A CASE OF STRANGULATED INTERNAL HERNIA INTO THE FORAMEN OF WINSLOW.

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THE following case, I think, deserves publication, although its details are, of necessity, very imperfect.

R. F., aged 25, a clerk, was apparently in perfect health when he sat down to his dinner at noon on May 7th. He made a good meal of beefsteak-pie and potatoes, and walked to his office as usual, a distance of about a quarter of a mile. Without any apparent cause whatever, about two o'clock he was suddenly seized with excruciating pain in the epigastrium. He walked home at once with difficulty, and was "doubled up with pain"; he was given brandy and water, and a dose of castor-oil, after which he vomited for the first time about four o'clock. Pain and vomiting continued, with sleepless nights, until the 9th, when he was so much easier that, in the afternoon, he sat out by the fire; but, in the evening, his symptoms returned, as severe as ever.

At seven o'clock, on the evening of the 10th, I saw him for the first time; practically nothing, until then, had been done for him. I found him in bed in a most excited state, his face anxious and somewhat pinched, his temperature 103.4° in the axilla, and his pulse 122, regular, and small. His parents had had great difficulty in keeping him in bed, and had found it quite impossible to keep the bed-clothes upon him. They were very inexperienced and foolishly nervous people, had none of his vomit to show me, and quite misinformed me as to its character; he had not vomited for an hour or two. The legs were not drawn up, and he said that he had then no pain, but that the pain over the ensiform cartilage, and immediately below it, had been excruciating. The abdomen looked natural, except that the umbilicus was somewhat prominent; in infancy, he had worn an umbilical pad. Percussion and manipulation gave no pain, except around the umbilicus and in the epigastrium, where there was decided tenderness. The abdomen was everywhere resonant, except in the flanks, very resonant over the transverse colon. The bowels had not acted since the morning of the 6th; the urine contained no albumen.

Feeling certain that there was an intestinal obstruction, I accordingly gave orders for treatment, and administered an injection of warm water and soap. Three hours afterwards I returned, and, finding that there had been no relief, gave a second larger injection, which soon brought away what might be termed a diarrhoea stool, with two solid faecal masses. This gave him great encouragement; and, after giving fresh instructions, and, having arranged for an early consultation, I again left him.

The vomit was now faecal, though without the offensive smell. At 3 A.M., in answer to an urgent summons, I was again at his bedside. He was much changed, and was in the most childish condition; we could neither keep him in bed, nor prevent him from throwing off the bed-clothes; his restlessness was intense. His hands and feet were cold and clammy, and his pulse feeble, though he was quite conscious. He was given three small hypodermic injections of morphia at intervals of about two minutes, and I left him moderately quiet at 4.30. He became quieter, and sank at 7 o'clock, after an illness of three days and seventeen hours.

The examination of the body was obtained with the greatest difficulty, and was performed at great inconvenience, without skilled assistance. On opening the abdomen, a moderate amount of peritonitis only was at first noticeable, with a small amount of lymph and bloody serum among the intestines. The umbilicus was quite free. The great omentum was drawn in among the small intestines, to the left of the middle line, and was moderately congested. The intestines contained only a very small quantity of faecal matter, but were distended with gas. Fully eight inches of the ileum, about two feet from its termination in the caecum, were firmly incarcerated in the foramen of Winslow, and were, with some difficulty, withdrawn. Its mesentery was much congested; the intestine itself much more so; and, though, at the junction of the two, there were three or four soft, disintegrating patches, in no part was there found any perforation or ulceration through the coats of the intestine. On withdrawing the intestine, the foramen gaped, and would easily admit two fingers; its margins were rounded, thickened, and congested. The caecum was freely movable, and possessed a meso-caecum. Had an operation been performed at an early date, I have every reason to believe it would have been successful.

SURGICAL MEMORANDA.

SCIRRHUS OF THE BREAST: RECURRENCE LONG AFTER REMOVAL.

THE recent correspondence on this subject has served a useful purpose. It has reminded us of two important factors in the prognosis of cancer of the breast, which, in these latter days, have been too much neglected.

In the first place, in a considerable number of cases, recurrence does not take place until long after removal of the primary disease. We are accustomed to say that the patient will enjoy a year and a half or two years of immunity, and this is the average period; but average results, though true in themselves, may be, and in this case are, misleading. Here is a tabular statement of 31 cases of recurrent breast cancer under treatment at the Middlesex Hospital during the last few years, which gives a good idea of what may be expected.

In 10 cases recurrence under 1 year after operation		
" 9	"	from 1 to 2 years after operation
" 5	"	" 2 " 3
" 2	"	" 3 " 4
" 1 case	"	" 4 " 5
" 1	"	" 5 " 6
" 1	"	" 6 " 7
" 1	"	" 8 " 9
" 8	"	" 10 " 11

In the second place, in many cases the progress of the disease was exceedingly slow. The average duration of from four to five years is often greatly exceeded. Of 125 consecutive cases under treatment at the Middlesex Hospital, 22 exceeded the limit, as follows:—

In 3 cases the duration was from 5 to 6 years		
" 3	"	" 6 " 7
" 4	"	" 7 " 8
" 1 case	"	" 9 " 10
" 3 cases	"	" 10 " 11
" 1 case	"	" 11 " 12
" 2 cases	"	" 12 " 13
" 1 case	"	" 14 " 15
" 1	"	" 16 " 17
" 3 cases	"	over 20

In one of the last cases, the total duration of the disease was close on twenty-four years. It is right to mention these facts to our patients. We ought not to withhold such consolation from those who are suffering from this most distressing disease.

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REDUCTION OF DISLOCATION OF THE SHOULDER BY ABDUCTION.

MR. CLEMENT LUCAS's note, in the JOURNAL for June 5th, will have served an useful purpose by drawing attention to the fact, that lateral traction for the reduction of a dislocated shoulder is by no means a novel method of procedure. As early as 1579, Paré, writing of "an expression of the first manner of putting a shoulder into joint," describes and figures the mode by abduction. A little later, Richard Wiseman, Sergeant-Chirurgion to King Charles II, describes a variation of reduction by the "coustaffe," which scarcely differs from that of Paré. Sir Astley Cooper advocated a similar method for obstinate cases; and, later, Samuel Cooper emphasised its importance. Clearly, therefore, it cannot claim to be modern. For years I have seen it practised, and consider it to be the best routine plan where manipulation has failed, being less dangerous to the axillary contents than systems which involve heels or pads in the armpit. I think, however, it is a mistake to adhere rigidly to any one plan. The best way is to note the exact position of the dislocated humerus and the glenoid cavity, and to exercise sufficient ingenuity to lift the one into the other.

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DR. ILLINGWORTH's claim to priority, in suggesting abduction for reducing this dislocation, is scarcely borne out by facts. He described a mysterious depression of the scapula, by way of slipping the glenoid cavity over the head of the humerus—a proposal of no value. He seems now to be aware that all he did was to steady the scapula, while his assistant reduced the humerus. Dr. Macleod attains this steadying by laying the patient on his back; and not, as Dr. Illingworth seems to suppose, by any pressure of hand or foot. On the other hand, Dr. Illingworth did not originally attribute any import-