All the circumstances of the case, both collateral and direct, must be attentively considered; and even then it is arrived at rather as the result of constant clinical observation and tact, than by the most careful study of the differential characters laid down by authors on these diseases. The patient and his friends will press strongly for a positive opinion upon the first visit; but if doubt exist, it will be prudent to withhold it until a repeated physical examination, under different circumstances and at varying periods of the day, justify our doing so with tolerable certainty. Although nervous palpitation is very generally relieved by taking exercise, still, if anæmia exist, the contrary result will obtain; and thus the diagnosis may be rendered doubtful, particularly if œdema of the ankles, from debility, exist at the same time.

The force of the action in nervous palpitation varies greatly. It may be scarcely perceptible to the examiner, while to the patient it very frequently gives rise to the most distressing anxiety. At other times, the pulsations are sufficiently violent to shake the bed.

Palpitations, to which the patient is sensible, are often functional in character; while those that occur with force, without the patient's attention being attracted by the circumstance, are more frequently of organic origin. The sounds of the heart in palpitation arising from functional disturbance of its action are sharp, loud, and ringing. The first sound is loud and abrupt, and is sometimes even audible both to the patient and the physician, without contact of the ear or stethoscope. The second sound is occasionally doubled; but this occurs generally as a temporary phenomenon only, and is not of material assistance as a diagnostic guide.

The impulse of the heart excited by inorganic causes is sharp and "slapping"; and sometimes a metallic ringing sound, produced by the energy of the contraction and smartness of the shock, is audible at the apex.

The existence of murmur will obviously require great care in forming a diagnosis, especially if the patient have formerly been the subject of rheumatism, and is now suffering from an impoverished condition of blood. Inorganic murmur is for the most part soft and blowing: it may, however, under great vibratory disturbance, become musical and somewhat harsh in its tone. It seat is usually at the base of the heart, over the aortic or pulmonic valves, from the former of which it is communicated to the aorta and carotid arteries.

The coexistence of a basic systolic murmur, with a continuous humming sound in the veins of the neck, affords strong presumptive evidence that the case is one of inorganic disease. Although it was formerly considered an established fact that inorganic murmurs were limited in site to the base of the heart, it is now admitted, and I can also verify the statement, that a murmur, varying in intensity and constancy, may exist over the apex, quite independently of organic disease. With all this, however, it must be admitted that there is no certain character by which an inorganic can be distinguished from an organic murmur; and it consequently behoves the examiner to weigh accurately all the existing and collateral phenomena of the case, lest, on the one hand, he inadvertently alarm his patient, rendering him more or less miserable for life; or, on the other, he find his diagnosis falsified, and his reputation injured, by the sudden and unexpected death of the individual in whom a functional disorder was alone suspected. I have already alluded to the irregular rhythm of the heart's action, as dependent upon derangement of the digestive organs, moral causes, etc.; but, in all cases of permanent irregularity of the heart's action occurring late in life, even though no physical sign of organic mischief be present, a guarded prognosis is called for, as not unfrequently the irregularity will be found to depend, not upon perverted function, but upon a softened or fatty degeneration of the muscular texture.

In the treatment of functional disorders of the heart, more may often be effected by judiciously observed moral advice and hygienic regulation, than by medicine. At all events, premising that the cause is fully ascertained and the diagnosis accurately determined, the particular selection of remedies may be left to the judgment of the medical attendant. As a rule, unless the heart be congested, venesection, in any form, is to be strictly avoided.

In that class of persons to whom I have referred—viz., the atrabilious—and in whom palpitation is very common, steel and tonics are in general not well borne, and the cardiac disturbance is rather increased than lessened by their use. Small continued doses of blue pill, with the compound galbanum pill, together with alkalies in combination with the compound tincture of valerian and henbane, I have found to be of the

greatest service. Wine also, mixed with water, will agree better with patients presenting these features of the disease, than malt liquors in any form. In the toxicæmic variety, if much headache prevail, a blister to the nape of the neck will be found useful, and it indirectly quiets the disturbed action of the heart. In the young female, whether the cause be a spæmic condition from deteriorated blood, or whether it be attributable to uterine irritation, the necessity for wearing warm flannel clothing, and taking regular exercise, short of producing excessive fatigue, must be strictly inculcated.

TUMOUR OF UPPER THIRD OF THE THIGH SUCCESSFUL AMPUTATION AT THE HIP-JOINT.

By WILLIAM JAMES CLEMENT, Esq., F.R.C.S.E., Shrewsbury.

MRS. DAVIES, aged 32, of slight figure and fair complexion, is the mother of four children; the eldest nine, the youngest two years old. Her family on the maternal and paternal side were healthy. Her mother died in childbed; but her father and grandmother, aged 84, are both living.

About three years ago, according to the patient's statement, she first observed a small tumour situated in the upper and inner portion of the left thigh. It was soft, moveable, and free from pain or tenderness. Its growth was at first slow and almost imperceptible; but after the birth of her last child, it increased with great rapidity.

I was desired to see her on April 2nd, shortly after her discharge as incurable from a public institution. I found a very large tumour occupying the entire upper third of the thigh, and extending within two inches of Poupart's ligament. The tumour was elastic to the touch, not nodulated, but having an even surface. Pressure caused no uneasiness, but the patient complained of acute darting pains through the substance of the tumour and numbness down the limb. There was no discoloration of the surface; but on one spot where an exploring needle had been introduced, the skin was red and inflamed. I made a careful examination of the parts above Poupart's ligament, but could discover no enlargement or affection whatever of the deep-seated glands. The stethoscope also failed to detect anything wrong in the lungs and heart. There was no great amount of constitutional disturbance, and the countenance had not that peculiar anxiety so common to patients labouring under malignant disease.

Taking into consideration the age of the patient, and the absence of all internal organic affections, I came to the conclusion that removal of the limb at the hip-joint was a justifiable proceeding. The only serious obstacle to the operation was the extension of the disease so close to Poupart's ligament, preventing the formation of an anterior flap. The tumour, however, did not encroach upon the posterior part of the thigh, and the muscles and integument there were apparently sound.

On June 9th, I was requested to perform the operation. A great change had taken place in the condition of the limb since I saw it on April 2nd. It appeared that soon after my first examination of the patient, ulceration of the surface commenced at the point where the exploring needle had been used, and rapidly extended. The skin had entirely disappeared from the surface of the tumour, and a large livid mass occupied the whole upper portion of the thigh, resembling in appearance putrid liver, and exhaling a most intolerable stench. There was not quite an inch of sound skin between the lower edge of Poupart's ligament and the upper part of the diseased mass. The patient was greatly emaciated since my former visit, the tumour having discharged daily more than a pint of bloody serous fluid. The pulse was very feeble, beating 140 in the minute. The pain was excessive, and large doses of opium failed to give any relief. The tumour, one inch below Poupart's ligament, measured thirty-four inches and a half, being two inches more than double the circumference of the opposite limb at the same place.

The rapid and successful removal of the thigh at the hip-joint depending so much upon the assistants and their simultaneous action, I was most fortunate in having the services of my friends, Mr. Heathcote, Mr. Keate, and Mr. Pidduck.

Chloroform was administered, and the patient was kept under its influence until after the last ligature was applied. The knee being slightly bent upwards on the pelvis, I thrust in a long knife at about an equal distance between the anterior superior spinous process of the ilium and the trochanter major, deep

below the vessels, and brought out the point just before the anus. As I cut rapidly upwards, Mr. Heathcote followed the knife with his fingers. Pressure with them and his thumb above the groin, secured the vessels as soon as they were divided; and not one ounce of blood was lost at this stage of the operation. Mr. Keate, who had charge of the limb, then suddenly depressed the thigh. Two strokes of the knife over the capsular ligament were made, and the head of the femur started out of the acetabulum, at the same time tearing through the round ligament. Disarticulation was rapidly effected, and the separation of the limb completed by making a long posterior flap. All hæmorrhage from the posterior flap was controlled by Mr. Pidduck. Five vessels only required the application of ligatures, and there was but very slight oozing from the surface. As soon as that had ceased, the posterior flap was folded upwards on the groin. Three sutures were inserted, some strips of adhesive plaister applied, and over all a wet compress.

The patient did not experience one bad symptom after the performance of the operation. A full dose of morphia was given at bedtime every night for a week.

The dressings were removed on the third day, and with the exception of a small part at the outer angle, and also where the ligatures hung out, the whole line of the incisions was found to have united by the first intention.

The patient was out of bed and on crutches at the end of the month from the time of the operation. She gradually regained flesh and strength, and is now perfectly well and able to attend to her domestic duties as far as a person so mutilated can do.

On examining the tumour, no trace of muscular fibres could be discovered in the upper anterior portion of the limb. A large mass of soft liver-like substance, intersected by thin fibrinous bands, extended from the lower third of the thigh within one inch of Poupart's ligament. The diseased substance extended down to the periosteum, covering the anterior portion of the femur, but the bone itself was quite healthy. In no part of the diseased structure could any medullary or cerebral-like substance be detected.

CASE OF STRANGULATED RIGHT FEMORAL HERNIA: OPERATION ON FOURTH DAY OF STRANGULATION: RECOVERY.

By ALFRED FLEISCHMANN, Esq., Gresford Cottage, Wrexham.

I AM induced to offer a few remarks upon the above case, because I believe the operation for hernia has been unduly surrounded with supposed difficulty and danger. In recent cases of strangulation, practitioners are, I fear, prone to wait, and indulge the too often delusive hope that long continued taxis may supersede the knife; whilst, where strangulation has existed for some days, the case is often looked upon as hopeless, and may be the patient dies unaided and unrelieved.

On Saturday afternoon, November 6th, I was summoned to a remote country district, to see a woman suffering under all the symptoms of strangulated hernia. I found they had existed for four days. Fæcal vomiting and hicough had set in; her pulse was 120, but her expression did not betoken excessive anxiety. The hernia was on the right side, and clearly femoral. Sixteen years ago, she had ruptured herself lifting a heavy weight: it then appeared as a marble, was down during the day, and up at night. She never wore a truss. She was of spare weakly habit, in age 44, the mother of two children. For the last few days she had been dyspeptic, vomiting her food. On Wednesday, November 3rd, whilst vomiting and straining violently, the rupture descended more than usual; she tried to replace it, but failed. Application was made to an unqualified practitioner, who sent her some hydrargyrum cum cretâ and rhubarb, which, however, produced no marked amelioration!

The symptoms grew more and more urgent, till, on Saturday, November 6th (the fourth day of strangulation), she sent to seek for further help.

The tumour was of stony hardness; reduction was out of the question; and I decided upon operating with as little delay as possible. I called into consultation Mr. Griffiths, who kindly attended, and rendered me most valuable assistance. He also tried taxis, but, like me, soon abandoned the attempt. The operation was a straightforward one, and presented no features

worthy of particular note. The sac was opened. The intestine was livid in hue, and incipiently gangrenous. Several ounces of straw-coloured serum escaped from the peritoneal cavity. The stricture was firm, and required free division. After the operation, she had a full dose of opium and ammonia. I sat with her all night: she was free from pain, and slept well. In the morning, her pulse was 106. The remission of all her urgent symptoms was total.

November 8th. Pulse 100. She had no pain in the wound. The tongue was clean. She lived upon strong beef-tea, and took small doses of ammonia and henbane.

November 9th. Pulse 104. She had not the slightest pain or uneasiness in the wound. I left well alone.

November 10th. Pulse 112. She felt no pain, but some stiffness in the wound. I dressed it, and was gratified to find the upper third united by primary intention, and the remainder looking very healthy. The discharge was sufficient, though not abundant. The bowels had not acted, and a simple enema did not bring much away.

November 12th. Yesterday an enema acted copiously; to-day the bowels were naturally moved. Pulse 100. The wound was very healthy.

I need not continue the record further. She rapidly improved; and, on the fourteenth day after the operation, the wound was healed, and she was ready to leave her bed.

REMARKS. This was, I think, a case upon which the most sanguine surgeon would have passed an unfavourable prognosis; and, taking into consideration that the strangulation had existed four days; that she was a weakly woman, debilitated by previous illness; that the extrapped intestine was congested to extreme lividity, and almost to gangrene; and that the peritoneal membrane had begun to sympathise with the gut,—I think most justly so. But, the operation over, all morbid processes ceased; and the *vis medicatrix nature* proved the wisdom of our attempt. That the pulse never rose above 112; that no sloughing worthy of mention followed; that the imprisoned bowel so soon recovered its natural function; and that the constitutional symptoms after the operation were so insignificant,—are all, I think, facts worthy of note, and full of encouragement for the future. I am convinced that *long attempted taxis*, where strangulation is not recent, is as useless as it is perilous; and that, if it succeeds once, it fails twenty times.

There is a point which, in hospital practice, has often struck me, and which this case, which after the operation was left for four days undisturbed, I think, well illustrates; viz, that where a wound is painless, where suppuration is not excessive, and where the constitutional symptoms do not indicate progressing mischief, the less it is interfered with, and the less it is exposed to atmospheric influence, the better. I feel sure, too, that in these days of pyæmia and proneness to typhoid symptoms, a generous diet and due administration of stimulants after an operation often ward off extensive suppuration and vital depression, or, failing that, enable the patient to survive them.

Transactions of Branches.

EAST YORK AND NORTH LINCOLN BRANCH.

A FALLACY IN THE PHYSICAL DIAGNOSIS OF ABDOMINAL TUMOUR.

By JOHN DIX, Esq., Hull.

[Read Sept. 23rd, 1858.]

THE records of medical literature and the observations of practical experience combine to teach us—that a question of diagnosis sometimes arises between renal enlargement and hepatic tumours—when one or other of these morbid conditions presents itself, on what may be termed debatable ground. In such a case, the presence or absence of resonance on percussion in front of the tumour is usually one of the most certain and reliable of the discriminative *physical* signs.

This is such a self-evident fact, and so obviously and so necessarily dependent on the anatomical position of the colon in relation to these two organs, that it is almost superfluous to quote authority on the point. I content myself with a single citation, which appears to state the whole matter clearly and succinctly.