a specimen of the same kind, which is very interesting. The patient was in this hospital, and you will find all the particulars in the Museum Catalogue, Series xi, No. 4. This man had, it was evident, extensive laceration of the kidney, from which he quite recovered; but two or three months afterwards he died of typhoid fever, and the healed laceration of the kidney was found. There can be no doubt about this case.

I have given you already the plan of treatment which you should adopt when peritonitis ensues in these cases. But when the laceration is at the back of the kidney, and diffuse cellular inflammation occurs in the loin, you must make a free incision to prevent burrowing.

The treatment of lacerated kidney is, for the most part, as I have told you, very simple; but much to my surprise, a new plan of treatment was given to me some years ago when I was examiner at the Army Board. It was to "cut out the injured organ—an operation which has not unfrequently been performed with success"! This answer was given to me in writing by a gentleman who possessed two diplomas! I need not tell you that this treatment I would not advise you to follow.

This patient, as I have said, is going out to-morrow; but he has been warned to be very careful in everything, but especially as to walking and going about much, owing to the injury which I suspect he met with about the pelvis.

ABSTRACT OF A CLINICAL LECTURE ON DROPSY.

Delivered at St. Thomas's Hospital on November 2nd, 1871.

By CHARLES MURCHISON, M.D., F.R.S.,

Physician to St. Thomas's Hospital, and Joint Lecturer on Medicine at St. Thomas's Hospital Medical School; etc.

AFTER noticing the general nature of dropsy, and tracing it to the osmotic circulation constantly going on in the tissues of the body, and between the vascular system and the serous and mucous membranes, Dr. Murchison said that the causes of dropsy may be reduced to two heads—(1) excessive venous repletion, and (2) diminished exhalation in one part of the body, leading to compensatory exhalation in another. There are some other causes, he said, which you will find mentioned, and which may contribute to the existence of dropsy: one of these is an altered condition of the blood. No doubt this may assist in the production of dropsy, as in anæmia or hydræmia, when the blood passes more easily through the membranes than in the state of health; still, in the dropsy of anæmia, you will find the heart at fault mainly: there is a deficiency in its propelling power. There is a general impression that, in renal disease, the dropsy is due to an altered state of the blood; but I shall give you some reasons for a different conclusion—that the dropsy from kidney-disease is to be explained by the second general cause which I have mentioned. Some writers speak of dropsy as sometimes having a nervous origin; and cases of dropsy, associated with paraplegia, and even with hemiplegia, have been recorded by Dr. Laycock of Edinburgh, in support of this view. But this cause of dropsy is certainly far from common. It is very important to remember the two main causes of dropsy, for the key to the whole treatment depends upon them.

Dr. Murchison then divided the forms of dropsy, from a clinical point of view, into three: 1. Partial dropsy, or dropsy limited to one part of the body throughout its course; 2. Dropsy which is first partial, but becomes general; and 3. Dropsy which is general from the first. The first form is due always to excessive venous repletion; and this overdistension of the small veins is the result of some mechanical impediment to the venous circulation. Dr. Murchison illustrated this by various examples, and called particular attention to the clinical characters of the dropsy due to obstructed portal circulation; viz., the beginning of the dropsy in the abdomen; the dyspnoea following, but not preceding, the ascites; the tendency to hæmorrhoids, vomiting, and diarrhoea, or to hæmatemesis; enlarged spleen and varicose veins on the right side of the abdomen. In the second form of dropsy, the swelling begins in the feet and proceeds upwards; and this also is due to excessive venous repletion, from obstructed venous circulation. But here the obstruction is in the central organ of circulation—most frequently mitral disease, or fatty heart, or dilated right side of heart, consequent on chronic bronchitis and emphysema. In the third form of dropsy, the swelling invades all parts of the body at once; and this is due to diminished exhalation in one part, leading to compensatory exhalation in another. This dropsy is almost invariably renal. Albumen is present in the urine. How is it that disease of the kidneys produces dropsy? On this point you will find great difference of opinion among different writers. In some works this question is rather evaded than answered; but the general view is, that in consequence of disease of the kidney, the blood becomes poisoned, and, as the result of this altered condi-

tion, the liquor sanguinis exudes. For example, Dr. Owen Rees, in the Harveian Oration a few years ago, made the remark that the retention in the blood of the urinary salts made the liquor sanguinis permeate the membranes with increased facility. But there is one very important objection to this view of the case—that, if it be correct, it is most remarkable that in the form of kidney-disease, in which of all others there is the greatest tendency to the retention of the urinary salts in the blood, there is little or no tendency to dropsy. I mean the contracted granular or gouty kidney, the peculiarity of which disease is, that the patients often die of uræmic coma and convulsions, with little or no dropsy. We must look, then, for some other cause of the dropsy. It is this: you get a diminished exhalation of water from the kidney; and hence dropsy is chiefly met with in those forms of kidney-disease in which the tubes are blocked up by diseased epithelium or inflammatory products (acute nephritis and fatty kidney).

Dr. Murchison then made some remarks on treatment. In the first place, one great object is to relieve venous repletion, which, in the case of portal dropsy, may be accomplished by purgatives, which cause a watery exhalation from the bowels. Another object is to remove obstructions to exhalation from the skin or kidneys by diaphoretics, warm baths, diluents, and diuretics. Thirdly, you must endeavour to stimulate compensatory exhalation from the skin and bowels. You will also find much good derived from tonics, such as iron.

Several cases in the hospital were commented upon as illustrating the above remarks, and the details were given of two cases now in the wards; viz., a case of ascites due to disease of the vessel, and a very remarkable case of general dropsy, in which there was no evidence of disease either of the kidneys or of the heart.

VISIBLE PULSATION OF THE ARTERIA CENTRALIS RETINÆ IN A CASE OF INCOMPETENCY OF THE AORTIC VALVES.

By C. E. FITZGERALD, M.B., M.Ch.(Dubl.),

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AT the Heidelberg Ophthalmological Congress held in September last, Professor Becker of Heidelberg, as my colleague Mr. Swanzy informs me, read a paper on Visible Pulsation of the Arteria Centralis Retinæ in cases of Incompetency of the Aortic Valves, and also showed a patient who exhibited the phenomenon. Quite recently I have had an opportunity of examining a well-marked case, which appears to me possessed of sufficient interest to make it worth while recording.

The patient is a man aged 40, who was admitted into the Infirmary of the South Dublin Union on the 3rd instant, under the care of Dr. W. B. Jennings, to whose kindness I am indebted in granting me permission to publish the following particulars. I do not think it necessary to give the history of the case; suffice it to say, that all the symptoms of incompetency of the aortic valves were present, and very well marked.

On the first occasion on which I examined the patient's eyes, I was able to detect in the right eye (the pupil being partially dilated with atropine) a very distinct pulsation of one of the retinal vessels, immediately at its point of emergence from the optic disc; this portion of the vessel presented such a dark purple colour, that, combined with its close proximity to one of the veins, which were somewhat congested, I failed to satisfy myself completely as to whether the pulsation was in the artery or in the vein. On a subsequent occasion, I again examined the patient several times, but was still unable to settle this point; a few days later, however, I dilated the pupils fully with atropine, and used a four-inch, in place of the ordinary two-and-a-quarter-inch convex lens. The large image thus obtained enabled me to determine clearly that the pulsation was certainly in the artery. Moreover, by resting the little finger of my left hand on the temporal artery, I found that its pulsations and those of the retinal vessel were synchronous.

It was in a portion of the superior branch (inverted image) of the arteria centralis, extending from its point of emergence to where it crossed over one of the veins, that the pulsation was visible; and I am inclined to think the difficulty of determining as to whether it was in the artery or vein was caused by the column of blood at each pulsation projecting this portion of the artery forwards; the rays of light were consequently no longer reflected directly from the walls of the vessel, which, in fact, became foreshortened and partially thrown into shade. I was unable to detect any pulsation in the retinal vessels of the left eye.

I may mention that there was no increase of tension in either eye; in fact, the tension of the right eye was, if anything, below the normal.

Dr. Becker states that the phenomenon is not invariably present in cases of incompetency of the aortic valves, nor is it at all times visible in those cases in which it has been observed. It was previously noticed by Dr. Quincke, assistant to Dr. Frerichs.

I am indebted to Dr. Purser for the sphygmographic tracings of the man's pulse.

MANAGEMENT OF THICKENED OR DISEASED OMENTUM IN HERNIA.

By THOMAS LEEDS, ESQ.,

Lecturer on Physiology in the Sheffield School of Medicine.

IN cases of hernia, where the sac has been opened and found to contain thickened or diseased omentum, what is to be done with the omentum? As the opinions of surgeons are still divided upon this point, I may, perhaps, be excused for describing the particulars of a case which has lately occurred in my practice. The plan of removing the omentum, applying ligatures, and returning into the abdomen, is, I believe, deservedly falling into disrepute. The best practice lies, it would seem, between the plans (1) of leaving the omentum in the wound; (2) of removing it and allowing the upper portion to remain in the wound; (3) of leaving the omental tumour outside the wound, and applying a ligature around it, with a view of causing it to separate, and of setting up adhesions around its neck. Various eminent surgeons, including Syme (*Principles of Surgery*, 1863) and Callender, recommend the first-named mode of practice. Mr. Callender says: "Unless, however, it" (*i.e.*, the omentum) "is unmistakably gangrenous, it should, as a rule, be left in the wound, and the wound should be left partly open for drainage. I never saw any result from removing omentum, except now and then a troublesome bleeding. I never saw any harm from leaving it in the wound; but I have seen the disastrous consequences of returning, even what one hears called 'not bad-looking' omentum, into the cavity of the abdomen." (*St. Bartholomew's Hospital Reports*, vol. iv). Mr. Callender elsewhere also urges the necessity of leaving a portion of the wound open for drainage. Of the second, or immediate removal plan, I know little; but, as there is some danger of hæmorrhage and its consequent debilitating effect upon the patient, and the possible risk of peritonitis through blood escaping into the abdomen, it seems to me inferior to the third plan—that of applying a ligature. In Holmes's *System of Surgery*, vol. iv, is given the result of some cases in which the ligature was successfully applied at St. George's Hospital (by Mr. Pollock, I believe). "Of twenty cases, in which the omentum was securely tied, a few died; but the notes of the after-death examination of these show the cause of death to have been, in all cases, independent of the ligature placed around the omentum. Of eleven cases in which the omentum was allowed to remain in the sac, many recovered, although abscess and sloughing of the tissue occurred in some of them."

CASE.—On November 3rd, I was sent for to see a woman, aged 61, who had been vomiting for four days, and was now throwing up stercoraceous matter. The history of the case pointed to an irreducible hernia of six years' standing. The taxis having been tried, without success, assisted by my friend, Mr. Fayer, I cut down and found a pad of omentum, of the size of a large hen's egg, under which lay a knuckle of liver-coloured intestine. The stricture (at the external ring) was divided, and the bowel returned. Taking into consideration the length of time that the omentum had occupied its present position, it was deemed unsafe to return it. The omentum was left outside the wound; sutures being placed on each side, so as to constrict it, as far as possible, and to prevent the escape of fluids into the abdominal cavity. A ligature was afterwards placed tightly around the omentum. On the

tenth day, the removal was completed by means of the *écraseur*. There was scarcely any hæmorrhage. The patient recovered without a bad symptom throughout, and is now (November 18th) able to sit up. By thus constricting the neck of the tumour, this patient—an old woman—was saved from the chance of exhausting suppuration, which occasionally follows the plan of leaving the omentum in the wound, and from the injurious effects of troublesome hæmorrhage, which has been known to occur through the immediate removal of omentum.

In another case of a similar nature I should be inclined to use the *écraseur* earlier—about the fifth or sixth day—as adhesions would by that time in all probability have taken place.

A PLAN FOR FACILITATING THE REDUCTION OF STRANGULATED HERNIA BY TAXIS.

By PHILIP CRAMPTON SMYLY, M.D., F.R.C.S.I., Surgeon to the Meath Hospital.

"THE objects to be attained in the treatment of hernia in a state of strangulation, are the release of the protruded parts from stricture, and their replacement within the abdomen, provided they are in a suitable condition." These objects are usually sought to be accomplished either by taxis or by operation with the knife."

Some years ago, a nurse in one of the medical wards in the Meath Hospital had a reducible femoral hernia. She neglected to wear a truss, and one day it consequently became strangulated. My father, being the surgeon on duty, tried taxis, as did also the other surgeons, without success. After consultation, an operation was decided on, but every argument failed to persuade the patient to submit—she would rather die than be cut. After the surgeons had left, the clinical clerk (since a very distinguished medical officer in the army) and I thought it a good opportunity to study the relation of the ring to the sac. The result of our examination not a little surprised us. On withdrawing my finger from the ring into which I had inserted it, we heard a distinct gurgle. My fellow-student pressed the tumour, and it passed into the abdomen. The patient lived for many years afterwards, and performed her duties in the hospital. I have since frequently tried to repeat this happy manoeuvre, and with most satisfactory results.

For inguinal hernia in the male, the index finger is applied to the lowest part of the scrotum. This is invaginated (as in Wutzer's operation for radical cure), the finger being passed behind the testicle and cord up to the external ring. The hernial tumour is then pressed down-

FIG. 1.—Scrotum invaginated.

wards over the finger towards the back of the hand, so as to make the structures in the ring tense, and consequently smaller. The invaginating finger is then forced firmly upwards and outwards in the direction of the internal ring. As soon as the finger is firmly grasped, the