

the administration of a simple enema. For the abstract of the notes of these cases we are indebted to Mr. Henry A. Dickson, house surgeon.

CASE 8. Strangulated interstitial congenital hernia.—A man aged twenty-nine years was admitted into St. Thomas's Hospital on Sept. 13th last. He had had a hernia on the left side for eight years, for which he had worn a truss. This was discontinued two years ago, but the hernia had not caused any trouble. He said that it came down again in the morning of Sept. 17th. He vomited in the middle of the day and again in the evening. He suffered a good deal of pain that evening and throughout the night. His bowels were last opened on Sept. 16th. On admission to hospital there was seen to be a soft elastic projection at the external ring which could easily be pushed up into a larger one occupying the inguinal canal. The swelling was about the shape of half an orange, and extended beyond the internal ring to the left, and measured about four inches from above downwards. The testis, which had never been in its proper position, could be felt as a small, soft body a third the size of the right one in the lower part of the wall of the swelling, which appeared to contain fluid. Some impulse could be felt on coughing, but was only conveyed from the abdominal wall. From the history and examination it was supposed that there was probably a small piece of intestine strangulated in the upper part of the sac. The temperature was 100·2° F. At the operation it was found that the sac was situated in the abdominal wall, under the external oblique, it contained a large quantity of inflammatory fluid, and coming through the internal ring, which was in the posterior wall of the sac, was a small piece of congested gut nipped by the neck of the sac. The constriction was divided, and the gut examined and put back. Some ounces of fluid of inflammatory origin escaped from the abdomen after the gut was returned. In order to get at the internal ring and dissect out the sac it was necessary to divide the external oblique muscle along the whole length of the inguinal canal. The sac and testis were removed, separate ligatures being applied to the neck of the sac and the cord. The conjoined tendon was approximated to Poupart's ligament by two silk sutures, the external oblique sutured so as to close the external ring and inguinal canal, and superficial sutures placed in the skin. The man recovered without a bad symptom, and when he left the hospital the parts were quite firm and there was no abnormal impulse on coughing.

CASE 9. Large strangulated scrotal hernia.—A man aged fifty-five years was admitted to St. Thomas's Hospital on Sept. 18th. He had suffered from a right inguinal hernia for ten years, for which he had worn a truss. He had been always able to reduce it until the 17th. In the evening of that day he had pain in the abdomen and vomiting. His bowels acted three times during the day, the result of a pill taken the previous evening. The sickness continued all night, and next morning he was seen by a medical man, who made unsuccessful attempts to reduce the hernia for a period of four hours. On admission to hospital the same evening there was a scrotal hernia the size of a large cocoanut, tense, devoid of impulse, tympanitic on percussion, and with a large neck. The skin over it was red and it was tender on manipulation; there was also a little bluish discolouration in parts. An ice-bag was applied; no vomiting took place after his admission, but there was no improvement in the hernia after two hours, so the patient was placed under ether and the sac opened by means of a long incision. The omentum was found adherent to the sac under the incision, and it was somewhat difficult to get to the side of this. The sac also contained about three feet of congested small intestine and some blood-stained fluid. The omentum was ligatured in sections just below the level of the internal ring, where it was not adherent, and divided. The intestine was returned, and then the sac dissected out with the adherent omentum, ligatured at the neck, and removed. There had evidently been an old-standing, irreducible omental hernia, the adhesions being very firm and the omentum hard and lumpy. The intestine contained in the hernia had a markedly cold feel, the result of the application of the ice. It was found that there was a recent rupture of the sac extending from the bottom up to the internal ring; there was also a small recent laceration of the mesentery with some bruising. The wound and deeper parts were closed with silk sutures after the method recommended by Mr. Banks. For a few days after the operation the urine contained a third of albumen, but it then disappeared. A week after the operation frequent "teasing" actions of the bowel caused much discomfort,

but this attack was relieved by a starch-and-opium enema. Some shock followed the operation, and he appeared to rally slowly at first. There were, however, no local complications, and when he left the hospital on Oct. 8th the bed of the hernia was occupied by a thick, firm band of tissue. There was no trace of hernia, and the albuminuria had quite disappeared.

CASE 10. Strangulated direct hernia.—A rather stout man aged forty-seven years was admitted to St. Thomas's Hospital on Sept. 19th. He had suffered from hernia on both sides since January of this year, and wore a double truss until Sept. 18th, when he thought he could do without it and discontinued its use. During the day the hernia on the left side descended and became larger and hard. His bowels had acted naturally in the morning. During the following night he vomited. Taxis was tried unsuccessfully in the morning of the 19th, and he was sent to the hospital in the evening. He was then found to have two hernial protrusions in the inguinal regions, neither of which descended into the scrotum, of globular shape, the size of a small fist. Of these the left was the larger, irreducible, tender, and without impulse; the right was reducible and with marked impulse on coughing; it passed almost directly backwards. He vomited immediately after taking some milk. Ether was administered in the usual manner and an operation performed on the left side. The sac contained a considerable quantity of fluid already coagulated, and some dark-coloured small intestine, the wall of which was thickened and slightly adherent to the sac by recent lymph. The stricture was at the neck of the sac. After reduction of the gut excision of the sac after ligature of the neck was done, and the opening closed by two silk sutures passed through the conjoined tendon and Poupart's ligament, behind the cord. The neck of the sac was about half an inch from the internal ring, through which the cord was traced. The deep epigastric artery could not be felt. No drainage-tube was used. The wound healed without any local complication. There were occasional rises of temperature soon after operation to 100° and 101° F. in the evening, and it was found on examination for the cause of this that he had signs of consolidation at the apex. He was able to leave the hospital on Oct. 13th, but suffered from cough and was becoming emaciated.

CASE 11. Strangulated femoral hernia.—A married woman aged forty years was admitted to St. Thomas's Hospital on Sept. 21st. She had suffered from a left femoral hernia for five months, and had worn a truss. On the 17th the hernia came down and she was unable to reduce it, but it caused her no pain or discomfort. On the 20th it got larger and became painful, and her bowels acted twice during the day. She vomited in the morning of admission, and again at 7 P.M. There was a small tense femoral hernia, resonant on percussion, without impulse on coughing, and very tender on manipulation. She complained of great pain all over the abdomen. She did not vomit again before the operation. The usual incision was made down to the sac, and as it was being pulled down to better permit of the division of some fibres about the neck the contents slipped back. The sac was then opened, proved to be empty, ligatured at the neck, and removed. The wound was closed without a drainage-tube. On the third day she had some commencing distension about the abdomen, and complained of pain, but these symptoms rapidly subsided after the passing of a long tube into the rectum. There were no further symptoms, and she was permitted to leave the hospital in a fortnight.

Two other patients, boys aged two years and ten months and two years respectively, were admitted to St. Thomas's Hospital on Sept. 22nd, the former being the child of the patient in Case 8. In both the hernia was on the right side; both suffered from phimosis. In the elder child the symptoms were those of strangulation in the other the hernia had been down for eleven days without symptoms. Both herniæ resisted taxis, but went back a few hours after a warm bath, followed by the application of an ice-bag. Circumcision was performed in one case. Trusses were fitted before the patients left the hospital.

LEITH HOSPITAL.

FRACTURE OF THE BASE OF THE SKULL; RUPTURE OF THE INTERNAL CAROTID ARTERY; NECROPSY.
(Under the care of Dr. J. W. STENHOUSE.)

THE following case is of interest on account of the rarity of the condition. One other case has been recorded of a

somewhat similar kind by Dr. Guthrie.¹ "I have even seen the fracture pass across the canal in the temporal bone for the passage of the carotid artery and the extravasation caused by its rupture—a fact which has been noticed by Bohn."

A woman aged seventy years, a chronic alcoholic, was admitted into Leith Hospital on May 27th, 1894, in a comatose condition. The history was that she was in a drunken state on the preceding evening, and while ascending a narrow winding stone staircase she fell backwards on to the left side of her head. She was picked up immediately afterwards by her husband in a perfectly unconscious condition. Her eyes were closed, her breathing was stertorous, and she made no voluntary movements. The condition remained unaltered up to the time of her admission to hospital twelve hours afterwards. On admission the patient was comatose. Her eyelids were closed. On opening the lids both eyes were seen to be divergent. The left pupil was pin-pointed, and the right moderately contracted. Neither reacted to light. There was a bruise on the left side of the head above the zygoma, and the left eyelid was ecchymosed. Some small clots were found in the anterior nares and nasopharynx, which seemed to indicate that some bleeding had occurred into the nose. She lay on her back with her mouth open, but on closing the jaws the cheeks flapped backwards and forwards with respiration. Her arms and legs were limp, but the knee-jerk was not abolished. The respiration was 28 per minute, regular and slightly stertorous; the pulse was 68 per minute, irregular in time and force, with medium volume; the temperature was 98.4° F. The patient lived until 6.30 P.M. on May 30th, almost four days after the accident. During that time her condition scarcely changed. The left pupil became less pin-pointed on the 28th, but on the 29th it again became pin-pointed and remained so until death. Urine was passed into the bed, while the bowels were never moved. The temperature rose steadily from 98° in the morning of the 27th to 102° in the morning of the 28th, reaching 105.6° in the evening of the 30th. There were slight falls in the temperature in the evenings of the 28th and 29th. The post-mortem examination took place on May 31st. On reflecting the scalp an ecchymosis was observed over the left side of the head as described above. On removing the calvaria there was no clot outside the dura mater. The dura mater being incised and stripped, an extensive blood-clot was found to cover the whole of the upper surface of the right hemisphere. No clot was seen on the upper surface of the left hemisphere, but the membranes were milky and opaque. Having removed the brain, the clot was seen to extend into the right Sylvian fissure and over the whole of the anterior and middle fossæ of the skull—i.e., as well on the left side as on the right. A very small clot passed down in front of the pons and medulla. The right cerebral hemisphere was much compressed, and the convolutions were flattened. On section a clot the size of a large pea was found in the substance of the pons. The right internal carotid artery, as it passed to the inner side of the cavernous sinus, was ruptured. The rupture was on the outer side, in the long axis of the vessel, and about three-eighths of an inch long. The dura mater at the base was next removed, and a fracture passing right across the sphenoid was exposed. Beginning on the left side, at the level of the lesser wing of the sphenoid and in front of the groove for the middle meningeal artery, it passed transversely inwards for about an inch, and then took a direction backwards and inwards towards the carotid canal, passing in its course between the foramen rotundum in front and the foramen ovale behind. The fracture passed across the canal to its inner side, clipping off the posterior clinoid processes. On the right side it passed transversely from these processes across the great wing of the sphenoid, posterior to the groove of the middle meningeal artery, to about the same level as on the opposite side.

Dr. W. M. Selby assisted at the necropsy.

¹ Head Injuries, p. 73.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Intracranial Aneurysm.—Acute Pancreatitis.—Fatal Form of Tetany associated with Chronic Dilatation of the Stomach.—Tuberculous Lymphangitis following Inoculation of the Finger.

THE first ordinary meeting of this Society for the present session was held on Oct. 12th, Mr. HULKE, President, being in the chair.

Dr. ROSE BRADFORD read notes of a case of Intracranial Aneurysm. The patient, a man aged twenty-nine, was admitted to University College Hospital at 8 P.M. on Feb. 3rd, 1894. During the last six months he had suffered from giddiness and noises in the head, and for the last fortnight had complained of occipital headache and stiffness of the muscles of the neck. On the morning of Feb. 2nd he was seized with vomiting after eating some bacon that was thought by him to be rancid, and during the day his wife thought he had a fit, but no convulsions were seen. His pulse was intermittent. The next day the patient was better, the vomiting had ceased, the pulse was still intermittent, headache was still present, and the patient was conscious and perfectly rational. He was removed to hospital at 7 P.M., owing to retention of urine. On admission he was partially unconscious, with the axillary temperature 98° F. and the pulse 70, irregular, and intermittent. There was no paralysis. Respiration was regular. The abdomen was not retracted. The pupils were equal and medium-sized, with the deep reflexes increased. The patient was rather restless. At 9 P.M. he became comatose, and the respirations became infrequent, ceasing at 10 P.M. Artificial respiration was kept up for four hours, but the pulse then failed, and on the cessation of artificial respiration the patient died at 2.10 A.M. The temperature at midnight was 97°. No convulsions occurred. The post-mortem examination showed numerous gummata in the liver and a fusiform aneurysm of the basilar artery, which had ruptured, the extravasation forming a blood clot a quarter of an inch thick on the under surface of the pons and medulla, and extending round the sides of the medulla into the fourth ventricle.

Dr. HALE WHITE read notes of two cases of Intracranial Aneurysm in Young Subjects unaffected with Syphilis or Malignant Endocarditis. The first case was that of a woman aged thirty-four who, while at dinner on Dec. 25th, 1893, suddenly fell off her chair insensible. On coming round she had intense headache and vomiting. The pulse was slow, and the temperature 100.4° F. On Dec. 30th the patient was suffering from retraction of the head and great pain down the spine. On Jan. 7th the symptoms were as before, with complete paralysis of the left third nerve. On the 15th she had a fit. On the 18th she suddenly became worse and died in ten minutes. The whole body was perfectly healthy, except that there was an aneurysm which sprang from the left internal carotid artery just before its termination. It pressed on the left third nerve. There was a large amount of clot on the under surface of the brain; it extended to the fourth ventricle and was one-eighth of an inch thick all down the spinal canal in the subarachnoid space. The second case was that of a man who for a few weeks had complained of right frontal headache. On Jan. 23rd, 1894, he suddenly fell down insensible and was then brought to the hospital. On admission he was unconscious, the pupils were fixed and dilated, and the eyeballs were prominent. There was right external strabismus, and from time to time there were spasms of all four limbs, and the back was slightly arched. On the outer side of the right optic disc was a large, prominent, dark, brick-red, subretinal swelling about four times the diameter of the disc. A similar swelling was seen in the left eye. Two pints of urine of specific gravity 1005 and containing 25 per cent. of sugar were drawn off. Between admission and death six pints were collected. The breathing became difficult, and he died seven hours and a half after admission. Blood clot was found in both the subdural and subarachnoid cavities nearly all over the surface of the brain; it had extended along the sheath of the optic nerve, ultimately getting under the retina. The hæmorrhage came from a small aneurysm springing from the right internal carotid artery just at its termination. The whole of the rest of the body was absolutely healthy.—

LITERARY INTELLIGENCE.—The third volume of Stevenson and Murphy's "Treatise on Hygiene and Public Health" is announced by Messrs. J. and A. Churchill for appearance next week. The articles in this portion of the work have been written anonymously, but it is well understood that they are all the work of gentlemen of recognised legal ability, each of whom is officially engaged in the administration of the law of that part of the United Kingdom to which his article relates.