Clinical Lecture

ON

HERNIA, LARYNGITIS, AND CARIOUS SACRUM.

BY SAMUEL SOLLY, F.R.S.,

SURGEON TO ST. THOMAS'S HOSPITAL, ETC. ETC.

GENTLEMEN,—Before continuing the subject of diseased bone, of which there are several more cases to speak about, I will comment on some of the patients who have been admitted since we last met.

First, the case of strangulated inguinal hernia on which you saw me operate on Tuesday evening, and which is reported by Mr. Orange, dresser.

William A—, aged seventy, has had an inguinal hernia on both sides, for which he has worn a double truss for about five and twenty years. The hernia on the left side, which is the largest, has never given him any trouble; if, from any cause, it descended, he has easily returned it, thus showing that the opening was large: not so with regard to the right hernia, for, on more than one occasion when it had descended, it has given him much pain to replace it.

Now, this little statement of the patient may serve to impress upon your minds that, *cæteris paribus*, a small hernia is more dangerous than a large one. It has often happened to me, when examining candidates for insurance, that they tell me they have a rupture, but that as it is a very small one they suppose it is of no importance, and they are generally very much astonished when I tell them that it is more dangerous to life than a large one. I always add, that they must be very careful never to leave off the truss, except in a recumbent posture; and if they are obliged to get out of bed during the night, always to place their hand over the opening. I do not mean to say that a large hernia is not more liable to escape than a small one, but I have scarcely seen a hernia which our best instrument makers in London could not command. I speak more particularly of Mr. Bigg and Mr. Lindsay, as I have seen more of their workmanship. In some of the large herniæ this has been extremely difficult, and the spring requires to be so strong that at first the sufferer complains bitterly of the pressure; but you must encourage such to bear it, as, after a few days, the discomfort passes away. For the last eleven years I have been surgeon to the National Truss Society, during which time four thousand persons have received trusses. In the application of the truss you must, however, be very careful that it does not press upon the brim of the pelvis, as this will be extremely and unnecessarily painful; in fact, the truss has no business there at all: it ought to be over the external abdominal ring, and above the linea ilio-pectinea. In some of these large herniæ it is a good plan to lengthen the pad by means of a tongue, carried down into the perinæum, and confined with a strap behind. The danger which a patient incurs by leaving off a truss at all, is shown in the present instance; for we find that he broke his truss, and endeavoured to supply its place with a common bandage.

Last Friday, that is, three days ago, the gut descended when getting up from his dinner, his abdomen being distended with his meal. He thought it would return as usual, and he did not apply for medical relief until this morning, when, he says, he was driven to it by pain, vomiting, and constipation, and the matter when he vomited, being very offensive, alarmed him. His medical adviser gave him a dose of castor oil, and applied the taxis; this failing, he was very wisely sent off to the hospital.

On examination Mr. Orange reports, "The hernia was round and about the size of a hen's egg, very hard, situated

exactly over the external abdominal ring. It was not very painful on handling, but it was so hard as scarcely to admit of any movement, and no impulse was given on coughing. The skin over the part was of the natural colour; pulse 96, regular and soft; tongue slightly coated with brown fur. The patient was placed in a warm bath and the taxis applied."

This, I am happy to say, was not continued long; the house surgeon and dresser sent promptly for me. I say happily, because the great reason why the operation for hernia is so frequently fatal in our London hospitals is, that the operation is deferred too long. The patient has frequently had the taxis applied by four or five different persons, at least, before he comes into our hands. There is the medical man to whom he first applies, then his assistant, then his apprentice, if the young gentleman has begun to walk the hospitals, and when the patient comes here he is subjected to it by the house-surgeon and at least one dresser. The consequence of all this handling is, that the gut becomes more and more congested, next inflamed, and sometimes at last gangrenous. I have found by experience that when a man has long been the subject of hernia, he generally manipulates that hernia better than even the best surgeon, as regards directing its course back again into the abdomen, and that if the patient himself cannot return it it is very seldom that the doctor can. Of course there are exceptions to every general rule, and these observations do not apply to recent hernia. I have often been amused to see the various positions ruptured individuals will put themselves into to effect their object. They will often raise the pelvis above their head, so as to remove the abdominal viscera from the lower part of the abdomen; they will bend their thighs back upon the belly, and grasping the tumour well with both hands, force it back through the abdominal ring. As a rule, with regard to the necessity for the performance of the operation, you will find that if the sac is excessively tense and hard, and the patient cannot bear any firm pressure on it without wincing, you may be sure there is no time to be lost.

With regard to the operation, I may first call your attention to the way in which I made my first incision on this occasion; not that I pretend to any originality in it, but you will find it a good plan to follow. You might observe that I nipped up a fold of skin over the neck of the tumour; one extremity of the fold I held in my left hand, the other was held by Mr. Fernie, our house-surgeon; and then, running a sharp-pointed bistoury through it, I had at once an incision about an inch and a half long, through the skin and superficial fascia. This incision is thus made more rapidly and with less pain than one with a scalpel cutting down over the surface of the tumour; and in hands unaccustomed to operate there is less danger of opening the sac unintentionally, or even the gut, as I have seen occur before now. You should next divide the other coverings of the sac, using the knife horizontally, having nipped up the tissues in succession with the forceps until you reach the peritoneum. Do not divide this—that is, do not open the sac, if you can avoid it, but divide the stricture external to it, as you saw in my operation on Monday last. The danger of the operation is much less if you do not expose the intestine. I have no hesitation in saying that, as a general rule, it is much better to avoid opening the sac. You might observe that as soon as I had exposed the sac I felt for the stricture with my little finger, and upon that divided the stricture. Always use your finger for this purpose in preference to a director. You will find that the probe-pointed knife is better for this purpose than the ordinary hernia knife; you are less liable to injure the sac. When you first attempt to perform this operation you will not find it so easy as it looks to divide the stricture external to the sac, and I cannot tell you exactly why. There is a knack in it, which, however, you will soon acquire with a little practice. After having divided the stricture, you gently press the sac between the finger and thumb, and if the contents all *pop* back, if I may so express it, leaving the sac quite empty in your fingers, you may be satisfied with the result; but if you do not empty the sac, feeling that something remains behind which you cannot get rid of, you should then open it to discover the cause. Most probably you will find an adherent intestine or portion of omentum; or if the contents of the sac suddenly give way, and the sac feels soft and not empty, you may apprehend a gangrenous intestine, and then you must open the sac. If you are operating in an old-standing hernia, where the patient tells you he has never been able to return the whole, you may expect to be obliged to open it.

The first time that a pupil sees an operation for hernia he is sure to mistake the sac for the gut, they are so much alike. How are you to distinguish them? There are certain circum-

stances to attend to which will assist you, but nothing except frequent personal observation of these operations will make you confident of the distinction. Never lose an opportunity while you are here of attending them. When the sac is opened there is an escape of fluid in ninety-nine cases out of a hundred, sometimes more and sometimes less; if therefore there has been no such discharge, you may be nearly certain that you have not opened it; but this is not without an exception, for I have opened a sac which has been so tensely filled by the gut that there was no room for any fluid. The direction of the bloodvessels on the peritoneum is different from those on the gut; they meander about in an arborescent, irregular form. On the surface of the intestine they run at right angles to the canal. Then again, if it be intestine, by drawing it gently forward, you will see the mesentery, but you cannot move the sac from its position.

With regard to the treatment of the wound after you have completed the operation, bring the edges well together; raise them, and with another hand to assist you, put in two or more sutures to keep them in close apposition. Over that place a piece of lint, and then the strapping, as you can thus keep the edges better in contact than with the plaster next to the skin. A figure-of-8 bandage, nicely and tightly applied, will act as a temporary truss, while the patient is confined in bed. I always order a dose of calomel, two grains, and opium, one grain, to be given immediately. Do not be anxious to get the bowels open; never mind if they do not act for the next twenty-four hours. If there are any signs of peritonitis, continue the calomel in two-grain doses, but with only half or quarter of a grain of opium. At the end of about thirty hours, if the bowels have not been evacuated, give a simple enema, and if this does not answer, then a dose of castor oil. Of course it is very satisfactory to see the complete success of your operation by the passage of the feces along the lately-strictured gut, but remember that you do not secure the ultimate success which you aim at by forcing the injured intestine to act before its natural circulation is properly restored. And of this you may be certain, that if there is any little local peritonitis, you are doing the most certain thing to diffuse it generally over the peritoneum, by inducing peristaltic action, and carrying the effused lymph through the cavity of the abdomen. This man has gone on without a bad symptom; he is free from pain or tenderness in the abdomen; his tongue is clean, and to this I attach the greatest importance, much more than to the pulse, as an index to any inflammatory mischief. The pulse varies very much in different individuals, and, alone, is a very deceitful guide: in this case it was soft and quiet, and though nearly forty-eight hours have elapsed since the operation, and the bowels are not opened, I feel no anxiety.

[The bowels acted comfortably the next day, after a small dose of castor oil, and on the following day the wound was nearly healed.]

The next case is one of syphilitic laryngitis, reported by Mr. Orange.

W. C. G.—, aged thirty-four, a lighterman, was admitted into Abraham's ward, on the 29th of October, 1855, at eight in the morning, suffering from all the symptoms of acute laryngitis. The characteristic whistling sound accompanied both inspiration and expiration, and his countenance was anxious, from the continuous efforts required for respiration, the muscles about the neck acting forcibly; but he was able to describe his condition and history without distress. There was some tenderness about the laryngeal cartilages when handled, and he also complained of pains in his head and face. Voice low and husky; cough irritating, and accompanied by troublesome expectoration of a frothy, rather viscid mucus; tongue coated; pulse 108, small and feeble; bowels not acted on for three days. It seems that seven years ago he had primary sores, but none since. About eighteen months ago his throat became affected, and within the last four months his voice has been affected. He has, however, remained pretty well in general health until Tuesday, the 23rd of October, when he caught cold, and the symptoms of laryngeal inflammation appeared. Little has been done for their relief, except the application of mustard poultices.

Upon examining the throat, the uvula and greater part of the soft palate are wanting. There is also an excavation in the posterior part of the pharynx; but at present no distinct ulcerating surface can be seen. The patient says that not unfrequently, in attempting to perform deglutition, the food escapes through the nares. As this has occurred, at times, for several months, the disease of the palate must be of some standing.

Mr. Solly ordered a blister to be raised on either side of the larynx, by means of an iron spoon, dipped in boiling water. [You will find this plan for raising a blister rapidly very efficient.] Thirty leeches to be applied below the jaw. Calomel, two grains; powder of tartrate of antimony, and powder of opium, of each a quarter of a grain,—to be taken every six hours. The cuticle having been removed, the part to be dressed with strong mercury ointment; and a pill of croton oil, (tiglii,) one minim, to be taken immediately.—Nine P.M.: Bowels moved twice; leeches have bled freely; voice and breathing much the same; pulse 108, soft; skin warm and perspiring.

Oct. 30th.—Eight A.M.: Slept a little since two o'clock; bowels acted on once more; complains of great difficulty in swallowing; cough and expectoration, referring to his chest as the place at which he feels most pain when coughing. The respirations are, perhaps, not quite so short as last evening, though still nearly 30 per minute; the sound produced not quite so dry and harsh; pulse 108; tongue cleaner; urine rather scanty; skin warm; drops of perspiration on the forehead.—Ten A.M.: Mr. Solly saw him, and ordered pills to be omitted on account of the great difficulty in deglutition, and to take instead, liquor of bichloride of mercury, two drachms; powder of tartrate of antimony, ten minims; tincture of digitalis, twenty minims; infusion of broom, one drachm,—to be taken every four hours.—Half-past one P.M.: A consultation was held on the case, Dr. Barker, Dr. Bennett, Dr. Bristowe, and Mr. Solly being present. On examining the chest, dulness was found on percussion under the right clavicle, and over the posterior part of the right lung; slight rhonchus existed in both lungs. Considering that the man had no more, but rather less, difficulty in breathing than when admitted yesterday, it was agreed to continue the present treatment, and to postpone for the present the employment of any operative means.—Nine P.M.: Continues much the same; has taken some beef-tea during the day; appears to feel relief from the draught; there is little difference in the character of the respiration; the sputa expectorated is thicker in consistency, and has a greener tinge.

31st.—Nine A.M.: Expresses himself as being better this morning, and having slept a little during the night; there seems less noise and difficulty in respiration; the cough and expectoration have been very troublesome; he has great difficulty in clearing his throat from the sputa, and this is the greatest cause of annoyance to him; is not at present affected by the mercury; has great difficulty in swallowing food, and complains of flatulence; pulse small, 110; tongue slightly coated.

The report of this case is given so clearly, that I need not point out the dangerous condition of this poor fellow. The probability of a tubercular deposit in the upper portion of both lungs make me very averse to the performance of any operation until I see no hope of relieving him by medical treatment. At the same time I do not forget how successful Dr. Barker has been in the treatment of laryngitis during the last few years, in consequence of his having had recourse to the operation in earlier stages of the disease than the profession generally have advised. I was very anxious, therefore, to have the advice of our Professor of Clinical Medicine in this important case, and, as he does not encourage me to operate at present, I am willing to wait. I feel the less hesitation in adopting this course, as we have always now on the spot an intelligent, well-educated man, in the person of either one or other of our house-surgeons, whose duty it is to perform any surgical operation of emergency, without hesitation or delay, if the necessity of the case requires it. As you are aware, these men are selected from the best that our school produces. It is therefore a post which you ought all to aspire to. It is true you cannot all obtain it; but you will never regret having tried for it, even if you do not succeed. I have been very much gratified this season by a fact, which shows how much the appointment is valued. A gentleman—I mean Mr. Fernie—who was already in possession of the post of house-surgeon to an infirmary in the country, with a salary of £100 per annum, gave this up to obtain the honorary appointment here, because, in addition to the honour thereof, it afforded him more practice in the surgery of his profession. You must forgive this digression. Now, remember that you should endeavour, in regard to the performance of tracheotomy for laryngitis, to avoid, on the one hand, performing it earlier than is absolutely necessary, or postponing till it is too late to save your patient.

I have spoken of *tracheotomy*, and for this reason, that, though more difficult to execute, it is more likely to be successful than *laryngotomy* in laryngitis. I am aware that cases

are frequently adduced by intelligent surgeons to show that laryngotomy is often performed with success; but the majority of cases are in favour of that course which, *a priori*, we should decide upon, to remove as far as possible the irritation excited by the presence of the tracheal canula from the seat of inflammation.

In performing the operation, make an incision through the skin exactly in the mesial line, so as to avoid wounding either the right or left sterno-hyoid muscles; separate them quietly with the handle of your knife before you use the trocar and canula; secondly, do not expect to find the trachea exactly in the mesial line, because you will not do so; you almost always find it a little either to the right side or the left; fix it firmly between your finger and thumb before using the trocar; the trachea will roll on one side, and you may thrust it you know not where, perhaps into the œsophagus and cervical vertebra. The last time I operated for syphilitic laryngitis, the case did well, but then the lungs were sound.

[In this case the symptoms did not change much until about half-past eleven P.M., when he became suddenly worse, and the house-surgeon, Mr. Ord, operated immediately, and the man has been going on well since.]

The last case that I shall have time to talk to you about to-day is one that I have often called your attention to in the ward. The patient lies in the bed next the fire-place at the lower end. He is a labourer, forty-seven years of age, and was admitted about a year ago with fistula dependent on carious sacrum. Such cases, I believe, are rare. The history is obscure; but, as far as I can make out, it has had a rheumatic origin. The poor fellow has been constantly suffering from rheumatism since he has been in the hospital. When he first came in, his sufferings were all referred to the rectum, and in a short time the fistula mentioned was operated on, but still the pain which he endured every time he passed a stool was frightful. An examination of the gut exhibited a considerable amount of unhealthy ulceration. The ulceration presented a good deal of the character of carcinomatous disease, but the man's general appearance, age, and the absence of any stricture, made me doubt its malignancy; but it was not until I discovered that the sacrum was diseased that I was satisfied. Since I made a free incision over the posterior surface of the sacrum, the man has been relieved; the pus finds its way in that direction, and the evacuation of his bowels no longer gives him any pain. The case is necessarily a very tedious one. We cannot use our friend the gouge, which we find so useful in the treatment of caries in other bones. You will all remember the part which the sacrum plays in protecting the termination of the spinal cord. It is perforated in all directions by the large nerves of the lower extremities. It would be scarcely possible to gouge away the diseased bone without injuring these nerves. In this case, then, we must adopt the plan of our forefathers—wait and see what Nature will do for us, and support the patient's general health.

RECORD OF A CASE OF CRIMEAN FEVER;

WITH REMARKS.

By C. HANDFIELD JONES, M.B., F.R.C.P., F.R.S.,

ASSISTANT-PHYSICIAN TO ST. MARY'S HOSPITAL.

CAPTAIN —, aged twenty-nine, of stout make and lively temperament, returned from the Crimea on July 20th, having remained there some months, during which time he had been much tasked both in mental and bodily exertion. He had been in India for several years, and had suffered from fever and dysentery. His health was pretty good in the Crimea until about six weeks before he left. The illness for which he was invalided was a derangement of the action of the liver, which occasioned, as he says, "an overflow of bile." He was highly jaundiced, but passed at the same time a large amount of bile in his stools. "Lots of blue pill and calomel" were given, as well as some emetics, to get rid of the bile; but it appeared to him "that he made more as fast as it was carried away." During the voyage home the jaundice disappeared; but remittent fever came on, and increased so much, that he was much more seriously ill when he reached England than when he embarked. The attacks of fever were nocturnal, attended with pains in all the limbs, clammy sweats, parched tongue, and determination of blood to the head. On account of this last symptom, quinine had not been given, and the disorder was still considered as essentially of hepatic origin. Alterative doses of blue pill, taraxacum, and bitters were re-

commended, to be followed by a course of the Cheltenham waters. When I first saw him he was utterly unnerved, and agitated violently by the merest trifles. His face was much flushed; his head very hot and aching. A day or two after I noticed that while asleep his eyes, though covered by the lids, were in frequent motion, the *alae nasi* twitching now and then, and the breathing quick. His whole condition was that of complete nervous prostration and disorder. The state of the urine, examined particularly on the 25th, was what might be expected: it was light-coloured, acid, not albuminous; specific gravity 1007; deposited no phosphates on boiling, and yielded no uric acid when treated with muriatic acid. His appetite was very indifferent, and the nutritive processes were clearly at a low ebb. Quinine was at once commenced, and continued pretty steadily throughout at the rate of about ten to fifteen grains a day. It was once carried to the extent of moderately affecting the head; but no particular benefit resulted from this full action of the drug. To give a full detail of the progress of the case would be tedious. I will notice only the more instructive features: "agonizing" neuralgic pain occurred for several hours on the 22nd, and was at once relieved by a liniment of belladonna, chloroform, and opium; it served to mark still more particularly the character of the disorder. From the 25th of July to the close of the illness a chief and most troublesome symptom was constantly recurring bowel disorder, at first of diarrhoeal, and afterwards of decided dysenteric character; a sudden gush of fluid would take place with almost no warning. The dysenteric attacks were also decidedly paroxysmal. For some hours the bowels would remain quiet; the abdomen soft and distended; and then sharp griping pains would come on, and he would pass a quantity of gelatinous, often blood-stained, mucus, with, on some occasions, "an extraordinary quantity of wind." Sometimes flatus only was passed at the accession of pain. About August 10th, the dysentery showed more tendency to assume a permanent form; he complained of abiding tenderness just on each side of the bladder; there was also much dysuria, and occasional sharp pain in the course of the transverse colon. The motions generally contained healthy-looking bile, and sometimes were nearly or quite natural; the morbid action once or twice affected the stomach, producing vomiting, or retching. In the night of August 5th, he was much alarmed by an uneasy sensation about the heart, attended with faintness, and a failing pulse; he described the feeling as most distressing, as if he were dying, and life was ebbing from him gradually. I regarded it as a form of cardiac neuralgia; it was relieved by electro-magnetism. By August 12th, he was quite free from the febrile paroxysms; but that evening he suffered from severe pain in the course of the right sciatic nerve and its branches, which ceased the next day, after affecting for a short time the right arm and shoulder. Once a hysterical paroxysm of sobbing and crying occurred, the mind remaining unaffected. Resort was had continually to opiates, both by the mouth and rectum, for the control of the bowel disorder, and mercurials were also administered as occasion seemed to require for the relief of the dysenteric attack. Their specially paroxysmal character and the absence of fever made it impossible, however, to treat the affection as a substantive, permanent disease. The cerebral determination soon subsided after the quinine was commenced. Small (one drachm) doses of castor oil were useful in the management of the bowels. However, the great means which triumphed at last over the obstinate dysentery was change of air. I had for some time advised my patient to drive out to Hampstead; but the great liability to irritable action of the bowels made him afraid to venture. As soon as he got to Hampstead he began to improve, and in four days was convalescent, walking about the common with the help of a friend's arm. One manifestation of the subsiding disorder was curious: On the night of August 18th, about half-past three A.M., he had a violent attack of gastric flatulence for about ten minutes; the quantity of flatus was so great as to cause retching, but no fluid came up. Some nights before the bowels had been similarly affected, so that the abdomen became tense. He improved so fast that, without my consent, he returned on the fifth day to town, and, in spite of a recurrence one night of some dysenteric disorder, was able to go about on business, and leave town in a day or two. He went to the south coast, and completely recovered, with the exception of occasional recurrences of an uneasy sensation referred to the heart, and attended with some faintness. These are brought on by any agitating emotion, and are relieved by stimulants.

Considered merely as a record of morbid phenomena, there is nothing very peculiar or novel in this case—nothing probably which would not be familiar to those who have had much ex-