CLINICAL LECTURE ON HERNIA.

By MR. PAGET, F.R.S.

MR. PAGET said that he had chosen the subject of hernia for this morning's lecture (Wednesday last) as he had lately had under care several cases which presented features of special interest.

The first case to which Mr. Paget referred was that of a woman who, at an advanced period of pregnancy, had become the subject of an acute strangulated inguinal hernia of large size. The gut rapidly became gangrenous, and was therefore not returned at the operation; and about fourteen days afterwards, a piece of small intestine, eight inches long, came away by the wound. She began to pass fecal matter *per rectum* about three weeks after the operation, and, at the present time, very little fecal material passes from the wound, showing that the continuity of the intestinal canal has been completely restored. She aborted soon after the operation. Mr. Paget considered that this case well illustrated the importance of disturbing the intestine as little as possible at the seat of constriction in cases where the strangulated portion is gangrenous; and gave as the rule for practice, that the constriction should be just sufficiently divided to enable the finger to pass into the intestinal canal above the seat of stricture, in both directions from an opening made in the strangulated portion, so as to make sure that feces will pass freely from the wound.

Mr. Paget next made some remarks on the subject of congenital hernia and undescended testis in connection with a case of this sort upon which he had lately operated. The patient, a young man, had never suffered from hernia before, and the rupture for which he was admitted came on suddenly after a strain; he was admitted four days after strangulation had set in, and two days after the bowels had ceased to act. The testicle on the ruptured side was very small and lay in the inguinal canal.

On the subject of the condition of undescended testes, Mr. Paget remarked that they are generally imperfect and sometimes very small. In speaking of the liability of these organs to be complicated with hernia, Mr. Paget said that this liability is *nil* when the testis is completely within the abdomen, but that if the organ be situated in any part of the inguinal canal, the patient lives in constant danger of hernia. Allusion has been made to certain rare cases in which persons with undescended testes occasionally suffer from attacks of obstruction, the symptoms of which closely resemble those of strangulated hernia, but no hernia can be made out. Mr. Paget considers that, in such cases, a small portion of the gut does get strangulated for the time being, but that it is so small as to escape detection.

Particular attention was drawn to the possibility of confusing an inflamed retained testis with a strangulated hernia, and the necessity of always examining the scrotum in every case of hernia in a male was insisted on. Apart, however, from the absence of a testis from the scrotum, Mr. Paget considers that the character of the vomiting is a great help to diagnosis in these cases: in *hernia*, the vomiting is free, but there is comparatively little nausea, while the nausea in cases of *inflamed undescended testis* is constant, and the vomiting comparatively slight.

Mr. Paget drew attention to the important fact, that a congenital hernia, when of large size, passes through the aponeurosis of the external oblique, instead of passing downwards into the scrotum, as in ordinary cases, so that in operating for congenital hernia, the surgeon often comes to the hernial sac immediately beneath the superficial fascia.

Treatment of Reducible Hernia complicated with Undescended Testicle.

—Mr. Paget advised that a truss should be worn for a number of years when the position of the testis will allow it; viz., when this organ is at, or immediately outside, the external ring; but that no truss should be worn when the testis lies at the internal ring, for it may descend lower; nor when it is situated midway between the external and internal rings, for then the pressure of a truss would be insupportable. Mr. Paget mentioned five years as the smallest period after the last descent of the hernia during which a truss should be worn; but alluded to cases in which a congenital hernia had reappeared after much longer intervals than the time specified, and thought it advisable that, if possible, the truss should be worn as a permanency.

Mr. Paget made a few remarks on the case of umbilical hernia in a boy on which he operated last Saturday (see page 104). This patient has died since the operation, but no *post mortem* examination has been allowed. He had suffered severely from rheumatic fever, and subsequently from ascites; and Mr. Paget remarked that some such history generally preceded the appearance of umbilical hernia in young persons, the hernia usually appearing after the relief of the ascites has left the abdominal walls weakened and lax; and in connection with this

subject, attention was called to a museum specimen (taken from the dissecting-room, and without history), in which four herniæ existed—two inguinal and two femoral—probably induced by some cause of distention acting at the points naturally weakest.

MUSEUM NOTES.

SPECIMENS ILLUSTRATING RECOVERY AFTER SEVERE FRACTURES OF THE SKULL.

OUR museums contain but few preparations which bear evidence as to the condition of the skull in cases of recovery after severe fractures. Such specimens are of much value in several directions, but chiefly in two; 1st, as to the kind of repair which ensues; and, 2nd, as to the history of the patient's subsequent health. In some instances, we find that the patient's after-life could scarcely be considered a gain either to himself or the community; whilst in others the recovery appears to have been perfect in all respects. We shall append some remarks to the conclusions of our notice of these specimens. In the mean time we shall be much obliged to any correspondents who can supply us with histories and descriptions of other specimens.

THE ARMY MUSEUM, NETLEY HOSPITAL.

THIS Museum contains some especially valuable specimens of injured skulls, and, among them, the following.

Nos. 2783, 2506. The calvaria of a man aged 30, showing a united fracture of the frontal bone to the left of the middle line. The fracture was caused by a blow with a broom. It is of an oval form, an inch wide and an inch-and-a-half long; the fragments slope down to a common centre, "ponded", the depression at the middle being a third-of-an-inch; consolidation is perfect. The man lived two years after his accident, but was liable throughout to epilepsy, and at length died in a fit.—[Qy. Would it not have been better to trephine?]

Nos. 2507, 2784. Calvaria of a young man who received a compound fracture of the frontal bone in the left side from a quoit. He was stunned, but soon recovered, and walked to the Hospital. He refused an operation, and recovered well. Three months later, he became liable to epilepsy. Fits recurred, and finally he died in coma after a severe epileptic paroxysm. The dura mater was thickened and adherent.

No. 2885. Union after a depressed fracture of the parietal bone. No history of the accident. Probably the fracture was not compound.

No. 2884. From a man who recovered after a simple fracture of the skull (gunshot). The soft parts were much bruised, and ulcerated afterwards. He recovered perfectly. This and several other specimens show the edges of the fractured inner table well smoothed down or concealed by new bone.

No. 2511. Recovery perfect, after fracture of frontal bone, with depression.

No. 2788. (Dr. Jameson, Assistant-Surgeon, Royal Dragoons.) A depressed fracture of parts of temporal and parietal bones well united by bone. The depression in the middle is about half-an-inch. The area involved is as large as the palm of a hand (nearly). Union complete. The patient's recovery was perfect in every respect; and he had good health until his death, from fever. No history of the injury, but probably the fracture was *not* compound.

No. 2505. A calvaria with a long fissure (Qy., sabre-cut) in the right parietal bone. It is partly closed by new bone, and partly still open. The patient, at the time of his death, was an epileptic lunatic, of morose and violent habits. No history as to the injury.

THE DUBLIN MUSEUMS.

State of the Bone in a Skull many years after Fracture.—E.a.279 (Museum of College of Surgeons, Dublin) is the skull of a young woman in whom a fracture had occurred in childhood. In all probability the fracture was compound, and bone was removed at the time. In the right frontal region there is a vertical cleft passing up from the orbital notch nearly to the coronal suture. This cleft is, in parts, closed by bone, but in several places apertures pass through it, one hole being large enough to admit a cherry-stone. It was presented by Dr. Minchin, to whose courtesy we are indebted for the following valuable particulars respecting it.

"56, Dominick Street, Dublin, 20th January, 1870.

"Sir,—The case of the individual whose cranium is marked E.a. 279 in the Museum of the College of Surgeons, has not been published, and is a very imperfect one. It is that of a young woman aged 20 years, who died in a violent epileptic fit a short time after admission into the hospital. All that I was enabled to learn of her history was,