

who was there while the epidemic was raging in Aleppo told me that the inhabitants believed that they owed the immunity which they had enjoyed to the purity of their drinking water. The same explanation is probably true in regard to the unexpected escape, in 1883, of Beyrout, whose water-supply is from the Dog river, conveyed in iron pipes to a distance of about eight miles. Cholera was then in Egypt, and more than 200 refugees came over and were put into quarantine. There were three cases of death from undoubted cholera among them, and a sentry at the lazaret, and two washerwomen, who washed their clothes, died soon after. Beyrout was pronounced officially to be infected, and was put into quarantine; but, to the amazement of everyone, there was no further extension of the disease.

Beyrout.

## PERSONAL OBSERVATIONS OF THE COURSE OF INFLUENZA AND OF CHOLERA IN ASIA DURING THE RECENT EPIDEMICS OF THESE DISEASES.

By BENJAMIN HOWARD, M.A., M.D., F.R.C.S.E.

THE following contribution to the history of recent epidemics as observed by me in Asia may be deemed worthy of a place in THE LANCET.

On leaving London in the autumn of 1889 for a prolonged detour in India and other parts of Asia, influenza was in the metropolis becoming the prevalent complaint. During November and December I encountered it in Naples and in Florence—the event most conspicuous in my mind in connexion with this epidemic in Italy being the death of Browning, the poet, who from a bronchitis following this disease died in Venice a few days after my arrival in that city. At Brindisi I took a steamer which had come direct from London. On board this steamer was a gentleman who landed with us in Bombay, still suffering from a severe and prolonged attack of influenza. As this was the only case on board, it became quite a subject of speculation whether or no he might not inoculate Bombay with his influenza. In Bombay, within six weeks, and before I left the hotel we were both staying at, influenza was common amongst the many regular residents of that hotel, and soon after appeared among the villa residents on the neighbouring suburban hills. From India there are three passenger steamship lines running to the healthy little port of Kohe, in Japan. After spending the following summer in the Okotsk Sea and Eastern Siberia, I returned in the end of autumn to Kohe, and immediately was myself attacked with influenza, with which about 30 per cent. of the inhabitants were confined to their houses, and many to their beds. From Kohe to Yokohama, the furthest eastern port, is a run of about thirty-six hours. Here nearly every house, European as well as Japanese, has been invaded by influenza, and of so severe a type that during my stay here many Europeans have died from it, many of the victims being men comparatively young, and of such robust habit that, from the ignoring of the disease, they invited the relapse which proved fatal. The only difference between the disease as it appeared in Japan and as I saw it both in London and India, is that in Japan the constitutional depression has been much greater, several weeks' confinement to bed having been not unusual.

Now for the cholera, which we know has been so severe throughout the greater part of the Japanese Empire the past year. In Bombay during the latter part of the winter of last year there was amongst the general public certainly not a thought about cholera. I was the more assiduous, therefore, to test the statement made to me by several medical officers to the effect that in the Bombay Presidency that disease is rarely or never totally absent. I was at last rewarded by finding a case in the city of Bombay. There had been rice-water discharges and cramps, and the identification of the disease had been endorsed by the removal of the patient to the cholera section of the General Hospital where I found it. I have spoken of the direct lines of mail steamers running from India to the various ports of Japan, Nagasaki, Kohe, &c., having their terminus at Yokohama. The July following cholera was reported to be at the first of these ports of call, Nagasaki. To this place I

went, where the reputed four or five cases I found by actual inspection to mean forty-five cases. Being myself *en route* for Siberia and a summer cruise in the Okotsk Sea, I took first the mail steamer route, the only line in direct communication with the eastern ports of Corea. Of these ports, Fusan and Jinsan, it was difficult to say which was the filthier, but both of them surpassed in this respect the dirtiest city I had seen even in China. One could not avoid the apprehension that, should cholera break out in either of these places, the whole population must be swept away by it. At Vladivostock, the first Russian port, and the terminus of this only line in direct communication with Japan, there appeared to be at first sight fairly good sanitary conditions. I soon found, however, that, although the situation is particularly good, all the water used is surface water, and this has to be paid for at so much a bucket, as everywhere in Siberia. Sewerage there is none. On the very next trip of this same steamer from Nagasaki, one of the passengers died of cholera, and the fire was lighted all along its route, including Vladivostock. Of Japan alone is it possible to give even proximate statistics; but, strange as it may seem, in Fusan and Jinsan—the Corean ports, where the corner of every street is an open and overflowing privy—the mortality has not been reported as astonishing. At the northerly Siberian port of Vladivostock the mortality was as great as in Japan, but the cases were comparatively few. In Japan, from July to Dec. 31st last, the total of reported cases was 45,034; deaths, 31,484, giving a mortality of over 69 per cent.

These travelling companionships I hope I have been in no way responsible for, but the coincidences mentioned have been interesting, and, as contributions to the history of these epidemics, may be deemed worth recording.

Yokohama, Japan.

## HERNIOTOMY, OR ABDOMINAL SECTION?

By HARRY LUPTON, L.R.C.P. LOND., M.R.C.S. ENG.,  
SURGEON TO THE STRATFORD-ON-AVON HOSPITAL.

I AM anxious to place on record the following two cases, and shall be only too pleased if their narration leads to the expression of opinions more authoritative than my own. My own bias is, and yet not strongly, to the abdominal method. I must let the cases speak for themselves.

On Sept. 28th, 1890, my friend, Mr. Fenton of Kineton, sent to me Mrs. B—, aged fifty-three, with a history of obstruction; no hernia could be detected at the usual seats; but her symptoms becoming so urgent that he considered abdominal section offered the only chance of recovery, she was admitted to the Stratford-on-Avon Hospital, and at once seen by the staff in general consultation. We could add nothing to Mr. Fenton's history of the case; and, as it was evident if the patient was not relieved she had only a few hours to live, it was agreed that I should at once open the abdomen, and endeavour to relieve the obstruction. This I did, and found a very small piece of small intestine, perhaps a third or a half of its circumference, nipped tightly in the right femoral ring. I withdrew it with very little difficulty, and found it dark but distinctly reducible, and returned it. Every precaution as to cleanliness was adopted, but no spray. The wound was dressed simply with absorbent wool. The operation was just done in time. For a time she looked almost like dying on the table; but the pulse improved with the withdrawal of the intestine from the ring, and half an hour after the completion of the dressings she was able to be removed from the table back to her ward. For the rest there is nothing to write about. Her symptoms were relieved, and she simply went on getting better. She was discharged cured on Oct. 28th, and has since been busy in her dairy. "Look on that picture and," alas! "on this."

Mrs. G—, aged fifty-seven, was admitted to the Stratford-on-Avon Hospital on Dec. 1st, 1890, suffering from strangulated femoral hernia. Her symptoms were urgent, and a consultation of the full staff agreed that immediate operation was necessary. When the patient was under chloroform, one of my colleagues, remembering the excellent result obtained in the case of Mrs. B—, said, "How are you going to operate, Lupton?" The same question was strongly at the moment present in my mind. I had been deeply impressed by the result of the former case, and was

half inclined to operate by the abdomen. But there was an obvious femoral hernia before me, and perhaps I lacked moral courage to depart from the beaten track. I therefore did an ordinary herniotomy, coming first to a piece of omentum, about the size of a walnut, firmly adherent along the margin of the ring. This was raised out of the wound, and under it was a knuckle of intestine, firmly gripped, but in no wise worse than in the case of Mrs. B—. Gimbernat's ligament was rather freely incised with Smith's combined hernia director and knife (to my mind one of the best surgical inventions of modern times), and the intestine returned without much difficulty. The finger following proved the ring to be free, and I had good hopes of the success of the operation. The operation was completed about midnight. On visiting the hospital the following morning, I found her symptoms, to my great disappointment, unrelieved. I was sure that I had freed the ring and returned the intestine; but, as apparently the only thing to be done, I opened the wound, passed my finger in, and found the ring free; no protrusion of intestine. The poor woman was too far gone to admit the question of any further operative means, and she died a few hours later. I obtained permission for a post-mortem examination, but on the following day my engagements were such as to entirely prevent my making it. It was therefore made by my assistant, Mr. Ivatts. He found the protruding omentum adherent along Poupart's and Gimbernat's ligaments anteriorly. Behind and within the abdomen was the returned knuckle of intestine; but behind the adhering omentum was a mass of adventitious tissue, the result, apparently, of an old localised peritonitis. Through an opening in this the intestine had passed, and thence on to and through the femoral ring. The intestine was held, but not firmly, in the upper opening, and was withdrawn without much traction being necessary. Mr. Ivatts stated that the capacity of the mass, in which the intestine lay, was about that of a small hen's egg. I deeply regret the result of this case, for I can but feel that, had I operated by the abdomen, I could easily have withdrawn the intestine from both its constricting rings. No doubt the state of the parts found was very unusual. Can it be of sufficient frequency to justify the abandonment of the old operation for the new? Again I say I shall be glad to hear opinions more authoritative than my own on the subject. I should be wanting in courtesy, no less than in gratitude, did I not refer to the kindly and able assistance rendered me by my colleagues, Messrs. Nason, Norbury, and Greene, in the treatment of the above cases.

Stratford-on-Avon.

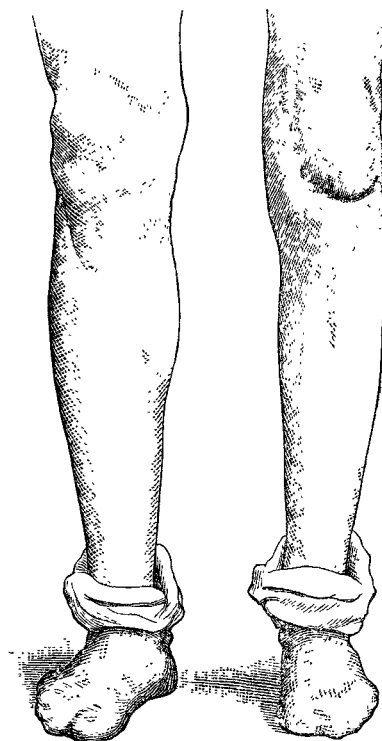
## NOTES ON TWO CASES OF ERASION OF THE KNEE-JOINT.

BY T. W. J. ALLEN,

HON. SURGEON TO THE GRIMSBY HOSPITAL.

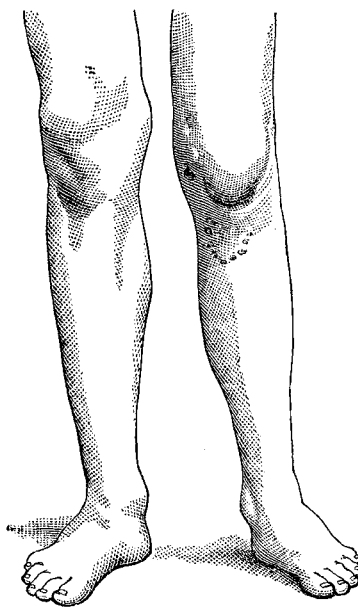
CASE 1.—E. A. S—, aged nineteen, was admitted into the hospital on Sept. 2nd, 1889. He had had a swollen knee for about twelve months. There was great pain on moving the joint, and nocturnal starting pains. He had been unable to work for the last three months. No history of an injury, and no family history of phthisis. The joint was slightly flexed and much swollen. There was also a sinus running upwards for three or four inches along the outer side of the external condyle of the femur. On Sept. 10th arthrectomy was performed. After applying Esmarch's bandage and tourniquet the usual horseshoe-shaped incision was made, the ligamentum patellæ divided, and the joint widely opened. The synovial membrane was much thickened, had grown partly over the cartilages, and was caseous in places. The whole of this pulpy granulation tissue, together with the infiltrated capsule, was dissected off; the crucial ligaments and cartilages, articular and inter-articular, were carefully scraped. The sinus was thoroughly scraped. The tourniquet was removed and the spurting vessels secured, and the tourniquet was then re-applied. The joint was thoroughly swabbed out with 1 in 40 carbolic. Iodoform crystals were rubbed into the recesses of the joint, the ligamentum patellæ was sutured with catgut, a drainage-tube inserted into the joint on either side and into the sinus, and the external incision was sutured with silver wire. The dressing was composed of carbolic gauze and carbolised wool, and a Gooch's back splint. The limb was elevated at right angles to the

body for twenty-four hours, and the tourniquet removed. The temperature remained about normal until the fifteenth day, and on the seventeenth day was 102°. The joint was then dressed for the first time. The external wound looked healthy, and good union had taken place. There was no pus. The drainage-tubes and wire sutures were removed. Temperature remained normal after this. The next dressing was on the fortieth day after the operation. The joint



was then perfectly healed and sound. The patient left the hospital in January, 1890, wearing a simple back splint. His general health has much improved, and now, fourteen months after the operation, he has a sound, useful limb, with movement to the extent of about 45°. He is working in a saw-mill, his duty being to feed a circular saw, and he is standing about ten hours a day. He says his leg feels tired at night, but he has no pain or swelling.

CASE 2.—A. W. S—, aged ten years, was admitted on Sept. 5th, 1889, in a very poor state of health, very thin and anæmic. Swelling and pain commenced in the left knee two years previously. It was first noticed that he limped a little, and complained of pain after exertion. The joint was very much flexed, there was a marked displacement of the head of the tibia backwards, and some



outward rotation of the leg. The lower end of the femur appeared to be much expanded. There was no family history of tubercle and no history of injury. Arthrectomy was performed, as in the preceding case, on Sept. 17th. On freely opening the joint a small amount of pseudo-purulent matter escaped. The synovial membrane was caseous in many places and extremely thickened, the fibro-cartilages had entirely disappeared. The articular cartilages were per-