

of any local application. The last case in which ice was applied to a hernial tumour, was in the instance of a man, aged sixty, who was admitted with an enormous left inguinal protrusion. The symptoms were urgent, and from the tympanitic resonance of the swelling, it was inferred that the protruded bowel was much distended with flatus. A large bag of ice was applied for half an hour, when the contents of the hernial sac suddenly went back into the abdomen without manipulation having been needed. The symptoms of strangulation went off, and the patient shortly afterwards passed three copious motions, apparently nearly all blood. From this time he gradually got weaker and weaker, and died on the sixth day. On post-mortem examination, the mouth of the inguinal sac was found to admit of the easy introduction of two fingers. The bowel that had been down was represented by nine feet of the small intestine, which was black from congestion. It was not ulcerated in any part, nor did its cavity contain blood. This patient, three weeks before his admission, had suffered from the descent of the rupture, but the symptoms of strangulation had not been so severe as on the last occasion, and the taxis, without the use of cold, had proved successful. On the first occasion he also vomited, and passed blood by the rectum. He, however, rallied afterwards. Without saying positively that the topical application of cold to so large a surface as to nine feet of bowel was the unfortunate cause of this patient's death, it still appeared to have produced an amount of shock on the organic nervous system, under which the patient sank. Had the hernia been one-half or two-thirds the size, a different event might have taken place. Regarding this as an exceptional case, and in reference to its fatal termination, as open to a different interpretation, I think highly of the topical application of cold in incarcerated hernia, and in conjunction with the previous or subsequent exhibition of enemata. It may be asked what is meant by an incarcerated hernia, for in systematic works on rupture and its complications, there is a vagueness of explanation of this expression, which puzzles the student wonderfully. If I may venture on the difficult ground of definition, I would observe, that in incarcerated hernia the obstruction, and possible ultimate strangulation, are *slowly* brought about by changes occurring in the gut itself; in strangulated hernia, properly so called, the obstruction is *rapidly* caused by changes in the gut, effected in consequence of the presence of structures extrinsic to the gut. It therefore follows, that in incarcerated hernia the remedial measures should be applied directly and indirectly to the gut itself; in strangulated, to the parts extrinsic to the gut, supposing, of course, the taxis not to have succeeded in the latter. In the former group of cases, the treatment directed for their relief is usually successful, without it being found necessary to enlarge by the knife, the mouth or neck of the sac, or parts around it; whereas in the latter group, the parts around the neck of the gut usually require more or less surgical interference, in order to do away with the primary cause of obstruction. In other words, general and local treatment, without the operation, usually answer in cases of incarcerated hernia; but the operation, without local and constitutional treatment, is fundamentally efficacious in strangulated hernia. In the group of incarcerated hernia, we may reckon principally old reducible or irreducible ruptures, with enlarged aperture to sac, and in which deterioration, or arrest of function, has slowly ensued, in consequence of distention by faeces above or below, or in the protruded bowel, vascular congestion from too copious or too irritating meals; the consequences of injury short of actual inflammation and lesion; and other obscurer causes.

Before proceeding to extract a few very interesting cases from amongst the thirty-one not mentioned in my pamphlet, I would say a few words concerning the examination of a patient supposed to be affected with strangulation of the bowel, or with symptoms resembling it, and also would make one or two remarks in reference to the operation for the relief of femoral hernia.

Whenever a patient is seized with pain in the umbilical region, accompanied with nausea or vomiting, the propriety of examining the abdominal apertures should be regarded as a cardinal rule. This rule, however, in consequence of the comparative rarity of rupture in private practice, is, I fear, apt to be somewhat slighted; and it now and then happens that a case is treated for many hours as one of dyspepsia, colic, or enteritis; leeches, counter-irritation, cataplasms, fomentations, and drugs are ineffectually brought to bear, followed by an aggravation, instead of a diminution of the symptoms. An examination of the abdominal walls is subsequently instituted, and a hernial tumour probably detected. An operation is performed, and the chances of death will mainly depend on the

time it has been deferred. I am personally acquainted with one or two cases of such fatal oversight. The ignorance and false modesty of patients frequently also aids the surgeon in the establishment of a faulty diagnosis, and it will be found, strange as it may appear, that patients suffering from strangulated hernia now and then are quite unconscious of the existence of any swelling, or if they know of it, are surprised on being informed that the severe symptoms under which they are suffering have anything to do with the swelling they have had for years, particularly as the pain that has accompanied these symptoms is usually referred to a part of the abdomen remote from the position of the tumour. My friend, Mr. Ray, of Sittingbourne, informs me that on one occasion an elderly female was operated on by him, who, he found on inquiry, had been suffering from symptoms of strangulation for thirteen days. During this period she had consulted no one, nor would her husband let her, but relied on his own medical powers, which consisted in the use of some simple medicines, and a recommendation to take exercise for her relief, so that the patient had accomplished several long walks during this interval. On Mr. Ray being eventually called to see her, and on his explanation of the nature of her affection, the astonishment and incredulity depicted on the countenance of the wife and husband was great, and the former remarked, before consenting to an operation, "Now, doctor dear, do you really think that this here (putting her hand on the groin) has anything to do with the sickness." The poor creature, I need hardly say, died, as on opening the sac a false anus became soon established, and she sank rapidly. When a tumour has been detected in, or protruding from, say, one femoral, or one inguinal canal, the examination should not even then be deemed sufficient, but all the abdominal apertures should be examined. However redundant such precaution may appear in the majority of cases, experience forcibly dictates the necessity of attending to it, and the mere circumstance of one fatal case having taken place from such deficiency of supervision, fully warrants its adoption. A large, fat woman was admitted suffering from symptoms of strangulation of more than usual severity. Examination detected a large umbilical hernia. This was reduced without much difficulty, but the symptoms were not relieved. It came down again, and then could not be returned, and an operation was performed. Omentum only was found in the rupture. The symptoms of strangulation continued, and she died. On a post-mortem examination a knuckle of intestine was found in the femoral ring, perfectly sphacelated. There had been also considerable peritonitis.

Independently of a small hernia being overlooked, when the attention is concentrated on a large one somewhere else, two or three herniæ may be detected at the same time, and there being severe strangulation symptoms, it becomes a question, which of the protrusions, or whether more than one, should be selected for the operative proceedings of the surgeon. The late Mr. Robinson, in a valuable paper, "*On the Complications of Hernia*," which was published in the *London Journal of Medicine*, quotes the following case:—"Mr. Luke was called to a female who was labouring under an inguinal and an umbilical hernia, with symptoms of strangulation. Both ruptures were very tense and painful, and both were irreducible. The former was small, and was apparently contained in the inguinal canal; of the two it was the more tense, and could be obscurely felt through a thick layer of fat." He was induced to operate on this one. He found, upon opening the sac, a portion of small intestine tightly strangulated. He divided the stricture, and returned the bowel. Relief followed; the symptoms subsided, and the woman recovered.

(To be concluded.)

ON THE TREATMENT OF SIMPLE ERYSIPELAS.

By J. HAWKES, Esq., M.R.C.S., &c.

DAILY experience teaches us that an adynamic type of disease generally prevails. Those vigorous, antiphlogistic, depletory measures once in vogue are now seemingly uncalled for; and thus the practice of phlebotomy has ceased to be the rule and is become the exception.

But it is principally in treating diseases of the blood that we learn how far the system is changed, and of these simple erysipelas affords a marked example. Space alone prevents us from

considering how, step by step, this change has been brought about; but those who carefully read the reports of our large hospitals, who examine the views of their medical officers, or who collect evidence in their own immediate sphere, must have found a tonic or stimulant plan to be almost universally adopted. In numerous cases during the past year or so, I have enjoyed several opportunities in my own practice for putting the efficacy of this plan to the test. It may be that constitutions nowadays more generally succumb to the influence of erysipelas, as well as furunculoid disorders; it may be that the crisis of the blood loses its integrity through a vitiated condition of the system, the *facilis descensus* of decay; be this as it may, the treatment for these diseases is sure. I know, indeed, of none which may be treated—nay, vanquished—so easily. We have all heard or read of the tincture of the sesquichloride of iron in erysipelas, yet it seems to me that very few give this medicine the attention it deserves. It is especially in erysipelas of the head, often attended with the gravest symptoms, that this remedy steps in like a charm. A stout man, of full habit, came under my care for a blow received from an iron wedge, of considerable weight, flying out of an hydraulic press, and striking him in the centre of his forehead. The integument was divided from the roots of his hair to the bridge of his nose; the margins of the wound were approximated and retained by strips of plaster, cold water applied, a purgative ordered, and the patient sent home. Three days passed, and he laughed at my warning of erysipelas. The wound was going on well; his health seemed perfect. About the fourth day, I found erysipelas of the scalp and brow fully established, and ordered accordingly a drachm of the tincture every six hours. A couple of days after he walked two miles, the affection having altogether disappeared; the wound rapidly healed, and he made a most successful cure.

Another case is that of a lad whom I was called to when head symptoms had already supervened. The report says, idiopathic erysipelas, with cerebral congestion.

J. H—, aged seventeen. Erysipelatous inflammation, extending over half the face and part of the scalp; swelling very great; severe pyrexia, with pain in the head and delirium. To have two ounces of cathartic mixture immediately; and chloride of mercury, two grains; rhubarb powder, eight grains; made into powders, and taken twice a day. Also a febrifuge mixture, (containing potassio-tartrate of antimony,) an ounce and a half three times a day. A cantharides plaster to be applied to the neck.

Following day.—Patient no better; the swelling seems increasing; general heaviness of expression; almost comatose; pain remains. Ordered, sesquichloride of iron, half an ounce; peppermint water, five ounces and a half; an ounce and a half to be taken three times a day. Repeat powder and cathartic mixture.

Improvement commenced soon after taking this medicine. In the space of two days, the worst symptoms began to disappear, the tumour was subsiding, and inflammatory action vanishing away. The cure was afterwards conducted with disulphate of quinine, two grains and a half every six hours. Under this treatment, he was soon quite well.

Another patient, a girl of fifteen, had sunk into a comatose state, under a most severe attack of idiopathic erysipelas of the scalp and face. After suitable purgatives, I administered the tincture in drachm doses; but the effect not being sufficiently marked, I increased it to two drachms thrice a day, with the happiest result. By the second day, the disease was overcome, and the child safe.

I need not recapitulate other instances with which I am familiar; they all tend to the same purpose; but, in conclusion, will state an interesting case that I witnessed on a recent visit to a professional friend in the south. One of his patients, an infant about nine months old, was suffering from severe, though simple, erysipelas of the face and scalp. The surgeon had employed the usual orthodox means—and he is one familiar with the weapons of our art—but still the affection continued. At my suggestion, a few drops, from three to five of the tincture, were exhibited, and, to his own surprise, and my great satisfaction, after the first three or four doses, the complaint had fled, and the child was cured.

These few cases, thus briefly and roughly drawn, may perhaps induce some who read them to give a fair trial to means which never fail.

January, 1856.

TRINITY COLLEGE, DUBLIN.—The degree of M.D. has been conferred on William Edward Steele, and John Waddy.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.* lib. 14. Proœmium.

KING'S COLLEGE HOSPITAL.

LITHOTOMY.

(Cases under the care of Mr. FERGUSSON.)

CASE I.—James F—, aged sixty, was admitted into the London Ward, with stone, on December 15th, 1855. He was a native of Scotland, but had lived for the last twenty years in Ireland, as a farmer and land-steward. He had been habituated to good but moderate living, was a married man, and had had good health. He first noticed something wrong in his urine five years ago, the micturition becoming frequent and painful. During the last two years the symptoms had increased, and about two months previous to coming to the hospital, he observed a thick gelatinous deposit precipitated from the urine.

On admission, he had the appearance of a healthy man, with some tendency to corpulency. He was forced to pass his urine day and night, every hour; but rarely more than an ounce, and that only with great pain, was passed. The pain following micturition was very severe down the urinary passages and at the neck of the bladder. A sharp turn in the bed or a sudden cough, caused the same pain. Urine acid, and containing a little albumen.

December 22nd.—The rectum having been cleared out with an enema, Mr. Fergusson performed the lateral operation for lithotomy in the usual manner, the corpulence of the patient and a narrow pelvis rendering necessary a deep wound. A large calculus composed of a nucleus of lithic acid, coated with super-phosphate, was withdrawn. The first time it was seized on, it crumbled partially under the forceps, and the greater part was taken out in a mass.

23rd.—Patient looks pretty well. He complains most of great pain in the left shoulder, which has been previously subject to rheumatic attacks, and he is a little feverish; otherwise he is doing well. A few clots came away after the operation, and since then the urine has passed freely. He complains of no tenderness about the abdomen.

24th.—The bowels not having been moved since the last enema, a dose of castor oil has been administered, which has opened them freely. A plaster has been placed on the left shoulder, in which he complains of severe pain. He did not sleep much during the past night, although he had taken a composing draught.

25th.—The patient does not look so well; pulse 118, irregular; he does not sleep, but still takes his beef-tea pretty well; great pain in the shoulder; scarcely any tenderness in the abdomen; urine continues to pass freely. He is ordered brandy and opium.

26th.—Looks better; otherwise much the same.

27th.—Pulse 94, very irregular and weak. He complained last night of much pain in the right knee, as well as in the shoulder. The affected joints have been wrapped in cotton wool. There is very little tenderness in the abdomen; and the urine continues to pass freely.

28th.—During the last twenty-four hours, the patient has been going from bad to worse, and worse. As long as he remained sensible, he complained of the great pain in the shoulder and knee-joints. He died this afternoon.

Post-mortem Examination.—The body was corpulent; a thick layer of fat covered all the abdomen and chest; the muscles were red and healthy. On detaching the deltoid muscle, pus was found in the bursa lying between it and the head of the humerus, not in any large quantity, but thick and yellow; it did not extend into the left shoulder-joint. In the knee-joint on the left side, there was a larger collection of sero-purulent matter. The back of the wound was dark and unhealthy, with little collections of pus about it. There were