known efficacy of the continuous bath in the latter disease possibly owes its power to the arrest of the development of micro-organisms—an effect that is attainable by the free and constant application of glycerinum boracis.

Queen Anne-street, W.

ON A

METHOD OF OPERATING IN STRANGULATED UMBILICAL HERNIA.

BY THOMAS F. CHAVASSE, M.D., F.R.C.S. EDIN.,
SURGEON TO THE BIRMINGHAM GENERAL HOSPITAL.

IN the *Edinburgh Medical Journal* for September, 1873, Mr. Annandale directs attention to a plan of relieving strangulated umbilical hernia by performing laparotomy above the protruded gut, and not cutting into the hernial sac at all. Through the opening thus made into the abdominal cavity the finger is passed into the umbilical ring. Any tight bands detected are divided, and the edges of the ring itself notched. This idea seems to have occurred to Mr. Crompton, who made an attempt to put it into practice in the year 1860. It was performed with a satisfactory result in the following case.

S. T—, aged fifty-eight, court bailiff, was admitted into the General Hospital, Birmingham, on Sept. 6th, 1881. The patient was a stout, florid man, who had had an irreducible umbilical hernia for twelve years; but as it had not caused much inconvenience no kind of support had ever been worn. Sixteen hours before admission, when coughing, the patient noticed that the size of the hernia had suddenly increased, and vomiting shortly ensued. On examination an irreducible umbilical hernia was found to exist, the protrusion from the belly being the size of a pint basin, pedunculated, and in appearance suggestive of a huge mushroom. The tumour was exceedingly tense, with no impulse on coughing, and the skin over it ecchymosed. Semi-stercoraceous vomiting was frequent, and great pain was complained of in the umbilical region. The patient having been anaesthetised gentle taxis was applied; this failing to effect reduction I made an incision, two inches and a half long, in the linea alba, between the pedicle of the hernia and ensiform cartilage, and opened the abdominal cavity. The left forefinger was then inserted into the neck of the sac, on the left side of which two constricting bands were detected, and divided with a herniotome. The upper edge of the umbilical ring was at the same time notched. Taxis being now applied, part of the hernia was reduced with a gurgle. No attempt was made to force the whole contents of the sac into the abdominal cavity. The edges of the incision were then united by silver sutures. Listerian precautions were taken throughout.

There was complete cessation of pain and vomiting after the operation. Evening temperature 98° 6' F.; pulse 120.

September 7th: The wound was dressed; the bowels were twice relieved. Evening temperature 100° F.; this was the highest recorded. The bowels acted again on the 8th and 9th. —10th: The wound was dressed and found to have healed by first intention; the sutures were therefore removed and strapping substituted. Listerism discontinued.—14th: Mr. Sunderland, the assistant house-surgeon reports, "Wound firmly united; patient eats, sleeps, drinks, defecates, and micturates well; says he is quite happy and thankful." He was kept under observation for ten days longer, and was sent home with a suitable support; he has remained well ever since.

Mr. Annandale suggests that two objections may be raised to this plan of operating: Firstly, the danger arising from opening the peritoneal cavity; secondly, the contents of the sac may be firmly adherent or gangrenous, and thus prevent the completion of the operation.

With regard to the first objection, judging from my own experience in recent years, and the practice at the Hospital for Women in this town, opening the belly is not a very serious matter if only proper precautions are adopted; while to lay open the sac of an umbilical hernia is a step which most practical surgeons shrink from and which eminent textbook writers deprecate, Agnew going so far as to say that such a proceeding in all probability seals the doom of the patient. On this point I have examined the hospital register of operations performed for the last thirty years, and find that umbilical herniæ requiring operative interference are not very commonly met with here; for in the period mentioned

nine cases (five men, four women) only occurred; three of these were in 1879, and one in each of the following years: in twenty seven years, therefore, there were only four cases. Excluding my own, the hernial sacs were laid open in all these instances; all proved fatal with the exception of the following remarkable case.

Edward S—, aged thirty-nine, brewer, attended my outpatient room at the General Hospital for some weeks in 1879, owing to ulceration of the integument over an irreducible umbilical hernia. This protrusion was the size of a large orange, and had existed five years. Soon after healing was complete the man, on December 4th, 1879, was admitted into the hospital, the hernia having become strangulated thirty-six hours before. Mr. Bartleet operated for the relief of this by making an incision on the left of the linea alba, opening the sac by a very limited cut, dividing the constriction upwards, and returning a portion only of the protrusion. The patient was subsequently attacked with delirium tremens and the integument over the sac sloughed off, but there was no visceral protrusion. In spite of these complications the man recovered, and was dismissed cured on January 29th, 1880.

The second objection raised by Mr. Annandale does not seem to be a very formidable one. Doubtless adhesions exist in all old irreducible umbilical herniæ, but if the constricting points can be divided from above, and some of the protruded gut returned into the abdomen, the strangulation is presumably relieved, and it would seem to be neither wise nor necessary to then attempt reduction of the whole mass.

With regard to the question of the existence of gangrene; by means of a limited incision above, the sac and its contents can readily be examined with the finger, and if necessary also with the eye, by drawing up to the abdominal opening, bit by bit, the suspected contents of the sac; should this condition be found to exist the cut can then be prolonged into the sac, and a false anus made. The ultimate result cannot possibly be rendered more hopeless by a little larger opening. This procedure was adopted in the following instance.

Jane F—, aged fifty-four, was operated on by Mr. Crompton, on September 7th, 1860, at the General Hospital for strangulated exomphalos. The hernia, in size equal to a foetal head, had been irreducible for twenty-two years, and symptoms of strangulation were said to have existed for seven hours. The report of the operation is as follows: "A small vertical incision was made in the median line above the hernia and the constriction divided. The gut, however, was found to be gangrenous, and the sac laid open." The patient lived six days, dying on September 13th. The post-mortem showed the contents of the sac to be omentum, part of the transverse colon and five or six inches of gangrenous ileum.

The high rate of mortality following the ordinary operative interference in this class of rupture is well recognised, and so active steps are often only undertaken at the last moment, consequently a gangrenous condition of intestine is now not an uncommon complication for the operator to have to deal with.

Listerism and an earlier operation, by means of a small incision above the ring to relieve the constriction, will, I believe, tend to diminish the death-rate in cases of strangulated umbilical hernia.

CASE OF FATAL CEREBRAL HÆMORRHAGE.

By GEORGE F. ELLIOTT, M.D., M.R.C.P.,
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HAVING read the particulars of a case of cerebral hæmorrhage detailed by Dr. Monckton in *THE LANCET* recently, I am induced to forward the following account of a somewhat similar case which has an interest of its own as well as being calculated to throw light upon some doubtful points in the one referred to.

S. S—, aged forty-four, of intemperate habits, ten days before his death fell down in the street when about half a mile from his own house. He got up unaided, but, he believed, fell a second time a little further on, and finally reached home without assistance. The occurrence took place in the early morning when very few people were about. His wife said that when he got home the left arm was powerless, and he complained of his head. It was not until the fifth day after the fall that he took to his bed. In the

meantime he used to get up and come downstairs, though complaining of his head and suffering from distressing vomiting.

The day before his death, and nine days after the fall, I was called to see him hurriedly for the first time, no other professional assistance having been sought previously. On the occasion of my visit I found him in bed, drowsy and stupid, but capable of answering questions. He had been wandering the previous night. There was paralysis of the left side of the face, and also of the left arm; the corresponding leg was unaffected (he walked downstairs with assistance shortly after my visit); pulse 120, irregular. He died the next day before my visit, during "a fit." I certified the death as having occurred from cerebral hæmorrhage and convulsions. Owing to an idea on the part of the widow that death from an accident would interfere with the payment of a sum of money for which his life was insured, she concealed the fact of his having had a fall from me until after I had given the certificate. I therefore felt it my duty to communicate with the coroner, who ordered an inquest and post-mortem.

There was no external mark of injury. On removing the calvaria and dura mater, a spot of extravasation was visible through the arachnoid—which was milky-looking for some distance around—about three-quarters of an inch to the right side of the median fissure, and situated at the junction of the anterior and middle third of the hemisphere. This proved to be the upper part of a clot about the size of a small walnut, embedded in the white substance, but extending upwards to the surface of the grey substance. The outer portion of the clot, for about one-eighth of an inch, was partly decolourised, and the brain substance in immediate contact with it was decidedly softened. I was much interested in observing the proximity of the clot to that portion of the hemisphere which is marked in Professor Ferrier's work¹ as being the centre for extension movements of the arm and hand, there being a clear history of paralysis of these parts from the first. From the appearance of the clot I stated my belief at the inquest that the hæmorrhage took place at the time of, and probably caused, the man's fall. Dr. Monckton asks concerning his patient, in the paper to which I have referred, "Could the man walk about for two days, and do his work for one, with this clot in his brain?" The answer to this it appears must be conditional, depending upon the seat of the lesion. Had the clot in the brain of Dr. Monckton's patient involved the motor centre of the leg, for instance, as completely as the one in my patient's brain did the motor centre for the arm, it is evident he could not have worked; but being near the surface of the brain, in a place where it did not necessitate paralysis of either upper or lower limb, there seems to be no difficulty in believing in the existence of such a clot for a limited period without definite symptoms.

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.

GUY'S HOSPITAL.

TWO CASES OF DISEASE OF THE EYE, SIMULATING GLIOMA.

(Under the care of Mr. HIGGENS.)

THE following cases illustrate the difficulty that may sometimes attend the diagnosis of intraocular tumours, at the same time that they tend to throw doubt on some of the alleged instances of non-recurrence of glioma after excision of the globe. Every case, in order to be complete, needs the corroboration of the microscope.

CASE 1.—Walter R—, aged one year. A glistening reflection had been noticed in the pupil of the left eye for a month previous to Dec. 14th, 1877. The ophthalmoscope showed a whitish growth, springing from the inner side of the eyeball in two nodules, upon the surface of which blood-

vessels were visible. There was a normal red reflection from the outer half of the fundus oculi. The case was looked upon as a probable glioma. The eye was excised and subsequently examined by Dr. Brailey, who reported as follows:—"There is a mass of connective tissue on the internal face of the retina on the inner side. It extends from the optic disc, which it covers as far forwards as the ciliary body. Its fibres are closely connected with the hypertrophied connective tissue framework of the retina, from which, however, its origin appears to be independent. It contains a few bloodvessels."

The patient was seen on Jan. 31st, 1882, and there was no sign of return of the growth.

CASE 2.—John H—, aged three and a quarter. A yellow reflection from the pupil of the right eye had been noticed a week previous to Dec. 10th, 1881. Several nodules of growth could be seen projecting into the vitreous chamber and coming quite up to the back of the lens, which was quite transparent. The ophthalmoscope showed the eyeball to be nearly filled with a yellowish growth projecting in several nodules; some bloodvessels could be seen on its surface.

On Jan. 2nd, 1882, the eyeball was excised; subsequent examination by Dr. Brailey showed the retina detached in loose folds, but not contracted. On its under surface were masses (very friable) of darkish colour, which were composed principally of large rounded cells, brownish in colour from containing pigment granules. These resulted from a proliferation of the pigment-bearing epithelial cells between the retina and choroid. A little of the same change was visible on the internal aspect of the ciliary body. The retina was thickened and contained some inflammatory corpuscles, and more were aggregated in loose masses on its internal surface. The ciliary body and iris exhibited glaucomatous changes. There was no conspicuous evidence of any inflammation of the optic nerve or its sheath. This patient had been under treatment at the Royal London Ophthalmic Hospital before coming to Guy's. Several gentlemen who saw him looked upon the case as one of glioma, Mr. Lawson, however, under whose care he was, did not share that opinion.

QUEEN'S HOSPITAL BIRMINGHAM.

A CASE OF SARCOMA.

(Under the care of Mr. JOHN CLAY.)

THE patient to whom the following notes refer was admitted into the Queen's Hospital under Dr. Carter, to whose courtesy I am greatly indebted for the privilege of superintending the treatment, my directions being carefully carried out by Mr. Johnson, late resident obstetric surgeon.

Thomas B—, aged seventy-nine, pattern maker for coach harness, was admitted into the hospital on May 2nd, 1881, for growths on the anterior part of the chest, and on the upper and posterior part of the head. He was pale, with an anxious expression of countenance, but was fairly well nourished. He stated that about six months previously some pimples appeared on the chest and head. They itched a good deal and discharged a thin matter, and then seemed to run together, although some of them died away; and eventually they formed the growths which he presented at the date of admission. After trying various simple remedies he placed himself under the care of a surgeon and had a variety of treatment, but as the growths had rapidly increased of late he applied for admission into the Queen's Hospital. His father died at seventy years of age, but his mother died during childbed. He had lived nearly all his life at Walsall, but had worked occasionally in London and in Paris for a few weeks at a time. He had never suffered from any particular illness, and strongly denied ever having had syphilis, but admitted that he had an attack of gonorrhœa at nineteen years of age. He had been twice married. He had no children by his first wife, but his second wife gave birth to a stillborn child. He had been a hard drinker, but had not drunk so much of late years. The patient acknowledged that he had led a hard life and had been much exposed to all kinds of weather, having been a great poacher. His bowels were much constipated; appetite capricious, urine normal and of average quantity. On examination four large growths were seen on the supra- and infra-mammary regions of each side of the chest. They were of a flattened hemispherical shape, with irregular lobulated surfaces and irregular

¹ The Functions of the Brain, p. 306.