplaced omentum; and that the testis remained in the groin, because its arrival in the scrotum had been anticipated and its place occupied by the protruded omentum. The canal of the processus vaginalis, when examined after death, was found to be contracted, first, at the internal abdominal ring; secondly, just above the testis; and, lastly, at the point where it formed the neck of the scrotal tumour. The contraction at the internal ring no doubt explains the reason why the hernia of the gut was not constant. I would again allude to the omentum. Is it possible that the testis passed, during foetal life, between the layers of the great omentum? It certainly was between them when we examined the body. The appearance, too, of this omentum was very deceptive and peculiar. The thin film in front of the testis (in the groin) looked just like a number of veins and nerves connected by fine fibro-cellular tissue, but coated on the external surface with soft, recent lymph. Posteriorly, this fine, vascular membrane was, as I have said, corrugated and crumpled up into a rounded substance about the size of the little finger, which expanded above and became firmly connected with the spermatic cord and the wall of the inguinal canal, and likewise expanded below so as to form the globular mass found within the fibrous capsule in the scrotum.

I must again express my regret that we were not allowed to open the abdomen; and I shall be most happy to afford information on any points connected with the case which my readers may think it worth while to inquire about.

June, 1861.

ON A CASE OF VESICO-VAGINAL FISTULA.

By EDWARD JACKSON, M.B., Sheffield.

THE previous history of this case, which I have obtained from the patient herself, was as follows:—In February, 1860, after being in labour about two days, instruments were used by her medical attendant, but delivery was not effected. Severe