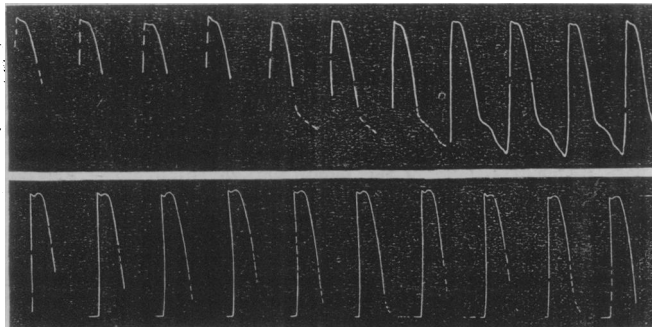


Dr. Becker states that the phenomenon is not invariably present in cases of incompetence of the aortic valves, nor is it at all times visible in those cases in which it has been observed. It was previously noticed by Dr. Quincke, assistant to Dr. Frerichs.



I am indebted to Dr. Purser for the sphygmographic tracings of the man's pulse.

MANAGEMENT OF THICKENED OR DISEASED OMENTUM IN HERNIA.

BY THOMAS LEEDS, ESQ.,

Lecturer on Physiology in the Sheffield School of Medicine.

IN cases of hernia, where the sac has been opened and found to contain thickened or diseased omentum, what is to be done with the omentum? As the opinions of surgeons are still divided upon this point, I may, perhaps, be excused for describing the particulars of a case which has lately occurred in my practice. The plan of removing the omentum, applying ligatures, and returning into the abdomen, is, I believe, deservedly falling into disrepute. The best practice lies, it would seem, between the plans (1) of leaving the omentum in the wound; (2) of removing it and allowing the upper portion to remain in the wound; (3) of leaving the omental tumour outside the wound, and applying a ligature around it, with a view of causing it to separate, and of setting up adhesions around its neck. Various eminent surgeons, including Syme (*Principles of Surgery*, 1863) and Callender, recommend the first-named mode of practice. Mr. Callender says: "Unless, however, it" (*i.e.*, the omentum) "is unmistakably gangrenous, it should, as a rule, be left in the wound, and the wound should be left partly open for drainage. I never saw any result from removing omentum, except now and then a troublesome bleeding. I never saw any harm from leaving it in the wound; but I have seen the disastrous consequences of returning, even what one hears called 'not bad-looking' omentum, into the cavity of the abdomen." (*St. Bartholomew's Hospital Reports*, vol. iv). Mr. Callender elsewhere also urges the necessity of leaving a portion of the wound open for drainage. Of the second, or immediate removal plan, I know little; but, as there is some danger of hæmorrhage and its consequent debilitating effect upon the patient, and the possible risk of peritonitis through blood escaping into the abdomen, it seems to me inferior to the third plan—that of applying a ligature. In Holmes's *System of Surgery*, vol. iv, is given the result of some cases in which the ligature was successfully applied at St. George's Hospital (by Mr. Pollock, I believe). "Of twenty cases, in which the omentum was securely tied, a few died; but the notes of the after-death examination of these show the cause of death to have been, in all cases, independent of the ligature placed around the omentum. Of eleven cases in which the omentum was allowed to remain in the sac, many recovered, although abscess and sloughing of the tissue occurred in some of them."

CASE.—On November 3rd, I was sent for to see a woman, aged 61, who had been vomiting for four days, and was now throwing up stercoraceous matter. The history of the case pointed to an irreducible hernia of six years' standing. The taxis having been tried, without success, assisted by my friend, Mr. Fayer, I cut down and found a pad of omentum, of the size of a large hen's egg, under which lay a knuckle of liver-coloured intestine. The stricture (at the external ring) was divided, and the bowel returned. Taking into consideration the length of time that the omentum had occupied its present position, it was deemed unsafe to return it. The omentum was left outside the wound; sutures being placed on each side, so as to constrict it, as far as possible, and to prevent the escape of fluids into the abdominal cavity. A ligature was afterwards placed tightly around the omentum. On the

tenth day, the removal was completed by means of the *écraseur*. There was scarcely any hæmorrhage. The patient recovered without a bad symptom throughout, and is now (November 18th) able to sit up. By thus constricting the neck of the tumour, this patient—an old woman—was saved from the chance of exhausting suppuration, which occasionally follows the plan of leaving the omentum in the wound, and from the injurious effects of troublesome hæmorrhage, which has been known to occur through the immediate removal of omentum.

In another case of a similar nature I should be inclined to use the *écraseur* earlier—about the fifth or sixth day—as adhesions would by that time in all probability have taken place.

A PLAN FOR FACILITATING THE REDUCTION OF STRANGULATED HERNIA BY TAXIS.

By PHILIP CRAMPTON SMYLY, M.D., F.R.C.S.I., Surgeon to the Meath Hospital.

"THE objects to be attained in the treatment of hernia in a state of strangulation, are the release of the protruded parts from stricture, and their replacement within the abdomen, provided they are in a suitable condition." These objects are usually sought to be accomplished either by taxis or by operation with the knife."

Some years ago, a nurse in one of the medical wards in the Meath Hospital had a reducible femoral hernia. She neglected to wear a truss, and one day it consequently became strangulated. My father, being the surgeon on duty, tried taxis, as did also the other surgeons, without success. After consultation, an operation was decided on, but every argument failed to persuade the patient to submit—she would rather die than be cut. After the surgeons had left, the clinical clerk (since a very distinguished medical officer in the army) and I thought it a good opportunity to study the relation of the ring to the sac. The result of our examination not a little surprised us. On withdrawing my finger from the ring into which I had inserted it, we heard a distinct gurgle. My fellow-student pressed the tumour, and it passed into the abdomen. The patient lived for many years afterwards, and performed her duties in the hospital. I have since frequently tried to repeat this happy manoeuvre, and with most satisfactory results.

For inguinal hernia in the male, the index finger is applied to the lowest part of the scrotum. This is invaginated (as in Wutzer's operation for radical cure), the finger being passed behind the testicle and cord up to the external ring. The hernial tumour is then pressed down-

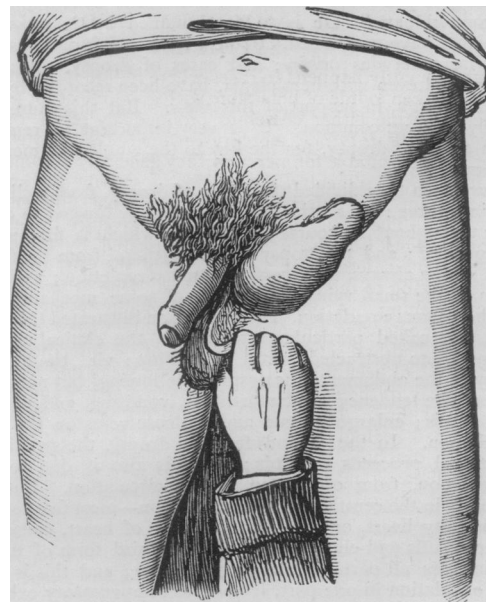


FIG. 1.—Scrotum invaginated.

wards over the finger towards the back of the hand, so as to make the structures in the ring tense, and consequently smaller. The invaginating finger is then forced firmly upwards and outwards in the direction of the internal ring. As soon as the finger is firmly grasped, the

hand should be slightly turned, and the finger pushed towards the middle line. Considerable force may be safely applied in this way, as



FIG. 2.—Finger pressing inwards.

all the delicate structures are behind the finger, which acts mainly on the stricture. On withdrawing the finger, the hernia can usually be easily returned. The same principle is equally applicable to femoral hernia. This plan may have occurred to others; but if so, it is perhaps not generally known, and any suggestion by which a cutting operation may be safely avoided is acceptable to the practical surgeon. My colleague, Mr. Porter (surgeon to the Queen in Ireland), was much pleased with the success of this plan in a case of inguinal hernia strangulated four days; and he has since tried it himself with satisfactory results.

The advantages which I claim for this procedure are—1. The strangulating portion of the ring is dilated before any pressure is applied to the bowel; 2. Much greater force may be applied to dilate than could safely be brought to bear when the intestine itself is employed for dilatation, as in ordinary taxis; 3. There is much greater probability of returning the bowel into the abdomen in a good condition, and, consequently, in a number of cases avoiding a dangerous surgical operation.

CLINICAL MEMORANDA.

THE IODIDES OF AMMONIUM AND SODIUM IN SYPHILIS.

It not unfrequently happens in cases where iodine is required, and the patient has taken iodide of potassium with good effect for a certain time, that this medicine either ceases to produce any result, or is no longer tolerated. *Faute de mieux*, mercury is sometimes resorted to; but, as the cases are not suitable for mercury, they generally become worse while taking it. In this difficulty, the iodides of sodium and ammonium are very useful, for they affect the body somewhat differently from the potassic salt. They can be borne by, and produce the effect of iodine in many persons who have become nauseated by the latter. They moreover contain less alkali per weight of the salt, and their alkali is less deteriorating to the blood than potash. One or two cases will illustrate my meaning. A gentleman was brought to me by his medical adviser, with extensive and obstinate syphilitic ulcers of the tongue and palate. He had had several other forms of syphilis during the nine or ten years he had been infected, and was in a weak and low-spirited condition. Early in the disease, he had taken mercury and other remedies in the usual way. Latterly, for the ulcers in his mouth, iodide of potassium had been given in doses gradually increasing to a scruple, and even half a drachm; but, when I was consulted, these had ceased to check the disease, and had produced iodism. In consequence of this, mercury and several other drugs had been tried again without benefit. Though his tongue was foul, his appetite, but for the pain of eating, was good. This is important; if the digestion be deranged, it must be set right again before iodine can have fair play. Under these circumstances, the patient was ordered to begin with eight-grain doses of iodide of ammonium in bitter infusion three times daily. He bore this well, and in the course of a few weeks his tongue and palate were nearly healed. For complete cicatrisation it was necessary to alter the form to

iodide of sodium; and, during two years, he has been taking this salt at short intervals to prevent the relapse of his disease. Here is another case of syphilis appearing unconquerable by either mercury or iodine, which had been given by several medical men whom the patient had consulted. The case was interesting from the probability of its being one of contagion through an infected monthly nurse "sucking the breasts." The child was infected at the mouth subsequently to its mother, and the history in the mother points to contagion having entered by the nipple. I did not see the patient until two years after infection; she had then severe ulceration of the tongue and of the soft and hard palate, and limited necrosis of the bone in the palate. From the prescriptions which she showed me, she had been taking scruple doses of iodide of potassium, for some time with good effect; but, latterly, even double doses of her medicine had only produced severe iodism without controlling the disease. It was with some reluctance that she consented to try iodine again; but, after a few eight-grain doses of iodide of sodium, coupled with frequent washing of the mouth with hyposulphite of soda and glycerine lotion, her sufferings were so far removed that she announced, a week afterwards, that she could eat crusts with ease; and, in a month, except that a morsel of necrosed bone still adhered, the mouth was quite well. The course of this case since has been obstinate; gummata appearing elsewhere after that in the mouth had healed; but she still takes iodine, sometimes in one salt, sometimes in another, and occasionally mixed with Bell's liquid extract of sarsaparilla. It would be easy to multiply instances where, iodide of potassium having lost its effect, the progress towards recovery can still be maintained by another form of iodine; but that is needless.

BERKELEY HILL, Surgeon to University College Hospital.

EFFECT OF ROCKING ON TEMPERATURE.

THE *Journal of Anatomy and Physiology* for November, in its report on the progress of physiology, mentions some experiments of Manassein concerning the effect of "rocking" upon the temperature of animals. This gentleman found that by this means the temperature was lowered from 0.66—1.2 deg. C. It is not stated what animals were experimented upon; but, on repeating his experiments with infants, I have not met with a similar result. On December 19th, I took the temperature of four children, varying from six months to a year old, and found it to register as follows: 98—97.8 deg., 97.4—97.3 deg. F. They were then cradled and rocked for a quarter of an hour, and the temperature taken again, when precisely the same results were obtained as before the rocking.

S. MESSENGER BRADLEY, Manchester.

THERAPEUTIC MEMORANDA.

VACCINATION-PAPERS.

SMALL-POX having entered our hitherto healthy town, there has been a great demand for vaccination; and I have, at times, found difficulty in keeping up a regular supply of lymph. To meet this, I have devised a new method of lymph preservation; it is most portable, and very certain in its effects. Taking a sheet of common sized (*i. e.*, cream-laid) note-paper, I paint it with fresh lymph taken from the vesicle with a fine camel-hair pencil. The lymph soon dries; and the paper is ready for use. When required, a minute piece may be cut out or torn off the sheet, and, after having been slightly breathed upon, should be stuck upon the freshened surface. If the paper be required to be kept for any length of time, it should, after being charged, be covered with a thin coating of white of egg. Isinglass will not do, as it cracks when dried.

THEODORE J. PRESTON, M.R.C.S., Mansfield, Notts.

CATHETERISM OF THE EUSTACHIAN CANAL.

IN DR. Hibbert Taylor's paper on this topic, in the *BRITISH MEDICAL JOURNAL* of November 11th, he says that the introduction of the catheter is by no means difficult, requiring the possession of a certain amount of dexterity; but he does not describe the procedure. It may be useful to learn that Mr. Henry Power has, in his translation of Kramer's *Aural Surgery* (New Sydenham Society's edition), at pp. 28-29, very clearly rendered the steps to be taken. Other portions of Dr. Taylor's paper induce me to add some remarks. Kramer is strongly opposed to any other insufflation into the Eustachian tube than from the mouth of the operator, objecting to the use of "any caoutchouc bag, bellows, or air-press, either large or small" (p. 30, *et seq.*) At page 31, he mentions how the "position, extent, and tightness", of any contraction of the canal can be ascertained by the "introduction of a catgut or