intestine, so that I was unable to draw it into the abdominal opening. I examined the condition more carefully by drawing aside the bowels while Mr. Hulke retracted the abdominal wall. I then caught sight of a knuckle of intestine on the opposite side of the ring or twist to that on which the coil I had been following ended. On pulling it, I found this to be continuous with a large distended loop, which passed under a part of the twisted bowel, and it occurred to me that, by drawing it out, I might relieve the twist. I did so, Mr. Hulke pushing the loop through on the one side, while I pulled it on the other. By this means we drew out a distended coil of small intestine, 18 inches or 2 feet in length, claret coloured with congestion, and heavy with its fluid contents; and the bowel at this point now seemed continuous without further kink. The collapsed portion was observed to be filling. I had not an opportunity of again examining the seat of obstruction, as the pulse was failing, and I was warned by the administrator of chloroform to finish the operation as soon as possible.

The distended intestines were returned into the abdomen, the wound closed, and the boy put back to bed. During the operation faecal vomiting occurred twice, once soon after the commencement, before the peritoneal cavity was opened, and once towards the end. He recovered from the chloroform without further sickness, but in the evening still complained of griping pain. Temperature 100.2°, pulse 112.

On September 11th he still complained of pain in the abdomen. In the morning the temperature was 100.6° and the pulse 128. In the evening the temperature was 99° and the pulse 120.

On September 12th an enema of warm water washed out some faecal matter. The temperature was 99°, pulse 104.

On September 15th the temperature was subnormal, the pulse 72. The wound was dressed for first time; it had healed by first intention. The superficial stitches were removed. The deep stitches were removed on September 17th.

The boy made a good recovery, and returned to his home a fortnight after the operation.

I am induced to record this case, first, on account of the unusual nature of the obstruction; and, secondly, because successful cases of laparotomy are the exception rather than the rule. Had the operation been unsuccessful I might have given a more decided account of the anatomical condition from *post-mortem* inspection; as it is, I can only describe what was revealed at the time of operation. We could see no band under which a portion of intestine might have slipped, no diverticulum by which it might have been snared. The bowel was engaged in what at first seemed a hopeless tangle, and was eventually relieved by passing one coil of intestine beneath another. I am inclined to think we had to deal with a volvulus of the lower part of the ileum, where one coil had become twisted around another. There may have existed an aperture in the mesentery, through which the loop had passed; if so, we failed to notice it on drawing out the loop, and to my mind this would not explain the peculiar twisted condition present. A further point of interest is the length of time the obstruction had lasted, and the small amount of mischief it had produced in the bowel. The intestine was not strangulated so as to cut off its blood supply; its calibre was totally obstructed, and its blood vessels greatly congested, but there was no gangrene in spite of the length of time the obstruction had existed.

CASE OF STRANGULATED RIGHT OBTURATOR HERNIA.¹

By CHARLES FIRTH, M.D.LOND., F.R.C.S.ENG.

Surgeon to Gravesend Hospital.

I was called, at 10.30 A.M. on Friday, to see Mrs. H., by Dr. G., who gave the following account of his patient: Mrs. H., a spare and feeble old woman, has had a swelling at upper and inner part of right thigh for several years, which has occasionally given her pain, but generally by pressing on the tumour herself it has gone back with a sudden gurgle, and the pain has been relieved. She has always worn an inguinal truss, though there is now no perceptible hernia there, but only some weakness of the abdominal wall. The bowels had been well open on Tuesday (three days previously) and again on Wednesday morning; then came pain in

the groin and tumour extending to thigh, knee, and leg, and urgent vomiting, frequent and feeble pulse, and great *malaise*. On examination no swelling could be found in the usual sites of herniae, but at the extreme inner side of the thigh and close to the pelvis was a soft doughy swelling, not painful on pressure. Ordered opium every four hours. Next day (Thursday) she was in same state. The sickness, constipation, and pain continued, she kept nothing down, and looked pinched and ill; had a foul tongue. The swelling was now much larger, firmer, and semi-fluctuating, and pressure on it gave much pain.

Next morning (Friday) I first saw her with Dr. G. She was then very ill, with an anxious expression, feeble and rapid pulse, subnormal temperature, and dry and brown tongue. At upper and inner part of thigh, and extending forward towards Scarpa's triangle, was a large tense fluctuating swelling (larger than the fist), painful on deep pressure, but with no impulse on coughing. The femoral vessels could be plainly felt to its outer side, seeming to be pushed aside by the tumour. Poupart's ligament could be clearly made out, and no hernia could be felt in either the femoral or inguinal ring. The sickness had stopped, but the pain and constipation continued.

Having agreed that it was probably an obturator hernia, and as the symptoms of strangulation continued, it was decided to take her into the Gravesend Hospital for operation. This was performed under the "mixture" at 6.30 p.m.

A vertical incision, 4 inches long, was made over the tumour, midway between the line of the femoral artery and the spine of the pubes, and carried through skin, fat and fascia till the adductor longus was reached; the upper edge of this was pulled downwards and inwards, and by using the handle of scalpel the fibres of the pectineus muscle were separated without being cut, when the sac came into view. This was thick and tough, and on opening it a very large quantity (more than a pint) of bloodstained fluid, with a urinous and offensive odour, was let out. Then the bowel could be felt deep down in the upper and outer part of the wound. The thyroid membrane was then nicked in a downward and inward direction, after which, with a little manipulation, the bowel was returned into the abdomen; the sac was then dissected out, ligatured in two pieces and cut off; a counter opening was made towards the inner and back part of the thigh for drainage, and the wound brought together. There was no hæmorrhage. The patient recovered from the anæsthetic, but died rather suddenly in the night, of collapse.

At the *post-mortem* examination there was a little lymph about the coils of intestine that had been strangulated, but they were of a good colour and had not lost their polish. As much as 8 or 10 inches of the gut showed signs of having been strangulated; the part was the lower portion of the ileum next to the ileo-cæcal valve; the large bowel was quite empty and very small. The other organs of the body were fairly healthy. I may mention that (as the specimen on the table shows) the position of the obturator vessels and nerve was to the outer and upper side of the neck of the sac between it and the bone.

REMARKS.—In glancing through what records I could obtain of this form of hernia, I find that the majority of the cases were in old people and women; and that in a very large proportion the exact state of things was only discovered after death. And it is this difficulty of diagnosis which is the chief peculiarity, as it forms the chief interest, of the disease; for the only points to guide us are, (1) the presence of more or less fulness at the upper and inner part of the thigh; (2) the characteristic pain in the thigh, knee, leg, and even foot, sometimes accompanied by numbness; and (3) the absence of irreducible swellings in the usual sites of hernia, with the continued symptoms of acute intestinal obstruction. In my case, owing to the size of the tumour, the diagnosis was comparatively easy; and there was a peculiarity not usually observed in these cases—namely, that the tumour was very noticeable when looked at from behind, the patient standing up, as I was informed by her daughter. She was also frequently in the habit of reducing it herself by pressure on the inner part of the thigh.

With regard to the operation itself, there is little to be said. In my case it presented no difficulties, and was accompanied by no hæmorrhage. The variable position of the obturator vessels and nerve renders it impossible to lay down rules for their avoidance in dividing the stricture [for in six recorded cases the vessels were on the inner side, in six on the outer, in three behind the sac]; but we may bear in mind that the upper and outer portions of the ring are bone, so that it is only on the inner and lower sides that we

¹ Read before the West Kent District of the South-Eastern Branch of the British Medical Association.

can cut; and then I think it is better to give two or three small nicks than one larger incision.

As to the cause of death—the patient died of pure shock, being an old and feeble woman, as there was nothing either in the operation itself or in the state of the bowels to have justified such a termination. But the records of these cases show a very great mortality; for out of 25 recorded cases recognised during life, 17 were subjected to operation, 8 were relieved by taxis, but only 5 altogether were saved by the two methods of treatment. Possibly it is to the late recognition of the disease, and therefore the absence of early operations found to be so important in other forms of hernia, that the high mortality is due. It is, therefore, in the direction of improved diagnosis that we may look for progress in the management of this disease; and I may remind you that a rectal or vaginal exploration should not be omitted in doubtful cases, as it is by this means that in more than one case the diagnosis has been established.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

MENIÈRE'S VERTIGO AND THE SEMICIRCULAR CANALS.

IN the article on this subject in the JOURNAL of April 5th, I read: "The influence of labyrinthine impressions on the maintenance of equilibrium of the body is now generally believed to have been demonstrated by the experiments of Flourens on the semicircular canals of pigeons, and to have been confirmed by the pathological researches of Menière. Indeed, all textbooks contain the doctrine that destruction of these canals produces definite and special disturbances of equilibration which render any proper co-ordination of locomotion impossible."

Will you permit me to call your attention to two short quotations. I wrote in 1883, in Holmes's *System of Surgery*; in 1873, in *Lectures on Diseases and Injuries of the Ear*, as follows:

1. "The experiments of Flourens, which at one time were thought to have settled the functions of the semicircular canals in regard to the maintenance of the equilibrium of the body, have since been controverted, so it seems improbable that this portion of the labyrinth is the seat of the lesion. As a matter of experience, when the giddy attacks cease the hearing suffers no further loss. Considering the association of vomiting with the giddiness, also the fact that irritation of the tympanum will often cause the patient to vomit suddenly without feeling any nausea; that irritation of the pneumogastric nerve causes unsteadiness of gait, as well as nausea or vomiting, and that the auditory and pneumogastric nerves are intimately connected at their origin, it seems quite possible that the giddiness and sickness in these cases may be due to reflex action of the pneumogastric, excited by some lesion situate on the course of the auditory nerve, or to some disturbing cause at the point of origin of these nerves."

2. "A circumstance which points very strongly to the fact that injury of the brain substance proper rather than to the semicircular canals is productive of inability to walk or run in a forward direction is one which I have, in common with many others, observed when a rabbit or hare is shot. Sometimes a few pellets only enter the brain, and the animal at once begins to run round and round in a small circle many times, and then tumbles down and stops, then he begins again running round in a circle at a great pace. Excepting by the entrance of the few pellets in the brain he does not appear to be injured. As he is approached he attempts to get away, but these attempts only result in his again running in the same circle. He is then caught and killed. I have noticed this phenomenon times out of number for many years, and have found that the few shots have not damaged the ear at all; what, then, about the semicircular canals?"

My daily experience leads me to believe that, in the minds of some, "Menière's disease" covers a good many conditions. I am content to be without a name for a train of symptoms with which I am very familiar, unless and until I can point to their origin. In

some cases I believe that I can, in many I know that I cannot; and I share this inability with others for whose powers of observation I have a great respect. If we are able to exclude the semicircular canals it is something, and if we confess our ignorance it leaves us in a position to learn, whilst to vainly clutch at the semicircular canals and pronounce "Menière's disease" is to court the confidence of ignorance.

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AN UNDETECTED CASE OF COLOUR BLINDNESS.

A NOTABLE case of colour blindness, occurring in an officer serving in the Mercantile Marine Service, has quite lately come to my notice. My notes are not so full as I could wish, but as the case has an important bearing on the question raised by Mr. Bickerton in his instructive paper on Colour Blindness, as to the Inefficiency of Board of Trade Tests, I shall be glad if you will give it insertion in the JOURNAL.

J., an officer of standing in the British Marine Company, was unconscious of the full extent of his colour sense, until accidentally meeting with a friend. He entered into an animated conversation with him, before the window of a druggist's shop, in which was displayed the commonly known coloured glass globe bottles. The friend remarked upon the dazzling effect of the light, and brilliantly coloured bottles, and I replied, "the light is constantly bright, but the colours you speak of are a confused mass to me, and all pretty much alike." "You must be colour blind," retorted my friend. "I have been told before that I do not see colours as other people see them, but whatever the defect may be, I had no difficulty in passing the colour test examination of the Board of Trade, so it cannot be very great. I never once made a mistake about reds and greens." Upon being further questioned, he said to me "the difference between a red and a green is palpable enough; the red is the fuller, while the green is decidedly the fatter." I can easily see this in the dark, meaning thereby at night, and I do not think I have ever mistaken one for the other when in charge of my ship.

Such is the sum and substance of this gentleman's knowledge of colour. He could give no other apparently, and as he naively remarked, "it had pulled him through at the Board of Trade examination." No one can doubt that had he been properly or more carefully tested, had a blue-green coloured glass, one orange, or a violet, or had Holmgren's wools been presented to him, the nature of his colour defect would have been quickly detected. I do not think I ever before met with so perverted a colour sense as in this case, for J.'s only idea of the difference between red and green appeared to be comprised in the vague terms of "fulness" and "fatness."

Bedford Square.

JABEZ HOGG.

A DIFFICULT CASE OF TURNING RENDERED EASY BY PLACING PATIENT IN THE GENU-PECTORAL POSITION.

I was called some time ago, by an experienced midwife, to see a primipara in labour at term; she saying a hand was presenting. I found not only a hand, but also a foot and the head, the last being impacted in the pelvis, having forced down before it the posterior segment of the partially dilated os and cervix uteri, which it was injuriously compressing between itself and the promontory of the sacrum. The membranes had been ruptured a long while before I saw her, and the uterine contractions were nearly incessant. Patient declined chloroform and, being on her left side, after attaching a tape to the presenting foot, I did what I could with the left hand in the vagina towards pushing the head above projection of sacrum, but without success. It then occurred to me that if I put her in the knee-chest position, so as to allow the womb and its contents by virtue of their weight to fall forward and downward, turning might be made easier. This I did, with the satisfaction of finding that I was enabled to complete the operation with the greatest ease imaginable; very slight pressure of the head with simultaneous traction on the leg being alone required. The child, which was of average size, was as might have been expected, stillborn.

I am not aware if this method has been suggested or practised in similar cases before, and have not found it described in those textbooks which I have at hand.

I report it in the hope that it may serve others as well as it has done myself.

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