Now has considerable difficulty in holding urine, is obliged to go at once when he has the desire; has occasionally passed small amount unconsciously. Brother had noticed slow pulse, 50 or less, while at the South. Weight about 185 and excellent condition physically. Memory poor, occasional lapse of consciousness; asked the same question over twice, etc. Was about as well as usual Wednesday evening, February 2, 1898.

Thursday woke at 5 A. M. complaining of intense pain in the back of the head, which apparently was immediately relieved by copious vomiting. During the day had considerable pain and repeated lapses of consciousness; toward evening grew comatose, and when seen by his brother could not be aroused. Pulse very slow, under 50. Heart-sounds impure; respiration intermittent; stimulants produced only temporary relief and death resulted two hours later with a primary failure of respiration. Pulse could be felt three minutes after respiration had ceased. This final fatal attack was very similar to a less severe one shortly before, already described.

The sudden and altogether unexpected death of the patient prevented an examination on my part, as had

this area shows a practical obliteration of convolitional structure. On palpation there is a distinctly increased feeling of resistance over that of the corresponding area of the opposite side. The left hemisphere, looked at laterally, seems to stand at least a quarter of an inch higher than the right. The same appearance as just described is present on the mesial aspect of the left hemisphere involving the frontal convolution and extending downward to the corpus collosum (see Figs. 1 and 2).

After hardening in formalin, 10 per cent., frontal sections were made through the tumor mass. On the outer surface of the hemisphere the new growth occupied the entire first frontal convolution with the exception of a very small area at its anterior part. The growth had also begun to invade the posterior portion of the second frontal convolution. Its outlines were not sharply marked out, but it certainly did not extend beyond the precentral sulcus. The tumor is most marked in the first frontal convolution, where it evidently began.

On the mesial surface of the brain the tumor extends through the entire first frontal convolution and

FIG. 1. Outer surface. Shaded area represents tumor.

FIG. 2. Inner surface.

been planned. It was, however, clearly evident from the symptoms developed during the last few months and from the outcome that he had been suffering from a cerebral tumor, whose location remained obscure.

In a later conversation with his brother it appeared that an extremely slight speech defect had existed for about three years, consisting merely in the inability to recall quickly a word. On one occasion, for example, the inability to say the word "bag" seemed about to bring on a convulsive attack. When the word was supplied the threatened motor excitement passed off at once and completely. This aphasic tendency was distinctly better during the last week of his life.

Autopsy.—It was impossible to perform an autopsy until nine days after death. The body and brain were, however, well preserved and appearances were in no way obscured. Examination of the brain alone was made. There was no deformity of the skull, nor external appearance of new growth. The dura was very tense, but beyond this presented nothing abnormal. Considerable blood in the longitudinal sinus. Dura strips easily and normal on inner surface. Convulsions much flattened and pale.

Over the left first temporal convolution blood is completely absent from veins over an area approximately two inches in transverse to two and a half inches in antero-posterior diameter. The brain at

involves also the gyrus fornicatus in its anterior half. On cross-section of the tumor the cortex shows a distinct involvement as was also evident from the surface appearance. The outline of the cortex as distinguished from the white matter may, however, still be made out.

(To be continued.)

TRAUMATIC VENTRAL HERNIA.¹

BY J. B. BLAKE, M.D.

THE following two cases, admitted to the First Surgical Service of the Boston City Hospital, seemed of sufficient interest to report and comment upon. Both were injuries of the abdominal parietes, following immediately upon trauma. The second case is reported by permission of Dr. H. W. Cushing.

CASE I. J. C., thirty years old, a teamster, was admitted to the City Hospital January 10, 1898. He was seen by the writer about 7.30 P. M., shortly after his admission, who found him perfectly conscious lying upon the accident table. He gave the following history: At 1 P. M. that afternoon, while unloading a team, he slipped from the wagon and struck on the

¹ Read before the Boston Society for Medical Improvement, May 2, 1898.

end of a crowbar, which he was using. One end of the bar was on the ground, and he fell upon the blunt upper extremity. He then fell upon his back in the street. He was not stunned. The pipe which he had in his mouth did not fall, nor did it break, and the man continued smoking. He put his hand to his side, under his clothes, and not finding any blood, concluded that his abdomen was only scraped. He climbed into his team and was driven to his room on Emerald Street. Unassisted he went up three flights of stairs to his room, stripped and went to bed. He then noticed for the first time a small amount of blood on his shirt, and a wound just above his right groin, from which a yellow mass about two inches long protruded. He sent for a physician, who happened to be out; another physician came and examined him, covered the protruding mass with gauze and sent him to the hospital. His overalls, pants and drawers were torn cleanly at the level of the wound.

When first seen, six and one-half hours after the accident, he was rather pale, perfectly conscious, not excited nor in pain, temperature 100° , pulse 70. He had not had vomiting, hiccough or other symptoms. Examination showed a strongly built man, whose abdomen on the right side was marked by a transverse gaping wound, one inch long, just above and a little outside the external abdominal ring. A small amount of straw-colored serum was escaping from it. The house surgeon told me that nothing protruded from the wound when he first saw it, an hour before, but that there was a soft swelling just above the wound which partially disappeared on manipulation and during the cleansing and shaving preparatory to operation. There was some question at this time whether the patient really saw anything protruding from the wound. His story after the operation was much more definite than before.

The site of the operation was again carefully cleansed with 1 to 6,000 corrosive sublimate, the nozzle being gradually introduced into the wound, which ran upwards and outwards towards the anterior superior spine. The skin was then incised and the wound was found to be three inches long and superficial to the external oblique aponeurosis. At the upper end a bit of omentum, about the size of the terminal phalanx of the thumb, was found protruding through the fleshy belly of the external oblique. It was not wounded nor strangulated, but several black hairs, apparently pubic, were found scattered over it. About three inches more of omentum were easily pulled out, bringing with it a few more hairs and a little more serum, but no blood nor turbid fluid, no sign of intestinal contents. It was washed with salt solution and replaced, and some salt solution put into the abdominal cavity. The finger introduced did not find signs of any abnormal condition. The wound seemed to be a splitting apart of the fibres of the muscles — rather than a clean cut — and resembled somewhat McBurney's incision wound for appendicitis. It was just below the level of the anterior superior spine and about one and a half inches above Poupart's ligament. It was packed lightly with iodoform gauze and the skin incision sutured; baked dressing and swathe. For two or three days there was considerable abdominal distention which was relieved by a high enema, and for a week it was impossible to move the bowels except by enema. The pulse and the expression of the face were always good. Packing removed on the

third day, bringing with it a small amount of clotted blood; otherwise uneventful recovery. Discharged February 18th. He did not return to work until the end of March and then began his old occupation of teamster and has worked regularly since, without symptoms referred to the site of injury.

When last seen, about ten days ago, the operation wound was a firm line scar, which does not bulge more than the other side of the abdomen when patient coughs. He wears a padded canvas swathe. On looking him over, the results of several other accidents were discovered. On his forehead is a long scar — and the tips of the second and third left digits are missing — the result of an encounter with a hay cutter, for which he says he was treated twenty-five years ago by Dr. J. G. Blake. On the left leg is a broad purple scar, one inch long, just below and behind the head of the fibula, where he was struck, since he left the hospital in February, by a bullet accidentally fired into the street. He may be said to have suffered many things from many men, and to have recovered from them all rather better than might have been expected.

CASE II entered the hospital on December 3, 1897. He was thirty-eight years old, and gave a history which seemed entirely inconsistent with the injuries which he presented. No amount of questioning, or cross-questioning, however, could elicit from him any variation in this story, which was, that four days before entrance, while endeavoring to jump across a small brook, he slipped and struck heavily upon his right side, particularly upon the right side of his abdomen. The fall caused him some pain, but he walked home unassisted and went to bed. Next day he noticed a swelling of the right side of the abdomen, larger than the fist, painful and tender. He did not notice whether it increased in size upon coughing. He was sent to the hospital by a physician, and came in an electric car.

The man was above medium size, and strongly built. A systolic murmur was heard at the cardiac apex. This murmur was not transmitted to the axilla. Cardiac hypertrophy was not present. On the right side of the abdomen, just below the ribs and extending into the flank, was a swelling which obliterated the natural contour of the waist. It was not discolored, was slightly tender and slightly dull upon light percussion.

There was also an ecchymosis covering the perineum from coccyx to scrotum, and another ecchymosis over the posterior part of thigh, just above the popliteal space.

The finger-nails were short and broken, and the finger-tips hard, discolored and contused, with a certain amount of blood under the skin. He did not present symptoms referred to either the peritoneal cavity or the alimentary tract. Except that he was sore and bruised, he was comparatively comfortable. It was considered that operation might be necessary, and he was prepared for it. A moist dressing of corrosive sublimate was placed over the abdomen and a tight swathe applied; he was given a diet of meat broths.

The swelling, which seemed to be in the abdominal wall, slowly subsided; ten days after entrance it had practically disappeared, leaving a hard edge, somewhat like the crater of an absorbing hematoma. The ecchymosis on thigh and perineum cleared up, he was allowed to have his clothes, and was about to be dis-

charged, when it was discovered that the subcutaneous crater-like edge was apparently more distinct than before, and that on coughing nearly the whole of that side of the right abdomen which is covered by the muscular belly of the external oblique bulged outward to an extraordinary degree; it was as if a considerable portion of the abdominal contents was pushed through the wall and presented immediately under the skin. The rounded edge extended from a little above the level of the umbilicus, at the outer edge of the rectus downward and outward in a curve, to be lost below the anterior superior spine of the ilium. This part of the wall was softer than the rest, and bulged a little even when the patient was breathing naturally. After careful examination the diagnosis was made of rupture of parts of one or more muscles of the abdominal wall, and a consequent traumatic ventral hernia (though it must be said, while in the minds of some of the surgeons, this diagnosis was only provisional, to the writer it seemed absolute).

Patient was again put to bed, and developed incidentally a mild tonsillitis. As the condition of the abdomen did not change and the patient was a laboring man, and this seemed to be a disabling injury, operation was advised, requested by the patient, and performed by Dr. Cushing about three weeks after the original injury.

An incision was made through skin and superficial fascia, in the direction of the fibres of the external oblique, beginning about one and one-half inches inside, and sloping above anterior superior spine, and going to edge of rectus. Fibres of the external oblique were carefully laid bare, and no laceration could be discovered, either of the muscular belly or of the aponeurosis. The external oblique was split and the internal laid bare. This was also intact. The sheath of the rectus was nicked, and the muscle found to be normal. The only positive condition suggesting the injury discovered was a certain thickening along the edge of the rectus in the aponeurosis of the external oblique, corresponding to the crater-like edge above mentioned, which the writer had taken to be the contracted edges of the ruptured muscular fibres.

The wound was closed, layer by layer, with catgut, and the skin by buried catgut suture. The result was uneventful healing by first intention, and a faint line scar. Three weeks after operation there was still bulging on moderate coughing, though less than before. About this time the patient was examined by Dr. Knapp, who found that the muscles seemed to react normally to the electric currents, but required distinctly stronger currents than upon the other side. On February 7th he was discharged to the Nervous Out-Patient Department, to which he returned several times, and during which time he improved steadily but slowly. Since the middle of February he has been lost sight of, and in spite of all efforts, no trace of him can be discovered.

According to the usual definition, a *ventral* hernia is one appearing at a part of the abdominal wall where no opening or point of diminished resistance normally exists. A *traumatic* hernia is one which results from accident or operation, regardless of situation. The post-operative herniæ which are extremely common form a distinct class by themselves, and will not be considered in this brief paper.

Given a perforating wound of the abdominal wall,

and the protrusion of viscera through it, the surgeon is confronted by four principal sources of danger: (1) hemorrhage; (2) injury, often laceration, occasionally strangulation of the protruding viscera or of the abdominal contents; (3) infection of peritoneal cavity; (4) resultant weakness of abdominal parietes.

From a moderately extensive examination of the literature it would seem that cases of traumatic ventral hernia are not often considered of sufficient importance to report, and when reported are classified under a variety of headings. The number of references is comparatively small, though the condition itself is not uncommon. Probably the first case recorded is found in Roman history, and occurred during a pugilistic contest. The contestants were exchanging alternate blows. One insisted that the other should place his fist above his head and while in this defenceless position drove his hand through the opponent's abdominal muscles and tore out his entrails. The judges awarded the laurel wreath to the dying man. This episode has been immortalized by two of Canova's well-known statues.

Coming to more modern times, in 54 cases of stab wounds and penetrating wounds of the abdomen found in the recent records of the Boston City Hospital hernia was present in 12 (about 22 per cent.).

Traumatic ventral hernia may follow gunshot wounds, stab wounds or perforating wounds made by blunt instruments, or direct violence, as in the cases recorded.

Hernia following gunshot wounds is extremely rare. Otis found but two cases reported to the surgeon-general during the Civil War. Connor says this is probably less than the actual number of cases which occurred and reports one more case; and Patzki, in 1872, reported a single case (omentum presenting, not touched till eighth day, then cut off with wire ecraseur without opening abdomen. Recovery). The indications at present in this condition would be immediate laparotomy, the hernia being entirely secondary in importance to the probability of injury to the viscera.

Hernia following sword or bayonet wounds is so rare as to have almost escaped mention in war reports.

The wounds most frequently followed by hernia are knife wounds (cuts or stabs) and wounds caused by falling upon broken glass or upon sharp instruments. They vary in size from a fraction of an inch to a foot or more. Hunter reports case of a girl eight years old, who fell while carrying a whiskey bottle. The wound was only three-fourths by one-half inch, yet the entire stomach was found outside the abdominal wall. The case recovered. Caine and Cuff report cases illustrating the other extreme, in which two men slashed themselves with razors, one vertically, the other horizontally. In both cases the stomach, almost the entire small intestine, the colon, and the omentum were found outside the abdominal parietes, yet both recovered. Clark reports a five-inch knife wound, in which the entire small intestine, colon and omentum protruded, and the omentum was found covered with shavings; the man recovered and was well three years later. Frank describes a case of multiple stab wounds, which occurred in Vienna, in which omentum presented from one wound, and gut, which was wounded, from the other. Recovery. Finally, Mitra describes a very unusual case, that of a Hindu who was suffering from marked ascites, and who slipped and fell to the floor after getting out of

bed. He ruptured his abdominal wall above the umbilicus, small intestine protruded; and was also ruptured completely across the circumference; it was cleaned and stitched to the abdominal wall *in situ*, forming a double artificial anus. This case died.

(1) Hemorrhage in these cases will depend on the position and size of the wound. In several reported instances the hemorrhage was extremely severe, and was from the deep epigastric, the internal mammary or the circumflex iliac. In the case referred to above, in which the abdomen was cut transversely from one anterior superior spine to the other, both deep epigastric arteries were severed, and the patient was pulseless. All four ends were tied, and a quart of hot salt solution (temperature 108°) was put into the median basilic vein, followed by a pint of coffee by rectum. This energetic treatment saved the man's life. The difficulty frequently found in these abdominal wounds is that the severed vessels contract into their sheaths; the incision should be enlarged, if necessary, and the vessel picked up and tied. Heat is of extreme value in these cases.

(2) Laceration of protruding gut should be closed by Lembert sutures. In the few cases in which this is not possible an artificial anus may be made.

Strangulation, or incarceration, is relieved by enlarging the incision.

(3) Infection may be introduced into the peritoneal cavity at the time of the accident, or afterwards. It may be due to material from outside, or to the contents of wounded viscera. It is the most serious of the dangers with which the surgeon is confronted, for it is present in greater or lesser degree in every case.

If the intestine is wounded, after the rupture is closed the peritoneal cavity should be irrigated thoroughly and drained, according to the majority of writers. But cases of recovery are reported in which the abdominal wound was sewed up tight. If the intestine is not wounded it should be most thoroughly cleansed and then returned; and the same is true of the omentum, save that in cases in which a small amount of omentum has been exposed for some hours it is probably better to tie and cut it off.

The length of time intervening between accident and operation has a most important bearing upon infection; the longer this interval, the greater the necessity of drainage. Frank, of Vienna, insists particularly upon drainage in every case where there is any injury of any viscus, and advocates cleansing the peritoneal cavity by gauze sponges entirely without irrigation. Infection is frequently absent where it might be most expected. Dr. Brough reports a case of a sailor stabbed by a case-knife in the hand of a comrade at sea. Gut and omentum protruded. The captain washed the protruding viscera in water from the cask, pushed it back and sewed up the wound with a sail-maker's needle and thread. When Dr. Brough saw the case, ten days later, the man was well and sitting up, and had not had any symptoms of infection.

(4) Resultant weakness of the abdominal walls is greatest in extensive wounds and in wounds which are drained. Its dangers are slight when compared to infection, and it should be allowed to exert only a secondary influence upon the choice of treatment of the wound.

The hernia consists most frequently of omentum; then come small intestines, large intestine and stomach in the order named, or two or more of these may ap-

pear together. The hernia may immediately follow the trauma, or a varying interval may elapse before it appears. In these delayed instances, the protrusion is usually due to vomiting, muscular exertion or both. In several instances men have run, walked or rode some distance, before realizing that they have been wounded.

The most important rule in operating is to begin at the earliest possible moment after the accident. The next most important is the thorough cleansing of all exposed viscera before operating. In the majority of cases the incision should be enlarged, usually in the direction of the original wound unless this would involve one of the larger arteries. Torn or dirty edges of the wounds should be resected. Stasis of the bowels frequently follows operation, and is probably due to a mild degree of peritonitis. It may be treated by immediate and repeated small doses of calomel (one-tenth to one-fourth grain every hour till movement, or ten doses) and high enemata. Reboul recommends ice on the abdomen as a preventive of inflammation.

The diet should be meat broths. The drainage may be removed on the third to fifth day.

The prognosis in cases in which the viscera is not wounded is good. Only one report of death has been found in cases of this variety.

The second case reported at the beginning of this paper was supposed to represent a variety of injury which seems to be very rare. Rupture of the abdominal wall, without external wound, is found usually as a result of severe violence inflicted by a blunt object, such as a wagon shaft. The writer has been able to find only very few cases which seemed to be authentic; of these, three were due to the impact of a wagon shaft, and one to a fall upon the handle of a hammer. Dr. Monks has kindly given me notes of one of these cases. A man, standing on the running-board of an open car, was struck in the abdomen by the tip of the shaft of a passing team. A tumor, the size of a fist, appeared under the skin, and surrounded with much ecchymosis and swelling. The tumor increased on coughing or muscular exertion. The skin was not broken.

Dr. Monks saw the case twice, two weeks and eight weeks after the accident, the hernia remaining unchanged, though all the ecchymosis had disappeared at one and a half years later; the man died of aneurism of the aorta. At the autopsy, Dr. Whitney found a rent in the muscular bellies of the abdominal wall, through which the intestines protruded.

Another interesting case is reported by Lotheisen. A bicycle rider ran into a wagon shaft, which struck him on the right just above the umbilicus. He had some pain, and went to bed. In a day or two he got up, but at the end of a week began vomiting, and was seen by Von Hacker, who found a tumor size of apple at point of contact. The man's general condition became rapidly worse. A diagnosis of tear of rectus with protrusion and incarceration of gut was made. Patient died during the operation and the autopsy showed a bit of transverse colon protruding and attached all around the edges of the tear. The man could have been saved by earlier operation.

The other two cases, one from the City Hospital Reports, and reported by Platt, were smaller in extent and existed for years. Hutchinson, in a paper on "Lumbar Hernia," says that five of twenty-nine cases which he reported were following trauma more or less.

closely, and were apparently through the abdominal wall rather than the triangle of Petit. If this is so, they must be considered true ventral herniæ.

Why the abdominal wall is ruptured in some cases and not in others is to be explained partly by the size and shape of the impacting body, and partly by the rigidity or flaccidity of the muscles at the time. If the impacting substance be sharp or small, the wall is likely to be perforated. If larger and blunt, the chance of injury to internal organs without laceration of muscles is increased. If the wall is tense and contracted at the time of impact, the chances of laceration are increased. If relaxed, it is carried before the impacting object.

The treatment of these cases is non-operative, except in cases of incarceration or strangulation. A well-fitting swathe appropriately padded will usually allow the patient to carry on any but very laborious work. The prognosis for life is good; for the hernia, bad. Operation, if resorted to, should be done when other methods of treatment are found to be insufficient to retain the hernia and permit the man to work. In any long-standing case the gut will probably be found closely adherent to the edges of the ring. After breaking up the adhesions the opening should be closed as in any ventral or umbilical hernia.

The case reported at the beginning of the paper was probably a contusion and hemorrhage into the muscle, with an injury to the lower intercostal nerves at point of contact. The only symptom of hernia which it did not possess was the bulging of the wall when patient was breathing naturally and not coughing. So far as the writer can discover, this case is unique.

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Clinical Department.

MASSACHUSETTS GENERAL HOSPITAL. CLINICAL MEETING OF THE MEDICAL BOARD.

(Concluded from No. 16, p. 391.)

REGULAR Meeting, Friday, February 11, 1898, DR. C. B. PORTER in the chair.

DR. FITZ: It seems to me the case illustrates that with favorable conditions immediate or early laparotomy is likely to prove a success and in this instance it was to be expected after a week had elapsed and the general condition was constantly improving, that re-

covery was to be anticipated. The occurrence of a second perforation, however, proved to be irremediable and it may be added that at the post-mortem examination some thirty or forty ulcers were found in the intestine.

I will now present for your examination a case of

ANEURISM OF THE ARCH OF THE AORTA (WITH RADIOGRAPH).

The patient, a Swede, recently entered the hospital. He worked in an iron foundry and until some six weeks ago was supposed to be in fairly good health. At that time he had attacks of dyspnea for the treatment of which he came to the hospital. There was also some disturbance of voice. He has had no pain whatsoever, but there has been slight difficulty in swallowing solid food. I have outlined on his chest the region of dulness which is connected with pulsation over the upper part of the sternum, although in the sternal notch there is no tumor to be felt. He has not only difficulty of vocalization, but also a peculiar barking, high-pitched cough. Dr. Coolidge has examined the larynx and has found paralysis of the left vocal cord. We have, therefore, dulness over the upper part of the sternum, paralysis of the left recurrent laryngeal, pulsation in the region of dulness and difficulty in swallowing and occasional attacks of dyspnea. Mr. Dodd has taken a radiograph of his chest, which shows at the upper part of the sternum a rounded, light patch corresponding to the position of the aneurism, which is evidently a dilatation of the transverse portion of the arch of the aorta. The patient has another sign to be observed in a certain number of cases of aneurism, namely, a tracheal tug.

The next case is one of

SUCCESSFUL RESECTION OF THE PYLORUS FOR CANCER,

which I will show in connection with Dr. Conant and Dr. Porter, as we all had to do with the treatment of this patient. It is now six weeks after the operation and the patient and the specimen are present. This man, forty-seven years old, entered the hospital December 7, 1897. About a year previous he had suffered from cutting epigastric pain after eating, not relieved by pressure or by vomiting and made worse by food. There was frequent vomiting at the outset and the vomitus occasionally was brown like coffee grounds and the stools also were occasionally dark. During the first three months the vomiting became less and finally ceased. The quantity of the vomitus was considerable, about two quarts, but it was not particularly offensive. Six weeks before entrance and nine months after the onset of the symptoms he noticed a lump in the epigastric region. When he entered the hospital the tumor was elongated, rounded, nodular, movable, apparently about the size of a small banana, and the dilatation of the stomach was such that when inflated it occupied the greater part of the abdomen. The general appearance was good, emaciation was not extreme, the mental condition was excellent and the suffering was chiefly from the distention of the stomach. He was informed of the probable nature of the malady, its course if let alone and the prospect of relief from an operation which was necessarily serious. After a few days of consideration he returned for operation, which, in the absence of Dr. Porter, was performed most successfully by Dr. Conant.