

cavity had been thoroughly flushed with hot sterilised water. On the 7th he was found to have been very comfortable and to have slept well, there being no pain. The wound was dressed, the discharge from the tube being distinctly faecal. For the next three days a small amount of faeces escaped daily, and the purulent discharge was abundant. After the 11th, however, there was no further appearance of faeces, and the pus, though still foul, became gradually sweeter and less abundant. He steadily improved in his general condition, the temperature remaining normal, and he rapidly regained flesh. The tube was gradually shortened and finally removed on the 30th, little induration remaining around the wound. On Oct. 7th the latter had entirely closed, and on the 9th he left the hospital well.

Remarks by Mr. MAKINS.—The main interest in the above case seems to centre in the question as to whether the original injury to the colon was intra- or extra-peritoneal in position. When such accidents are not rapidly fatal the explanation is usually to be found in the fact that the rent in the colon has occurred in the extra-peritoneal segment, hence extravasation takes place into the retro-peritoneal tissue of the loin, and the general peritoneal cavity escapes. In these cases, however, the abscess usually forms in the loin, while in the above instance the abscess was intra-peritoneal and also within the line of the ascending colon. Two modes of explanation seem to suggest themselves. First of all there seems to be little doubt that the original injury did not amount to an actual rent, or, if it did, that the rent was very small in extent. Under these circumstances adhesive inflammation may at once have commenced, and when the serious trouble took place on Aug. 26th there may have been some preparation for the limitation of the faecal abscess. It seems, however, more likely that the injury in this case was in the posterior segment, the injury in the first instance being perhaps either a very slight rupture or severe contusion without an immediate rent, escape of the contents of the gut occurring only on the twenty-fifth day, when the patient tried to get about (Aug. 26th). The simultaneous occurrence of hæmaturia seems to afford corroborative evidence of some value in localising the injury to the inner side of the bowel—i.e., that nearest to the right kidney; while the adhesion of the bowel to the anterior abdominal wall noted at the time of operation also seems to point to the bowel having been pressed forward. Hence the absence of a palpable swelling of the loin in the usual position would be explained by the fact that the original injury, affecting the colon and kidney, so damaged the peritoneum covering them both as to render the passage of escaping faeces and pus more easy in the direction of the abdominal cavity than into the loin, and this is perhaps the more likely when the chronicity of the sequence of events is taken into account, the retro-peritoneal tissue in the immediate neighbourhood of the injury having become more dense from inflammatory induration. The dark colour and lumpy nature of the faecal discharge seemed to leave no doubt that the colon was the portion of bowel injured.

SWANSEA HOSPITAL.

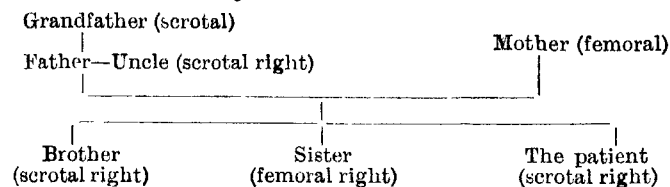
A FAMILY HISTORY OF HERNIE.

(Under the care of Mr. J. KYNASTON COUCH.)

A SERIES of cases of hernia all occurring in one family has not often been brought forward. The tendency to defective construction at those spots in the abdominal wall where the anatomical design is weakest is hereditary—as would be expected; but the fact is so very familiar to all that surgeons have been prevented from publishing their experiences. In this interesting series it will be seen that this particular patient had a double vicious history, both parents having been affected, the father with the right scrotal hernia common to his father, brother, and son, and the mother also having a femoral hernia. It would seem most probable that the lad inherited his defect—over-patent inguinal rings—from his father, but the laxness of tissue present in his mother's case, and shared by his sister, as shown by their possession of femoral herniæ, may have counted for something in the size of the protruded mass. For the notes of the case we are indebted to Dr. Stephen Floyd, resident medical officer.

A well-developed boy aged seven months was admitted into

Swansea Hospital with an enormous congenital scrotal hernia. It was as large as a good-sized orange and quite obliterated the penis. On radical cure being performed it was found to contain a great part of the small intestine, the cæcum, and part of the ascending colon. The patient made a perfect recovery. The appended schedule shows the different members of the family affected.



Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

On Posture in its Relation to Surgical Operations under Anæsthetics.

THE first meeting of this society for the present session took place on Oct. 22nd, Mr. HUTCHINSON, President, being in the chair.

Dr. ORD presented to the society the volume on "Climatology and Balneology" recently published by Messrs. Macmillan and Co. A committee was appointed by the society during the presidency of Sir Edward Sieveking, and the present book was the first volume of the work. It comprehended chiefly the climatology of the south coast of England and a description of the more important medicinal springs of Great Britain. Dr. Dickinson had dealt with Cornwall and the Scilly Isles, Dr. Symes Thompson and Dr. Lazarus-Barlow had described Devonshire and the Channel Islands, Dr. Mitchell Bruce had undertaken the compilation of that section dealing with Somerset, Dorset, and Hants, while the south-eastern counties—Surrey, Sussex, and Kent—had fallen to the lot of Dr. Ewart. All had worked zealously, and it was hoped that the medical public would appreciate the results of their labours.—The PRESIDENT remarked that the committee was an innovation on what had been accomplished by the society in the past, and he alluded in grateful terms to the valuable services rendered by Dr. Ord, the chairman of the committee.—Sir EDWARD SIEVEKING considered that the committee, which had admirably managed its business, should be made a standing one, to which the profession could turn in case of requiring advice or desiring to record climatological or other phenomena. He moved a vote of thanks to the committee and eulogised especially the services of the secretary, Dr. Archibald Garrod.—Dr. DICKINSON said that the committee was indebted to many observers in various parts of the country for valuable information. He proposed that each of these gentlemen should be presented with a copy of that paper in which his contribution appeared.—The vote of thanks to the committee was carried unanimously. The President presented the annual volume of the Transactions for 1895.

Dr. FREDERIC HEWITT and Mr. MARMADUKE SHEILD brought forward a paper on Posture in its Relation to Surgical Operations under Anæsthetics. They pointed out that the posture of a patient prior to, during, and after a surgical operation under an anæsthetic was a matter of considerable importance to the surgeon, to the anæsthetist, and in many cases to the patient himself. The subject was discussed under the following headings:—1. The posture of the head in its relation to that of the trunk; extension, flexion, and rotation of the head were considered. Stress was laid upon keeping the head, whenever practicable, in the longitudinal axis of the body. The circumstances which favoured the entrance of blood into the larynx and trachea were defined. 2. The influence of the force of gravity upon the circulation and respiration. The observations of Snow, the Hyderabad Commission, and of Dr. Leonard Hill were quoted; and the administration of anæsthetics to patients in the sitting and semi-recumbent postures was discussed. 3. The postures of surgery individually considered: (a) The dorsal, supine, or horizontal posture; the advantages of keeping the head turned to one side, and the disadvantages