for while abdominal aneurism in the female is of very rare occurrence, inorganic aortic pulsation is very common. *Fæcal* accumulation and impaction has been mistaken for aneurism of the abdominal aorta. The oval shape of the tumour, with its doughy, inelastic feel, and the result of free purgation, will, in general, suffice to clear up the diagnosis.

Enlarged glands, or organic disease of the abdominal viscera, either lying over, or pressing laterally upon the artery, will sometimes closely simulate aneurism. The history of the cases, and especially the existence of malignant disease in other parts of the body will aid our opinion; while in pulsation from superimposed tumours, the murmur may often be interrupted by change of position, or by applying the stethoscope laterally, and displacing the tumour from off the artery. The obscurity of symptoms and pain accompanying lumbar and psoas abscess may resemble the phenomena of aneurism; but the swelling, elongating downwards, without sound or impulse, and the want of the globular tumour of the enlarged artery, will, in general, distinguish these affections.

Tumours of the kidney may, by extending irregularly inwards, and receiving the shock of the artery, sometimes resemble an aneurismal swelling; but the condition of the urine, and previous history of the case, will sufficiently assist the diagnosis. It should be borne in mind, however, that an aneurism pressing upon the emulgent vein may render the urine albuminous. In all cases in which the symptoms are obscure—and in very many they will inevitably prove at first to be so—it will be advisable to examine the patient both in the erect, horizontal, and lateral postures, and, in some instances, it may be prudent to watch the case for a time before risking an opinion.

CASE OF ARM AND SHOULDER PRESENTATION IN WHICH EVISCERATION WAS PERFORMED.

By ROBERT MANNERS MANN, Esq., Manchester.

As cases requiring an operation of this description are of rare occurrence, I think the publication of the following in our JOURNAL may prove interesting, as well as instructive, to some of our readers.

CASE. On Thursday evening, April 3rd, I received an urgent message to attend Mrs. L., aged 22 years, who was said to be in premature labour of her first child. On arriving at her residence, I found her suffering from tolerably strong and expulsive uterine pains. An examination *per vaginam* informed me that a considerable portion of the bag of membranes was protruded through the os uteri into the vagina, and all but without the os externum. Neither during a pain nor in the intervals between, could I detect any presentation; but I discovered high up the os uteri, and the not as yet obliterated cervix, shewing me that she was between her sixth and seventh month. The os was perhaps so far dilated as to be capable of receiving two or three fingers.

Strong expulsive efforts continuing, the membranes soon gave way; and I now expected some portion of the fœtus to follow shortly. In this, however, I was disappointed; for, although there was an immediate and considerable flow of liquor amnii and much dribbling afterwards, I could only just by pressing my finger firmly upwards perceive that there was a limb of the fœtus, but whether an arm or leg, could not make out to my satisfaction. The pains now ceased entirely; and after waiting some time, I advised my patient to get up, and think no more about it, until the action of the uterus should again be excited. I left strict orders to be sent for on the return of pains, as I have often known delivery take place very suddenly in such premature cases, even in *primiparae*. No message, however, came for me till Saturday morning, April 5th, at eight o'clock.

I now found her having both strong and frequent pains; and on examining, discovered the right hand, arm, and

shoulder, presenting, together with a very dry, unyielding, and undilatable state of the soft parts. The pains continued to increase in violence; and as the state of parts would not as yet justify me in attempting to turn, I resigned myself patiently to the hope, that as the fœtus was premature, and consequently softer and more yielding, that nature's efforts would suffice, or that the possible but unusual circumstance of spontaneous evolution might occur. After waiting a few hours, however, the shoulder only got lower, and the chest more and more firmly wedged in the pelvic cavity; but in the mean time the os uteri was becoming more dilated, and I therefore decided upon making an attempt to turn. Using lard freely, I then in the usual way, but with much difficulty, succeeded in passing my left hand into the vagina, and afterwards, by long continued pressure through a rigid and strongly resisting os uteri, managed to insinuate it into the uterus. Owing, however, to the two circumstances of the liquor amnii having been so long evacuated, and the vigorous muscular action going on cramping my hand, it was with considerable difficulty that I at length reached what proved afterwards to be the right foot. I could not by any efforts I dare use bring this down more than just barely to shew itself through the labia majora. A slip noose was then made in some tape, and passed over the foot and secured round the ankle, but still all traction failed to make any change, and the arm kept slipping down as fast as I returned it. My patient had suffered very severely, and was getting exhausted, so that after mature consideration, I decided that evisceration of the fœtus would not only afford her speedy relief, but would be the only means left for her delivery. My perforating instruments were soon brought, and I got an assistant to hold the arm and employ traction by it, for me to steady the chest; after which, I was enabled easily to evacuate the contents of the thorax and abdomen, and directly afterwards hooked my finger in the pelvis, brought down the legs, and without much more trouble the head followed.

There was no doubt whatever in my mind that the fœtus had been dead for a considerable period previous to the operation. The pelvis is diminutive. My patient is now (April 16th) sitting up, and progressing in every way extremely well.

A CASE OF STRANGULATED FEMORAL HERNIA, WITH PROTRUSION OF THE INTESTINE ON THE FIFTH DAY: RECOVERY.

By T. M. WARD, Esq., Exmouth.

CASE. Mrs. E. H., aged 66 years, a spare but tolerably healthy woman, has fallen under my care several times during the last two years, with strangulated femoral hernia. I have always had considerable difficulty in returning the bowel. The tumour was large and hard, and the symptoms very urgent. In spite of my repeated remonstrances, she neglected to wear a truss regularly; and in this state, with a severe cough, she walked on the 10th of February to Lympstone, two miles from home. While there, the hernia descended, and became strangulated. My friend Mr. Price, of that place, was called in, and after a long and patient trial of the taxis, failed in reducing it. He then gave her an injection with a flexible tube, and a pill with three grains of opium, repeating a grain dose every hour. When under the influence of the opiate, he tried the taxis upon her again, unsuccessfully.

On the morning of the 11th, she was brought home, and placed under my care, when I repeated the attempt, with a like result. Mr. Price then coming to my aid, we made her inhale chloroform, and then we both made a final but fruitless effort to return the hernia.

Having explained to her the necessity of an immediate operation, to which she at once consented, I procured the kind aid of my friend Mr. Eustace (a retired surgeon), and at 3 p.m. proceeded to operate. Mr. Price kept her all the time well under the influence of chloroform, and also afforded

me most valuable assistance and advice during the operation. The hernial tumour was ovoid in shape, large and tense, and reflected over Poupart's ligament. I transfixed the integument with a long straight knife, and made the usual T shaped incisions. The superficial fascia and fascia propria were very thin, and required great care in dividing them. The sac was now fully exposed, of a very dark colour, and so extremely tense, that I could not make out by the touch what were its contents. I then felt for the stricture, and with some further careful dissection, came down on the falciform process, between which and the sac I endeavoured to insinuate a director; but from the great tenseness of the latter, I found considerable difficulty in doing so. I at last succeeded in dividing the edge of the falciform process; but as I was unable to return the tumour, I felt for and divided the margin of Gimbernat's ligament, which was found the seat of the stricture. I was still unable to return the hernial sac, and was therefore obliged to open it—a stage of the operation involving considerable anxiety—as from its extreme tenseness, it was some time before I could pinch up a fold of it in the forceps; and I feared, if the bowel should be in contact with the sac, it might be accidentally wounded. I at last succeeded, when there was a copious gush of bloody serum, amounting, I should think, to nearly half a pint. I then opened the sac more freely, and found its contents to be, besides the serum, a large clot of blood, some adherent omentum, and a small knuckle of intestine in good condition, so I at once returned it, leaving the adherent omentum in the sac; I drew the edges of the wound together with a few sutures and adhesive plaster, compress bandage, etc. The operation was somewhat prolonged; but she was well under the influence of chloroform the whole time, taking nearly half an ounce of it, the effects of which, however, soon passed away. At night, some degree of tenderness of the abdomen came on, which soon yielded to two or three doses of calomel and opium.

The next day I gave her a little castor oil and an enema; the bowels acted well. With the exception of the violent cough, which I was never able to check completely, all went on well till the 15th. I found at my morning visit that the wound had nearly all healed by the first intention, and as the sutures had ulcerated through in one or two places, I removed them, giving at the time great hopes of a rapid convalescence. I was however deceived, for during a violent fit of coughing, which came on soon after, she endeavoured, in the absence of her nurse, to raise herself in bed. The effort was too much for the as yet weak adhesions of the sides of the wound; they gave way, and protrusion of the intestine was the result.

I was from home, but saw her about an hour after; and judge of my disappointment, when I saw protruding at the edge of the compress a coil of intestine eight or nine inches long. The intestine was reddened and dry, and speckled with particles of the resinous matter of the adhesive plaster, which it had rubbed off from the dressings. I had no chloroform with me, or any assistant; but I first sponged the bowel very carefully to free it from all extraneous substances, and then endeavoured to return it, which I found very difficult, as it was so full of flatus. I succeeded at last, and brought the edges of the wound together once more with sutures, etc. The poor woman showed great fortitude during her severe suffering; and I left her with but faint hopes of her recovery. In a few hours great peritoneal tenderness ensued, but it yielded again to calomel and opium. She was for some time in urgent danger, but ultimately recovered, and is now well, and able to sit up all day.

I think the case remarkable, as showing the great amount of injury the peritoneum will at times bear without fatal consequences, and the triumph of the powers of nature over so severe an operation, and so untoward an accident as followed it.

Clinical Lectures:

DELIVERED IN

ST. BARTHOLOMEW'S HOSPITAL, LONDON.

By F. C. SKEY, Esq., F.R.C.S., Surgeon to the Hospital.

NO. III.

ON THE PHAGEDÆNIC SORE AND TRUE CHANCRE.

GENTLEMEN,—In the previous lectures, you will remember, I commented on what is called the “common sore”, or venerola of Evans. The amazingly practical nature of the subject will be my apology for going to-day into the history and pathological characters, so to speak, of the Phagedænic Sore. I see that many of you are yearning rather, as this is the last week of the Session, towards the sunshine and showers of April in the country; so I must be necessarily very brief, and condense into one lecture what might more fitly be adapted to four or five. Do not lose sight of the essentially practical nature of the subject of venereal diseases. I told you the poison of venerola was a sort of sub-poison, which exhausted itself in one sore, and that it left no constitutional taint. Let the books say what they please to the contrary, the common sore or venerola in this particular is perfectly regular. The phagedænic sore is perfectly irregular: it commences, I think, as venerola, or as true syphilitic sore, and something is added—it is then phagedænic. I entirely concur in the opinion of the army surgeons, who had seen a good deal of it—Mr. Guthrie, for instance, Rose, Hennen, etc.—that any sore of a venereal character may become phagedænic. All this probably you have observed for yourselves in the wards of the hospital. The term phagedænic—from *φαγεω*, to eat—is a very good one; for, if you look closely, you observe the eating action—the sore looks literally as if “nibbled”. You will see even at one side of the sore this “nibbling” or eating process, while at the opposite side a reparative action may be going briskly forwards; and then you know what we call upstairs the “horse-shoe shaped sore”—the nibbling action at one side, but the reparatory action beginning to tread closely on its borders, till the whole is healed.

Now there are some subdivisions of phagedæna of more or less practical importance. There is the very irregular or slough-like sore on the glans, named by Wallace, of Dublin, who studied these diseases with singular accuracy, the *white slough*, or surface. On more minute examination of it, however, I do not think it is a slough; by treatment it turns into red, and you know a slough is something dead, and incapable of any such transformation. There is also the second subdivision—the *red or dark slough*; and lastly, the third form, or *sloughing phagedæna*. This last sore is most destructive; it goes on to destroy all the parts with most alarming hæmorrhage very often, and burrowing all round into the adjacent tissues. You must be on your guard for this sore. You will not find induration, so dwelt upon in true chancre, but you observe great tumefaction. It is a very intractable sore, no doubt of it. But look to the constitution of the patient, and you almost invariably find this sloughing phagedæna to be a poison developed in a cachectic constitution, a something grafted on the system by scrofula, or irregular living, want of food, bleeding, or mercury improperly administered, or some other evil agent. It is an *educt*, as the chemists call that which is not a product, or something new, of certain changes in the constitution; it is a flat sore. It is attended, also, I need hardly remark, with bubo. Any of these phagedænic sores may show effects of the poison on the system in from one to three months: when the effects show themselves early, they are very severe; when late, they are milder. Do not forget this. The first “secondary” effect is fever; which, by the way, is sometimes not recognised at all as part of the disease. Ask your patient, and you will find him talking of