

obtain skiagraphs of a part with a needle in it, it does not necessarily mean that the said needle will be always found by the operator with the same ease. This has been well shown in a case now under treatment at the hospital. A woman aged twenty-six years was sent up from the country on April 29th, 1896, having trodden upon a needle ten days previously. On the sole of the foot a mark was found just internal to the base of the fifth metatarsal bone and on a level with the spur of that bone deep tenderness could be easily elicited and the patient was unable to walk and do her work on account of pain. The cryptoscope having shown that a needle between a quarter and half an inch long was present photographs were taken in two positions and these apparently showed the needle in an accessible position. However, an exploratory incision down to the spot failed to reveal any indication of it, so the wound was sewn up and re-photographed. Finding the needle in the same position experiments were conducted with a skeleton foot on the screen and the same shadows were found to be produced by a needle lying in the sheath of the peroneus longus, so the wound was opened and the sheath and tendon carefully explored, but no trace of the needle was found. The foot was then photographed in four different positions with a guide needle placed in the wound and the relationship of the two thus determined, and a third operation was undertaken, but was equally unsuccessful. The skiagraph taken after the wounds were healed reveals the needle still in the same position. This case shows very clearly the great difficulty which may be experienced in removing a foreign body when one has the shadow only to work from.

Since these cases I have been successful in obtaining a skiagraph of a bullet of which no indication by external manipulation could be obtained. The man had shot himself, and the wound of entrance was over the fourth intercostal space about one and a half inches to the left of the left nipple. A probe passed back and slightly upwards for about three inches and appeared not to enter the chest, but to skirt the ribs. On admission the patient had no symptoms of wound of the lung, but there was a slight trace of dark blood in some sputum eighteen hours afterwards. The apparatus was all put upon a trolley with indiarubber wheels and wheeled into the ward to the bedside, and the plate being adjusted behind the left shoulder without moving the patient, with a fifteen minute exposure a skiagraph was obtained showing the position of the bullet external to the ribs, lying close to the axillary border of the scapula. This case is interesting, as it shows that the bullet does not lie in a dangerous position.

(To be continued.)

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF STRANGULATED FEMORAL HERNIA.

BY CLARKE WAKEFIELD, M.D. BRUX., F.R.C.S. EDIN.

THE following case seems to me to present several features of interest. A spinster aged sixty-nine years was first seen on April 13th at 11.30 P.M. The history was that she had worn a truss for thirty years without discomfort. During the last six months she had noticed that the hernia had increased slightly in size, but she had had no pain until the 12th at about 7 P.M. The pain gradually increased and the patient began to vomit. Late at night on the 13th, on examination I found a tense nodular hernia as big as a large horse-chestnut. The patient was retching violently and brought up some distinctly stercoraceous vomit. Her countenance was pinched and pale, her pulse thin and wiry. I tried gentle taxis, but from the history of the case and the rapidity with which the symptoms had come on I deemed it wise not to persevere with the attempts to reduce the hernia in this way. An hour after seeing the patient Dr. G. N. Adams kindly gave ether for me and I proceeded to operate. The operation was comparatively simple as the patient was very thin, the sac being exposed without any vessel requiring to be ligatured. On opening the sac some dark sanious fluid escaped, and a knuckle of bowel, which appeared by lamp-light to be black, was exposed. The bowel had not lost its

lustre and I decided to return it; this was easily done after incising the base of Gimbernat's ligament. It seemed wiser, in view of the deeply congested state of the gut (a piece of small intestine), not to attempt a radical operation or even ligature the neck of the sac, so I contented myself with removing a piece of omentum which was adherent to the sac and closed the upper three-fourths of the incision with cat-gut sutures. The temperature remaining normal the wound was not dressed again till the fifth day, when it was dressed for a reason which will presently be given. To return to the course of events following the operation. She vomited six times, and the bowels acted twice with loose motions early on the day after the operation. There was no vomiting on the second and third days, but on the fourth there was an attack of tympanites accompanied by frequent vomiting of bile-stained fluid. On the fifth day, these symptoms continuing, I gave a turpentine enema and changed the dressing to see whether anything to account for the symptoms could be seen in the wound, which, however, I found had healed by first intention. Eight hours after the enema was given she passed a scybalous motion, and from that time the recovery was uninterrupted. I last saw her a month after the operation; the patient was up and about, the scar was quite sound, and there was no impulse on coughing.

Remarks.—It is hardly necessary to remark on the insecurity of a person who wears a truss over an irreducible omental hernia, as I presume was the case of this patient for the thirty years during which she had worn the truss—a hollow Coles's truss. Perhaps the chief interest of the case rests in the attack of tympanites and vomiting mentioned above. Seeing that this attack ended suddenly after a large quantity of scybala had been passed there is little doubt that it was due to a temporary block in the large intestine.

Ladbroke-grove, W.

NOTES ON THE TREATMENT OF MEASLES.

BY A. DUNLEY OWEN, M.R.C.S. ENG., L.R.C.P. LOND.

DURING the early months of this year an epidemic of measles of a severe type visited Northampton and the surrounding district, and there was an unusually high mortality from this disease, chiefly, I believe, from concurrent bronchial and pulmonary inflammations. Of the cases that fell to my share I took notes of over 300 with a mortality of only 4, of whom one died from capillary bronchitis three hours after I was first called in, and the others were under two years old and succumbed to broncho-pneumonia. I attribute this low rate of mortality to the method of treatment I have invariably adopted—namely, to order jacket poultices, changeable every three hours, as soon as any indications of measles show themselves and before the rash appears, and I think this has been beneficial, for death has only occurred in those cases in which the mother discontinued the poultices after the first application, or, as in one case, thought proper not to poultice at all. The only medicinal treatment adopted has been ipecacuanha wine with acetate of ammonia, with a boric acid wash for the eyes in those cases which were complicated by catarrhal inflammation of the lids. Stomatitis occurred in about one-half of the cases and invariably yielded to the application of a saturated solution of chlorate of potash to the inside of the mouth, the children being too young to use a mouth wash.

I venture to think that these notes may be of some slight interest, as all the cases noted were of a severe, and some almost of a malignant, type, the slighter ones being passed over. Convalescence proved slow in nearly all the above cases; curiously, though, the town children gain strength far quicker than those in the surrounding country districts, possibly owing to the higher wages of the town workers procuring for their children a more generous diet.

Northampton.

CONGENITAL LUMBAR HYPERTRICHOSIS AFFECTING TWO SISTERS.

BY L. A. PARRY, M.B., B.S. LOND., F.R.C.S. ENG.

THE following examples of a not very common abnormality may be of interest to the readers of THE LANCET. The subjects are two girls, the third and seventh children of a family of seven; the remainder are not

affected. The hirsuties dates from birth in either case. Both parents are English. The condition of the elder child as an infant was identical with that of the younger at the present day. The elder of the two girls, aged ten years, has in the lumbar region a triangular patch, base upwards, of fine silky golden hair; the base of the triangle reaches a level one inch above the highest point of the iliac crest, and the apex is one inch above the gluteal cleft. The hair, which is directed downwards, is of a slightly lighter colour than that of the scalp and attains a length of five inches; there are no mental defects. The younger patient presents the same condition as her sister, but in a much less degree. The elder is the subject of old infantile paralysis of the right leg, giving rise to local peripheral gangrene and talipes equinus. There is no sign of spina bifida or perforating ulcer, as in the cases referred to by Mr. Bland Sutton in THE LANCET of July 2nd, 1887.

South Norwood.

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.

ST. GEORGE'S HOSPITAL.

A CASE OF PERFORATED GASTRIC ULCER TREATED BY
LAPAROTOMY; RECOVERY.

(Under the care of Mr. C. T. DENT.)

COMPARATIVELY few cases have hitherto been published of the successful treatment by laparotomy of this formidable complication of a somewhat common disease. It seems, therefore, desirable to place this one on record, as showing that perforation of a gastric ulcer is not necessarily fatal if skilled assistance is obtained and the opening promptly sutured. It also affords a good example of the promptitude of the medical attendant in recognising the occurrence of a perforation before peritonitis has set in and the necessity for surgical interference. The chief points in this case are the occurrence of a perforation on the posterior aspect of the stomach and the oblique line taken by the perforating ulcer. It has been calculated that only 2 per cent. of ulcers of the posterior wall perforate.

A spare, anæmic woman aged twenty-six years who had suffered from indigestion for many years was admitted into St. George's Hospital on Nov. 19th, 1895. On one occasion three years previously she had had a tolerably profuse attack of hæmatemesis which came on suddenly at night. At 4.30 P.M. on the day of admission she was seized with sudden and severe epigastric pain which developed shortly after she had been moving some heavy boxes. She felt sick and, with the idea of relieving her symptoms, drank some hot water. This made her pain worse. Shortly after taking the water she vomited it all together with some half-digested food. As she had not eaten anything for some hours previously it was evident that her gastric digestion was very slow. She was seen shortly after the onset of the attack by Dr. Roxburgh Fuller, who, recognising the probability of perforation, sent her at once to the hospital for operation, acting thus with a promptitude all too rare in such cases, but to which she probably owed her recovery. The patient had for some time previously been suffering from menorrhagia. When seen directly after admission she complained of intense epigastric pain. The abdomen was rather distended and there was tenderness in the epigastric region. There were considerable difficulty of breathing and cardiac distress. The apex beat was an inch or an inch and a half higher than natural. The resonance in the left hypochondriac region was very marked and gave a higher note than natural. There seemed to be little doubt that the patient was suffering from the effects of perforated gastric ulcer. Judging by the physical condition of the abdomen it

was thought that the ulcer was on the posterior wall of the stomach. The operation was at once undertaken, between six and seven hours after the first onset of acute symptoms. Mr. Dent opened the abdomen in the median line above the umbilicus, an incision which in such cases appears to him on the whole to answer as well as any other. The peritoneal cavity contained some opalescent fluid of acid reaction; but there was no undigested food free in the cavity, so that presumably the perforation was a small one. The fluid was, as usual in cases of perforation on the posterior wall, chiefly in the left hypochondrium. Even at this early stage moderately firm adhesions had formed, limiting the characteristic cavity formed by the diaphragm, the falciform ligament, and the stomach. There was a slight amount of lymph on the under surface of the diaphragm and on the posterior surface of the stomach, and such coils of intestine as presented were of bright colour and injected, with their surfaces slightly roughened by lymph. Some tolerably firm bands of peritoneal adhesions about the stomach suggested previous trouble; one of these bands, passing obliquely, compressed the stomach very markedly. After separating the adhesions Mr. Dent was able to expose the posterior surface of the stomach. There was no gap to be seen. Midway between the greater and lesser curvatures and towards the pyloric extremity was a thicker and rougher deposit of lymph extending over an area of the size of half a crown. A probe passed into this rough surface entered a sinuous track but did not appear actually to enter the stomach. The operator of course avoided making more than the very lightest pressure. On grasping the posterior wall of the stomach between the fingers and thumb an indurated area of about the size of a five-shilling piece, circular and with well-defined edges, was readily felt. The rest of the stomach was fairly healthy. It seemed probable, therefore, that a small perforation had taken place at some point in this indurated area, probably about the centre. Mr. Dent therefore passed sutures through the muscular and serous walls of the stomach on either side of the indurated portion and sewed the two re-duplications over the induration. The cavity which contained the fluid that had escaped from the stomach was irrigated with hot boracic solution until the injection returned quite clear. No drainage-tube was employed. The patient vomited once after the operation. She was placed in bed with the head and shoulders well raised—a position which Mr. Dent considers to be of the greatest importance in all such cases and especially where, as in this instance, the heart's action is impeded by abdominal trouble. After flushing out the peritoneal cavity, especially after a long and tolerably exhausting operation on a heated operation table, patients are prone to break out into very profuse perspiration and, if not very carefully watched, run some risk of chill. The sweating may be largely obviated by sponging out the peritoneal cavity until nearly dry; but this seems to Mr. Dent an undesirable practice and one that prolongs the operation unduly. In such cases his usual practice is to avoid all linen clothing next the skin and to direct the nurse to rub over the limbs and the whole surface of the body gently and constantly for a couple of hours, if need be, with soft, warm towels. The effect of this very mild massage not only prevents any chill but constantly sends the patient off to sleep; and the rubbing may even be persevered in with advantage, if very gently done, during actual sleep. For the first twenty-four hours the patient was kept on nutrient enemata and suppositories. After that small quantities of food such as peptonised beef-tea, milk, chicken broth, and the like were given by the mouth. The day after operation there was considerable distension, obviously of the colon, and the temperature ran up a little, but the trouble passed away at once after an enema rectæ had been given with a long tube. The highest temperature was 100.2° F. on the second day after operation. After this the temperature fell to normal and remained so. Throughout the patient was kept well raised in bed and turned on to her right side with the idea of keeping the food away as much as possible from contact with the ulcerated surface and favouring its passage through the pylorus. In all gastric operations the patients will do better if they are kept well raised in bed from the first, and in cases of pyloroplasty Mr. Dent has seen vomiting at once checked by merely raising the patient. Save for a little stitch-hole suppuration the recovery was uninterrupted. Such suppuration, which merely signifies the separation of minute sloughs owing to the pressure of the stitches, is almost invariable, he thinks, when there is any degree of