that a considerable number of cases of congenital hernia show no tendency to spontaneous cure, even when a suitable truss has been worn for long periods and the child has had every needful attention. Among the children of the poor the tendency to spontaneous cure is even smaller, owing to the want of the necessary care and attention.

I should recommend an operation for all cases of congenital hernia in which the hernia persists at 2 years of age and over—especially so if the hernia be large and if other measures have been adequately tried and failed. I should not urge the operation very strongly if the hernia were small, and if other measures had not been adequately tried, provided that such measures were at once tried and persisted in, say for six months; but, if afterwards the hernia remained uncured, I should strongly recommend operation. In children of the working classes, who when grown up would have to work hard for their living, I have no sort of doubt that a radical operation is the right thing to recommend in all cases after 2 years of age, and in some large herniæ even short of that age. Among the better classes a hernia is a grievous infliction; during school life a hernia makes participation in outdoor exercises more than usually dangerous; and a little later in life bars the entrance to many a career, which would otherwise be open, and for which the individual is in other respects well qualified.

The Listerian doctrine has brought about such a remarkable change in the results of surgical operation, has placed success on such a secure footing that it can now be relied upon almost with certainty, and has reduced mortality so much by demonstrating the real sources of danger, that an operative measure can now be recommended with much greater confidence than was the case even in the near past. Hence a greater confidence in recommending the radical cure of hernia in cases in which formerly the surgeon might reasonably have hesitated to do so.

The results of operations are already very satisfactory, and it can hardly be doubted that improvements in our procedures will continue, and so constantly reduce the minimum of danger which is still an element to be reckoned with, though hardly a substantial argument against operation in a considerable number of the total cases. I venture to hope that within a few years it will be quite an exception to meet with congenital herniæ in adults, and that all such deformities will be treated during early childhood, while the tissues are healthy and in the best conditions to secure a perfect result.

As to the method of operating, probably every surgeon has his own method and prefers it to that of others. I incline to think that a method which is well adapted for adults with large scrotal herniæ cannot be applied with equal fitness to a young child. Some of the methods described appear to me unnecessarily complicated; this may, however, be necessitated by the amount of the deformity and the distortion which the parts have undergone anatomically, and which are seldom or never seen in young children.

The operation I have practised now for many years is exceedingly simple. An incision about 2 inches long is made, the upper portion of which corresponds with the position of the external abdominal ring, and the sac is exposed; the latter is then cleared of its looser and more external layers. I do not dissect off all the adventitious structures of the sac, for the sac proper, peritoneum, in children is exceedingly thin and liable to tear; moreover, I think the result is firmer and less liable to relapse. Then, after getting the spermatic cord well out of the way, I pull down the sac as far as possible, and put in three or four stitches, drawing the neck of the sac firmly together, but not tight enough to strangle it. My object is to retain the silk ligatures permanently *in situ* or as long as possible; if they are drawn very tightly together the stitches are liable to cut their way out, and so lead to failure. The neck of the sac is now allowed to retract itself back within the external abdominal ring, after which the pillars of the latter are sewn together and the wound closed, being first well irrigated and all bleeding arrested.

I prefer silk which has been well boiled in carbolic lotion, 1 to 20 to any other material; the longer it remains unabsorbed the better, for thus we have the mechanical help which its presence gives until complete adhesion of the sac walls has been brought about.

ON THE TREATMENT OF CERTAIN CASES OF RECENT HERNIA BY ASPIRATION OF THE PROTRUDED GUT.

By JOHN HERN, M.D. EDIN., F.R.C.S. ED.,
Surgeon, Darlington Hospital.

ON being called some years since to a case of recently strangulated hernia which I failed, under chloroform, to reduce by taxis, finding the tension in and distension of the protruded gut apparently the main obstacle to reduction, I emptied it by means of my hypodermic syringe, with the result that reduction was at once easily accomplished. I have since repeated the operation on thirty-two occasions, in twenty-eight of which reduction was readily accomplished, and in the remaining four three were, subsequent to aspiration, subjected to the usual operation (with one death from gangrenous gut), and one steadfastly preferred death to further operation, and succumbed on the tenth day. In neither of the three cases of herniotomy could any traces be found of the previous aspiration, due, I think, to two causes (1) the small size of the needle used—small hypodermic syringe; (2) the arrangement of the fibres (muscular) in the wall of the gut.

The class of cases which have appeared to me most suitable for the operation are (1) recent cases—36 to 48 hours or less; (2) where the patient or friends refuse to submit to herniotomy. The simple aspiration can be designated “doing a little something.” The advantages claimed for this procedure are:—

1. It avoids the delay almost inseparable from the herniotomy, for example, gaining consent of friends, procuring adequate assistance, etc.

2. It avoids rough and heroic attempts at reduction by taxis by placing in the hands of the general practitioner a means of reduction easy of application, and requiring no extensive surgical skill for its performance, and, moreover, a proceeding which, by reducing the tension of the protrusion, lessens the danger of the taxis subsequently employed.

3. It avoids the risks of pyæmia and septicæmia, inseparable from all operations in which the skin is divided.

Let us consider in how far this operation is based on a consideration of the anatomical and pathological conditions present. We must remember that the internal abdominal ring, the inguinal canal, the external abdominal ring, the crural ring, the crural canal, and the saphenous opening in the fascia lata of the thigh are all bounded chiefly, if not solely, by aponeurotic structures, which have become thickened and resistant although the openings have all become dilated. The margins of these openings forced back and thickened offer a strong passive resistance, so that if the protrusion becomes distended in any way by feces or flatus, the neck or narrow portion is so wedged into these fascial openings or canals that it becomes compressed, the venous circulation impeded (both arteries and veins are, of course, compressed, but the thicker coats of, and the greater force of circulation in, the former render them less affected by the pressure), the proportion between the protrusion and the opening or canal through which it has descended becomes so altered, that the hernia becomes irreducible. Now, seeing that (in recent cases, at any rate) it must be the distension of the protrusion which is the main obstacle to reduction, there having elapsed no time for the effusion of lymph or other inflammatory changes to occur, having failed to reduce by taxis, it appears to me to be a perfectly justifiable proceeding to at once empty the protrusion of whatever fluid or flatus it may contain, and, having thus lessened its bulk, to reduce by taxis.

CASE OF FATAL REVOLVER WOUND OF THE SKULL.

By PAUL SWAIN, F.R.C.S.,
Surgeon, South Devon and East Cornwall Hospital, Plymouth.

ON Sunday evening, November 30th, 1890, J. C., aged 28, went up into his bedroom and, in a fit of alcoholic mania, shot himself with a revolver. He was found lying on the

floor, somewhat dazed, but soon recovered consciousness. Mr. Carlyon, of Redruth, was immediately sent for. The man stated to him that he stood before the looking glass, and turning his head well round to the left, placed the muzzle of the revolver behind his right ear. He then fired and was aware of the fact that the bullet fell out of his mouth on to the dressing table. It was subsequently found by Mr. Carlyon on the floor of the room.

On examination it was discovered that he had shot himself through the right mastoid process; the wound of exit into the mouth was conjectured to be somewhere behind the soft palate. There was some considerable hæmorrhage both from the wound and also from the mouth.

On December 5th I saw this case in consultation with Mr. Carlyon. He was in bed, perfectly collected and apparently suffering but little distress, except from a somewhat troublesome cough, accompanied with blood-stained muco-purulent expectoration. His breathing was natural, his lungs were not affected, and he could swallow with but little pain. His tongue, which was very much coated was, on protrusion, strongly deflected to the right side. His sight was normal in both eyes, and his pupils active. He was a little deaf in his right ear. His upper extremities were not affected; but on getting him out of bed I found that he slightly dragged his right leg. His patellar reflex on that side was diminished, and on tickling the bottom of his right foot there was no response. Sensation was normal. On lifting the soft palate I found the wound of exit at the back of the pharynx, a little to the right of the median line, and surrounded with extensive ecchymosis. His temperature was 99.2° (having been subnormal the night before), and his pulse 123.

From this date Mr. Carlyon tells me he rapidly became worse. His temperature and pulse rose daily, and on the day of his death his temperature was 102.6°, and his pulse 163.

On December 4th he was attacked with acute congestion of his right lung. The deafness in the right ear increased. I append two drawings, one illustrating the original size and shape of the bullet, and the other the condition in which it was found. In the interstices of the lead a quantity of bony tissue was deposited. Unfortunately, no *post-mortem* examination could be obtained.

The probable course of the bullet was as follows:—Penetrating obliquely the posterior surface of the mastoid, it just missed the lateral sinus and, without entering the skull, it then passed between the jugular fossa and right condyle of the occipital bone, cutting the hypoglossal nerve at the anterior condyloid foramen, and injuring the pneumogastric and glosso-pharyngeal as they emerge from the anterior part of the jugular fossa. It then made its way forward under the basilar process of the occipital, emerging through the posterior wall of the pharynx, and probably in so doing bruised the upper part of the spinal cord on the right side, which would be somewhat exposed to injury by flexion and rotation of the head to the left.

Such a course and the injuries inflicted would account for the various symptoms noticed.

ON THE PREVENTION OF INFANTILE OPHTHALMIA.¹

By KARL GROSSMANN, M.D., F.R.C.S.E.,
Ophthalmic Surgeon, Stanley Hospital, Liverpool.

IF I were to discuss the treatment and the prevention of blenorrhœa neonatorum, I should have to repeat almost word for word what I said last year before the annual meeting at Leeds; and it will be less tiring and more expedient to dis-

¹ Read in the Section of Ophthalmology at the Annual Meeting of the British Medical Association, held in Birmingham, July, 1890.

tribute a reprint of my paper read on that occasion, and to make a sort of addendum to it. Not that our knowledge of the disease has undergone any great modification. That was scarcely possible, since its etiology and pathology are familiar enough to us all. Neither was there any urgent need to add to the remedies by which it may be treated. We have already a sufficient number at our disposal; and although we shall always be glad to add to our armamentarium such new names as pyoktanin, we need not forget that what we have had hitherto has proved itself thoroughly efficient.

The reason why I recur to this subject to-day is twofold. First, it is our duty to strive to prevent disease. The individual can do something to this end; but individual efforts are limited; and, to secure substantial results, combination will be needed and State enforcements of precautions. We know how the efforts of the Committee of the Ophthalmological Society on this subject collapsed, because the resolutions which were put forward were not adopted in proper quarters; and the matter ended there. Distribution of cards may have been very good as far as it went, but, even if carried out, would probably have fallen short of the desired effect.

The possibility of the prophylaxis of the disease rests chiefly with midwives, because confinements in those classes which yield the largest percentage of blindness from this cause, are principally attended by midwives and not by medical practitioners. It is, therefore, through the instrumentality of midwives that we must hope to banish this scourge. The present time is very favourable for considering what steps ought to be taken. Of course, legislation only can help here. In Saxony, where Professor Crêdè was the first to point out and to prove by thousands of cases the possibility of effectually preventing infantile ophthalmia, the regulations for midwives treat fully on the matter. As far back as 1882 regulations were made and were further amplified in 1885. In Prussia less stringent rules exist, but the midwives are fully instructed as to the danger of the disease, and are directed what to do.

It was therefore a great satisfaction to me to see that quite recently the State of New York has legislated on the matter. Through the kindness of Dr. Swann Burnett, of Washington, who was with us last year at Leeds (and who personally has been instrumental in bringing about this law), I am enabled to give its text. It is short and decided, and runs thus:

"Section I. Should any midwife or nurse having charge of an infant in this State notice that one or both eyes of such infant are inflamed or reddened at any time within two weeks after its birth, it shall be the duty of such midwife or nurse so having charge of such infant to report the fact in writing within six hours to the health officer or some legally qualified practitioner of medicine of the city, town, or district in which the parents of the infant reside.

"Section II. Any failure to comply with the provisions of this Act shall be punished by a fine not to exceed one hundred dollars, or imprisonment not to exceed six months, or both.

"Section III. This Act shall take effect on the first of September, eighteen hundred and ninety."

Here, then, is a step in the right direction. I think it is all the more necessary for us to take some steps, as a Bill was recently brought before Parliament concerning midwives, and, though shelved for six months, is likely to be heard of again.

BLEPHAROCHEILOPLASTIC OPERATIONS.¹

By ARTHUR BENSON, F.R.C.S.I.,
Assistant-Surgeon, St. Mark's Ophthalmic Hospital, Dublin.

Two years ago I brought before the Ophthalmological Section of the British Medical Association (Glasgow meeting) the subject of entropion and trichiasis, with special reference to the operative measures for their cure. I would not again venture to bring the subject forward in any form but that I have received so many letters from different ophthalmic surgeons asking for further information regarding the operation of transplanting mucous membrane from the mouth to the eyelids.

¹ Read in the Section of Ophthalmology at the Annual Meeting of the British Medical Association held in Birmingham, July, 1890.