with her elbows on the chair, in an attitude of great prostration. On her attempting to move, considerable muscular agitation and trembling took place. The features were relaxed, heavy, and expressionless; the pupils were equal; the conjunctivæ were injected, and discharging thick mucus. She took little notice of what was passing. When she looked up, the eyelids drooped. The brow was arched. In speaking, the voice trembled; and there was considerable twitching of the lips and chin. She said she was "very well and very happy". Her appetite was good.

Feb. 3rd. She took to bed, being unable at last to stand. Pulse 72; no emaciation.

Feb. 6th. She began to play with the bedclothes. Dementia was increasing; sensation was generally appearing dull. She did not evince the least pain when pinched; tickling the soles of the feet produced only slight movement. (This last has been proposed as a diagnostic sign between spinal and cerebral disease; but the evidence appears to be equivocal.)

Feb. 19th. There was slight improvement in strength and mind; and variation in the state of the pupils.

March 3rd. Both pupils were dilated, and slightly irregular in contour.

April 11th. The mind continued to be slightly improved. Her general powers were failing. The pupils varied. Breathing was quick, with slight rhonchus. At intervals she gathered up the bedclothes.

April 12th. She died.

[*To be continued.*]

NOTES ON HERNIA.

By John Thompson, M.D., F.R.C.S., Bideford.

[*Continued from page 546 of last volume.*]

Before applying the taxis, every surgeon endeavours to assure himself of the species of rupture which is the subject of strangulation, and the precise course the protrusion has taken. A hint may not be out of place that, to carry out this intention the more effectively, it is well to use the sense of sight as well as that of touch. Herniæ of different species sometimes resemble each other very closely; and a femoral, tilted by the superficial epigastric vessels over and above Poupart's ligament, may, especially in a female, be confounded with an inguinal, and so the taxis be applied with disastrous effect.

I have, in more than one instance, seen a first and erroneous impression conveyed by the touch, corrected, when, by the eye, the position of the tumour has been examined in relation to the processes of the ilium and os pubis, and the course of the connecting ligament. In the case of ladies, a surgeon often feels some hesitation in proposing an examination by the sight; but where so serious a disease exists, delicacy of feeling must give way to considerations affecting the welfare of the patient and the reputation of the surgeon.

As aids to the taxis, I have used, in almost every case where required, the warm bath, and esteem it beyond all other remedies. I have sometimes bled with benefit; and in two cases had the patients suspended by the legs, in the manner described by Mr. Griffin, but the latter was without advantage. I have never used sufflation; but have tried the injection of cold water for the distension of the bowel, much on the same principle that injected air is supposed to act, but without success. I have little experience of chloroform. Topical applications of cold water have never seemed to me of any avail in femoral; but I have, in two or three cases, known them succeed in old inguinal herniæ, where continued for a long time, the patient being at the same time laid in a favourable position in bed.

The taxis, as used by the surgeons with whom I have acted, as well as by myself, has never resulted in any harm; where unsuccessful, no prejudice has been done to the cutting operation; and where reduction has been accomplished, the health of the patient has promptly returned, unless, by the long continuance of the strangulation, peritonitis had previously come on, and then recovery was not so speedy.

A curious case once occurred in my practice, in a man who was a bootmaker and small farmer. He was the subject of inguinal hernia, which became strangulated, and he sent for me. I was unable at first to reduce it, and had to employ bleeding to faintness, when I completely succeeded. The man felt immediate relief and restoration. After due tarry with the patient, I left. Next day he prudently remained in bed; but having a good appetite, and knowing that some fresh pork had been obtained for the household, he requested to have some steaks for dinner, which were accordingly cooked and brought to him. He ate freely and with relish, and proposed to have some sleep after. In the course of some hours, as the bedroom seemed very quiet, the wife went upstairs to see how her husband was, and, to her astonishment, she found him quite dead. I got no *post mortem* examination in the case; but if I had, my attention would have been directed to the head rather than the abdomen, as the man had suffered some while before from ocular spectra and illusions, dependent, as the event seemed to show, on disease within the encephalon, which, at this particular juncture had resulted in death; the family, however, connected the hernia more closely with the result, and talking people intimated that the doctor probably did not thoroughly understand the complaint he treated.

Obstruction in old irreducible herniæ occasionally occurs, attended with symptoms resembling those of strangulation, although no additional protrusion has taken place. Several symptoms have been laid down as diagnostic in this condition; and Mr. Erichsen has remarked that, "where obstruction occurs in an old irreducible hernia, vomiting is not feculent." I, however, met with a case where vomiting much resembled that in truly strangulated hernia; and yet no new protrusion had taken place, the mischief having arisen from morbid action set up in an old adherent rupture, the condition of which was verified by an operation.

Sometimes a new protrusion exists with an old irreducible hernia, the strangulation of which is a condition co-existent with inflammation of the old rupture; in which case, reduction of the strangulated portion may not be attended with complete relief, because the disease in the other portion is not removed at the same time. I have known two cases lately, where the administration of a brisk purgative was attended with complete relief, at the same time that it assured the surgeon of the reduction of the strangulated portion having been effected. It is necessary to use much tact in these instances; for a purgative may otherwise be administered whilst strangulation exists—an undesirable practice, but still one that may occur without a practitioner being fairly chargeable with blame.

In a case of strangulated enterocele in connection with irreducible epiplocele, which came under my advice within the last month, the taxis so much reduced the size of the hernia, that the patient supposed it no larger than usual; and as the symptoms of obstruction were mild, the surgeon hoped they might depend on the morbid action excited in the

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old hernia, and he ventured on purgatives, but as reduction of the fresh rupture had not truly been effected, the plan was of course abortive. When I saw the patient, the vomiting was decidedly feculent; and this, taken in conjunction with the other symptoms, determined the advice for an immediate operation. As the case was anomalous, the sac was opened before division of the stricture, and found to contain firmly adherent omentum, almost enveloping a small intestinal protrusion.

Strangulation had here existed for six days, and the parts were discoloured and in bad condition. Death occurred in another six days from peritonitis (verified by a *post mortem* examination), although the operation bade fair to be successful for the first four days.

[*To be continued.*]

A SUGGESTION FOR THE TREATMENT OF OVARIAN TUMOURS, BY COMPRESSION AND OBLITERATION OF THE TUMOUR AT ITS BASE OR PEDICLE.

By Benjamin W. Richardson, M.A., M.D., Senior Physician to the Royal Infirmary for Diseases of the Chest.

On rising from the perusal of Mr. Spencer Wells's remarkable work on *Diseases of the Ovaries*, a suggestion has occurred to me, in regard to the treatment of ovarian tumours, which is, I believe, new, and which, if successful, would simplify the present operation to an extent that none, except those who have seen the operation performed, can understand.

My suggestion is simply to operate, so as to compress and obliterate the tumour at its base or pedicle, either by ligature or acupressure, and thus to cut off its vascular connection with the body; then to evacuate the fluid in the cyst, as far as is possible, by the trocar; and, lastly, to leave the cyst in the body to undergo natural shrinking and absorption.

The suggestion is based on the consideration, that an ovarian tumour is, after all, virtually an enormous aneurism. True, it is filled only with the water of blood, a little albumen, and a little saline matter; but all the fluid is derived from blood; and when death occurs, it is as from slow hæmorrhage. To cut off, therefore, the blood-supply from the tumour, would be to prevent the secretion of new fluid, and to stop the nutrition of the sac altogether.

From the comparative ease with which the ovariotomist turns out the sac, when the abdominal walls are laid open, I cannot assume that the cyst derives any important blood-supply, except from its base; from the point, that is to say, where it originally was developed. If this be the anatomical fact, it follows that the nutrition of the cyst can be commanded at the base; and that to tie or otherwise compress the cyst there, and cut off all vascular communication from it, is simply equivalent to the performance of Hunter's operation on the femoral artery for the treatment of aneurism in the popliteal space, and is the same as removing the cyst itself.

The details of the operation, subject to modification, would be the following.

1. The patient being under chloroform, a trocar should be passed into the cyst: the trocar should be so constructed, that, without the necessity of removing it, the current from the tumour could be stopped at any moment, as the operator should direct.

2. When the body is relaxed to a proper extent by the withdrawal of fluid, a small incision should be made over the base of the tumour, and the parts dissected down until the tumour is reached. An incision such as is made for tying the common iliac artery would probably suffice.

3. The tumour reached, the operator would isolate its neck as low as possible, with the finger, and would then cast two strong ligatures, an inch apart, round the neck, with a large aneurismal needle. He might now entirely evacuate the tumour of its fluid contents, through the trocar, and then tie his ligatures; or he might tie first, and draw off the fluid afterwards.

4. The ligatures, cut off close, might be let remain in the abdomen; and, the wound being closed and pressure being applied to the abdomen, the cyst, I think, might be left without danger.

I have here suggested the compression of the neck of the cyst by a ligature, to apply which requires an incision. But in so doing, I only insist on the act of compression, not necessarily on the incision. I see indeed, if the principle be correct, that the details may be much simplified. It would not be difficult—for example—to pass through a very small incision, a long acupressure needle behind the tumour, and by a figure of eight twist round the extremities of the needle outside the abdomen, to bring the neck of the cyst fairly up to the abdominal wall and secure its compression.

Or it might be possible to obliterate, subcutaneously, by means of a needle and thread only; I mean by passing a long curved blunt-pointed needle armed with a strong thread, and introduced into the abdominal cavity by a subcutaneous incision, clean round the tumour at its base, and by tying the thread, after the needle was withdrawn, in a firm slip noose that should grasp the pedicle of the cyst with the required force for compression.

Again, a clamp might be invented to open round the neck of the cyst, like the blades of a lithotrite, and to close by a screw movement upon the neck, and destroy the vascular connection.

If the principle thus suggested be sound, it will admit of application in all cases of ovarian tumours demanding operation. But it has the advantage of being applicable in cases where the present operation is impossible; I mean in cases of multilocular cyst, or where the cyst is fixed too firmly by adhesions. It might be best to try the operation by compression in one of these cases first; in a case where, the present operation being hopeless, the patient must die, unless some other operation be at hand to save.

12, Hinde Street, February 27th, 1865.

The French Academy of Sciences has offered for 1866 a prize of 20,000 *francs* for the best essay on the question: The Preservation of Limbs by Preservation of the Periosteum.—The academy has awarded the Lalande medal, the highest astronomical prize in the gift of the academy, to Mr. Richard Carrington, of Redhill, the indefatigable observer of solar spots.

Mütter Lectureship on Surgical Pathology. The late Dr. Thomas D. Mütter left to the College of Physicians of Philadelphia the sum of $30,000, and his extensive collection illustrative of surgery and surgical pathology. The conditions having been complied with—the chief one being the erection of a fire-proof building within a specified time, adapted to the purpose of the College—it has come into possession of the thirty thousand dollars, the interest of which is to be expended in making additions to the museum, paying a curator, and sustaining a course of lectures on some department of surgery—the lecturer to be appointed annually by the College. The choice of the College of Physicians of a person to deliver the first course of lectures has fallen on Dr. John H. Packard, who has begun a course on surgical pathology.

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