

28th, when it died, faecal matter being vomited about two hours before that occurrence.

Post-mortem examination.—On opening the abdomen the ileum was found much distended both with faecal matter and air; the stomach quite empty and collapsed; the caecum, ascending and transverse colon, with a portion of the ileum, had passed into the descending colon as far as the sigmoid flexure; the intus-suscepted parts were in a high state of congestion, with patches of extravasated blood here and there.

King's-row, Walworth-road, March, 1853.

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, tum aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Prooemium.

KING'S COLLEGE HOSPITAL.

Complicated Dislocation of the Os Calcis, carrying with it all the Bones of the Tarsus, with Pott's Fracture of the Fibula; Death; Autopsy.

(Under the care of Mr. HENRY LEE.)

THE different dislocations to which both the upper and lower extremities are liable have up to the present time been carefully studied; the works of Sir A. Cooper and Malgaigne (the latter unfinished) prove how much diagnosis can be aided by the accurate noting of symptoms, and how the luxations which accompany certain accidents can be calculated and foreseen. Our continental brethren are in the habit, in order to elucidate obscure points relating to dislocations, of experimenting upon the dead body, simulating falls and the application of violence. This is hardly a satisfactory mode of investigating the matter, as muscular action, which so powerfully influences either the occurrence or the direction of luxations, is in such experiments necessarily absent. In spite of these investigations and careful observation, accidents will here and there occur, which present an unexpected combination of circumstances, and are followed either by fractures or dislocations of an unusual and startling kind. Such is the luxation which Mr. Lee had recently to treat.

It will be seen by the sequel that the os calcis was forcibly driven outwards, retaining its connexions with the other tarsal bones, and leaving the astragalus jammed between the two malleoli. Dislocation of the astragalus forwards and the necessity of removing that bone occur pretty frequently; so does also a luxation of the os calcis and astragalus from the rest of the tarsus; but there are few or no cases on record in which the os calcis alone was driven outwards, retaining its relation with the cuboid bone. We hasten, therefore, to put Mr. Lee's case upon record, aided by the notes of Mr. Tomkyns, the dresser.

John L.—, aged twenty-two, a printer, of temperate habits, was admitted December 20, 1852, under the care of Mr. Lee. He states that while at work a large iron slab fell on his right ankle, and remained on the limb three or four minutes, at the end of which time he was extricated. As there was much hæmorrhage on admission, Mr. Lawson, the house-surgeon, put a temporary ligature on two arteries.

When Mr. Lee arrived, he had the patient taken into the theatre, and chloroform administered. On examination, he discovered a complicated dislocation of the os calcis, carrying with itself all the bones of the tarsus. In fact, the os calcis had been forcibly driven outwards from the astragalus, which latter bone was left in its situation between the two malleoli; there was also fracture of the fibula. The posterior tibial artery and vein were exposed for about two inches, but not torn, though some of the branches were wounded.

Mr. Lee, after some efforts, reduced the dislocation, removed a splinter from the upper part of the os calcis, and tied the arterial branches which were ruptured. The wound was closed with sutures, a pad of dry lint placed on it, and the limb gently placed on an outside splint. The patient was then removed to bed, and ordered to be well watched.

For the next two days the man passed very high-coloured

urine, slept badly, and felt severe pain in the leg. The urine was soon tinged with blood, and the restlessness increased.

On the fourth day Mr. Lee opened an abscess which had formed on the external aspect of of the ankle; the discharge from the original wound at the same time was considerable.

On the fifteenth day, rigors and vomiting set in; the patient perspired profusely, and he stated that for the last two days the sputa had been tinged with blood.

For the next six days the rigors recurred almost every twenty-four hours, and two days afterwards Mr. Lawson, the house-surgeon, opened a large abscess which had formed in the lumbar region, and let out seventeen ounces of pus mixed with dark-coloured blood.

This collection of matter was explained by the fact of the patient having hurt that portion of his back at the time of the accident. He became, however, gradually weaker, and died January 18, 1853, twenty-eight days after admission.

The examination of the limb showed that the accident had been exactly what Mr. Lee had diagnosed. The large tuberosity of the os calcis had been broken off, and the lower end of the fibula was fractured. The articulating surfaces between the os calcis, astragalus, and the cuboid bones, were denuded of cartilage. The femoral vein, up to the iliac veins, was filled with pus or putrid fibrine, and the left pleura also distended with purulent fluid.

The great point of interest in this case, besides the unfrequent occurrence of the dislocation above mentioned, is the question of amputation. We have often ventured to say that rules, as given in systematic works, are sometimes peculiarly inefficient, and that a great deal of judgment is ever necessary for their application. Cases occur like the present, for instance, when a compound luxation seems to demand immediate amputation; but when it is found that no principal arterial branch has been injured—when the soft parts are not extensively torn—when the patient is young, and enjoys tolerable health, the surgeon may waver and make an attempt to save the limb. The pathological complications which may then be apprehended are, of course, severe inflammation, profuse suppuration, erysipelas, and lastly pyæmia. In the present instance, the mischief is clearly attributable to the latter affection; and we see it occur so frequently, that we are inclined to think that the possibility of the patient being attacked with pyæmia should be allowed to have considerable weight in the surgeon's calculations. We would fain enter upon the controverted question of the poisoning of the blood by pus, but must reserve this discussion to a further occasion. We alluded to Mr. Lee's theory in last week's LANCET, (vol. i. 1853, p. 296.) and shall gladly return to the subject, as also to the arguments used by Mr. Gamgee, house-surgeon to University College Hospital, who combats Mr. Lee's views.

ST. MARY'S HOSPITAL.

The Case of Uterine Epilepsy in which Tracheotomy was performed.

(Under the care of Dr. TYLER SMITH.)

DR. MARSHALL HALL, as is generally known, advised tracheotomy to be performed upon patients suffering from inorganic epilepsy with laryngismus, where danger to life, mind, or limb, was present. Dr. Marshall Hall wished to counteract the effects of the spasmodic closure of the glottis by this operation. It has been erroneously supposed by some medical practitioners that the immediate object held in view by Dr. Hall was the cure of epilepsy by tracheotomy; this is, however, not the case, if we may judge from the papers which have been published in this journal on this important object. It is plain that the circulation of venous blood in the brain must give rise to a state of parts which may aggravate the fits, render them more frequent, or act injuriously upon the cerebrum during the intervals; whilst the constant and uninterrupted supply of arterial blood to the brain is likely, in these cases, to have a contrary effect. This beneficial result is being exemplified in the case of which we published the first part a short time ago, (THE LANCET, vol. i. 1853, p. 224.) and we now gladly return to it, as the patient is on the eve of being discharged.

Our former notes of this case extended up to the 1st of March, and we now proceed to place before the readers of the "Mirror" an account of the patient up to the present time, March 31st.

Before the performance of the operation, the patient remained in the hospital one calendar month, during which time she had nine fits. Nearly seven weeks have now elapsed since the operation, and she has had, during this period, five seizures.

The first of these attacks occurred on the 3rd of March, eighteen

days after the operation. On the morning of the 10th, or twenty-five days after tracheotomy, the catamenia appeared: she had one fit that day, at half-past two P.M., and a second at half-past seven P.M. A fourth fit occurred on the 11th of March; and the fifth and most severe, at two P.M. on the 13th, twenty-eight days after the operation. Since this time the patient has been free from any epileptic attacks.

The woman has been carefully watched during the whole of her stay in the hospital; and it is interesting to observe the modifications caused in the fit by the opening of the trachea. The face becomes dark and livid, but not so much so as before the operation. There is foaming at the mouth, the face is convulsed, and the tongue has been bitten. She does not now utter the epileptic cry before the seizure is established; but the limbs are convulsed, and a great noise is made during the struggle by the passing of air through the tube. Altogether, the fits have been considerably slighter since the operation than they were before.

The patient used to fall into a heavy sleep after each fit, and remain sleeping for several hours, being very stupid on awaking. She now sleeps for a short time after the fit, but is soon recovered from its effects. Her intellect has decidedly improved: to this all the persons in the ward bear testimony. Before the operation, she remained sullen and silent; she was, in fact, in a state of fatuity, and believed that the other patients were constantly "talking at her": she now enters into conversation, and is comparatively rational. Before the operation, she had several fits of maniacal excitement; but she has since been quite orderly and under the control of the nurses.

The noise made through the tube, during the fit, as compared with the former arrest of respiration, and the improved state of the brain, show that the oxygenation of the blood is much less interfered with now than formerly. The circulation of venous blood in the brain, and the strain upon the cerebral vessels, are probably the chief reasons of the sopor which so commonly succeeds the fit and the chronic deterioration to the brain. From these, the opening in the trachea appears to guard the patient; and perhaps this is the most positive benefit which has accrued in the present case. She has had a less number of fits, and they have certainly been less severe, but a greater length of time than has hitherto elapsed will be necessary before any positive conclusion can be arrived at on these points. The patient will shortly be sent into the country; but we shall probably be able to give the further results of the operation, whatever they may be.

During the severe weather in the middle of March, the patient caught cold, and there was so much secretion in the trachea as to clog the tube, and seriously interfere with her breathing. The tracheal secretion was extremely fetid. For two or three days she was dull and stupid, evidently from the imperfect respiration; but a new tube, admitting of more perfect respiration, was put in the opening, and in two or three days she became better. With this exception, no local irritation of any kind has followed the operation.

ST. BARTHOLOMEW'S HOSPITAL.

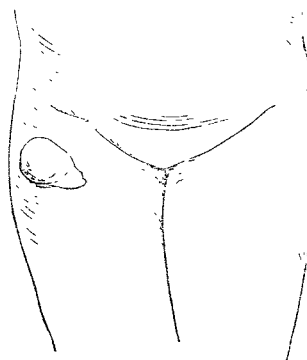
Femoral Hernia in an Epileptic Patient; unusual Situation of the Tumour.

(Under the care of Dr. ROUPPELL.)

IN the wide field of hospital practice, cases in which diagnosis is somewhat difficult are not unfrequently observed, and among these we must put tumours in the first rank. When the latter are situated in the abdomen, the most disheartening uncertainty as to their nature often exists; and even when they are properly classed, the physician experiences the annoyance of finding the disease beyond his control. We need not say that tumours about the head, neck, trunk, or extremities, also offer, now and then, considerable difficulties as to diagnosis, since it is mostly *after* ablation only that their nature is satisfactorily ascertained; but the same amount of obscurity does not obtain respecting hernia, though great uncertainty may exist in exceptional circumstances. Such doubts are sometimes very perplexing, and many cases might be cited in illustration, but we shall just refer to a few of them. Among these two occurred at Guy's Hospital (see *THE LANCET*, vol. ii. 1852, p. 300, and vol. i. 1853, p. 266), and one was noticed a short time ago in Dr. Roupell's wards. Mr. Croft, the clinical clerk, was kind enough to direct our attention to the case, and to furnish a drawing, which accurately represents the situation and relative size of the tumour. It is unfortunate that no satisfactory history could be obtained, as the patient's state of mind is not such as to allow of clear statements; the only particulars of this seemingly *external crural hernia* are the following:—

Mary Ann S—, aged fifty-four years, was admitted into Mary's ward, under the care of Dr. Roupell, October 7, 1852

The patient has been affected with epilepsy for several years, and it is for this malady that she was seeking relief in this hospital. Whilst under treatment it was observed that a tumour existed in the upper and external part of the thigh. The swelling was soft, elastic, painless, globular, and very moveable. It was at first supposed that this growth was composed of adipose substance, as it had many of the characters of such tumours; but, on being handled, it was found that it yielded to a pressure upwards, and when this pressure was continued, the tumour passed upwards and inwards towards Poupart's ligament, and remained within the abdomen. But, on the patient coughing, or resuming the erect posture, the tumour would again escape from the abdomen and resume its place in the above-mentioned locality. (See the accompanying wood-cut.) We had frequent oppor-



tunities of examining this patient, and found no difficulty in reducing the tumour, which latter, from the symptoms enumerated, can hardly be called anything but a hernial protrusion. No account of the rise and progress of the swelling could be obtained from the patient; but it would appear that she had worn a truss on the *left, or opposite* side, for twelve years or more. No sort of uneasiness was ever felt in the tumour situated in the right thigh; from this circumstance, and the peculiar feel of the part, it may be inferred that it consists principally of omentum. What peculiarity in the anatomical arrangement has caused this tumour to take this unusual direction? Probably a laxity in the fascia at the saphenic opening, which has caused the protrusion to press downwards and outwards, rather than to turn upon itself and mount over the pubis. Without pretending to rely exclusively on this explanation of ours, we beg to leave the case in the hands of our readers.

Mr. LAWRENCE's Case of malignant Tumour of the Dura Mater. (*THE LANCET*, vol. i. 1853, p. 267.)

A few inaccuracies have crept into the account of this case, and we are anxious that they should not remain uncorrected. Some of these are self-evident: *practically* (p. 268, half column) should have been printed *practicably*; and the woman was operated upon Dec. 15, 1852, and not 1853. The patient did not die *one week*, but *one month*, after her return home; and what we called a clot of blood situated in the cerebellum was really a portion of *medullary disease* surrounded by a clot.

MIDDLESEX HOSPITAL.

Tumour over the Parotid Gland; Removal.

(Under the care of Mr. SHAW.)

WE call attention to this case, as the patient seemed to be affected with a cancerous degeneration of the *parotid gland*, and because the operation which was performed might be looked upon as an extirpation of the latter. It has, however, been often denied that the parotid gland could be safely excised, and the doubts raised on this subject are certainly very legitimate; for it is very probable that the removal of growths, pressing upon and *almost* annihilating the gland, have been taken for actual ablation of the gland itself. When we recollect the vessels and nerves which are imbedded in the parotid, it becomes clear that paralysis of one side of the face must unavoidably follow its extirpation, that the external carotid must be tied, and that the salivary secretion must considerably suffer. Nor is it possible that the *whole* gland be extirpated, from the great depth to which its different processes are known to reach.

The cases which were looked upon as instances of removal of the parotid gland, were probably similar to the present case, in which a tumour of large size has gradually encroached upon the gland, and almost taken its place. We witnessed this operation with great interest, as the tumour was so situated as to require a dissection of a most delicate description, both as regards vessels