eighteen hours; but, with the usual native stupidity, he did not seek assistance until the pain grew unbearable. In this case, I was most fortunately situated in being able to have the benefit of a consultation with so eminent a surgeon as Surgeon-General W. A. Mackinnon, C.B., Army Medical Department, who was then on his way to Malta from Hong Kong. The patient was at once placed in a hot bath, and gentle taxis applied for a few minutes, but, as we anticipated, without success. The symptoms becoming more urgent, he was placed under the influence of chloroform, and the taxis again unsuccessfully applied. Everything being ready, the operation was commenced without delay.

The usual incision was made over the neck of the sac, and the soft parts carefully dissected down to the peritoneum. The seat of stricture was then felt for, and discovered by Surgeon-General Mackinnon to be near the internal ring, and was carefully divided by him. At this stage, it was quite evident that the constriction external to the sac was not the sole cause of strangulation, but that it was in a great measure due to the neck of the sac itself, and the condition of its contents. This being the case, it was clear that the only chance to effect safe reduction was by opening the sac, and satisfying ourselves as to the condition of its contents. On opening the sac, we found that it contained about two feet of intestine. There was a good deal of serous effusion into the sac; the bowel was enormously distended with flatus, greatly congested, and in some places of a deep purple colour—though the natural glistening aspect of the surface was still to be observed. So greatly was the bowel distended, that reduction by gentle manipulation could not be effected. Such being the case, Surgeon-General Mackinnon suggested puncturing the peritoneal coat of the intestine with a capillary trocar. This proved very effectual, and the entire hernia was easily returned. The operation was then completed, and the wound carefully brought together by sutures. Carbolic silk was used for the deeper ones, and for tying one or two vessels; silver wire for the external wound. A compress of several layers of lint, saturated with carbolic lotion, was then applied, and over that a layer of cotton-wool—the whole being kept *in situ* by a spica bandage. The patient was then removed to a cabin that I previously had prepared for him. I administered a full dose of opium, which procured him some sound sleep. At six o'clock that evening, his temperature was 100° Fahr., and he said that he felt quite easy and free from pain.

I may mention here that the temperature of the cabin in which he was averaged between 86° and 90°. This high temperature was due to having the ports shut, as we were going against a head sea. He passed a quiet night, complained of very little pain, and slept a good deal.

Space will not permit me to give an account in detail of the progress of this case towards convalescence. Suffice it to say, that he made a wonderfully rapid recovery. On one occasion only did his temperature exceed 100° Fahr., this increase occurring on the fifth day after the operation, and then it only reached 100.5°. With this slight rise in temperature, there was also a sudden increase in the abdominal pains. As, up to this, there had been no indication of any discharge from the wound, the dressings had not been disturbed. These unfavourable symptoms now coming on, we thought it advisable to satisfy ourselves as to the state of the wound: we therefore removed the dressings, and were very pleased to find that primary union had taken place—there not being the slightest trace of any purulent discharge. The silver sutures were then removed, and the carbolic dressings renewed. Hot turpentine stupes were applied to the abdomen, and a full dose of opium administered. By these means the pain was soon allayed, and that evening his temperature was down to normal. The next morning, there was a decided improvement in all the symptoms, and our fears of peritonitis were quite allayed. Up to this, there had been no action of the bowels; but now he felt that a motion would make him feel easier. A small dose of castor-oil was administered, which acted in a couple of hours, and had a very beneficial effect.

We arrived at Point de Galle that evening; and the next morning I had him carefully removed to the Civil Hospital, to complete his convalescence, which was now fairly established. Surgeon-General Mackinnon had a letter afterwards from the colonial surgeon at Galle, informing him that the patient had been discharged from hospital in three weeks, perfectly cured; and he was of opinion that a radical cure had been effected.

On my return to Galle, about three months afterwards, I heard that he had resumed his old work as a coal-trimmer on board one of the Peninsular and Oriental ships.

My object in making this case public is twofold. 1. The enormous size of the hernia, the amount of surgical interference that was necessary under the circumstances, and the unusual rapidity of the recovery, were remarkable. 2. I think it is a striking example of the unsusceptibility to inflammatory changes that exists in the negro and Indian races; and which, I fancy, is in a great measure due to the un-

stimulating nature of their dietary. I could mention several other cases in which wounds in these men have healed with a rapidity that surprised me, especially as circumstances rendered it impossible properly to carry out antiseptic measures.

In conclusion, I must express my thanks to Surgeon-General Mackinnon, for his kind and valuable assistance in the operation; and it is only fair to say, that the success achieved in this case was in a great measure due to his skill.

A CASE OF PORRO'S OPERATION: RECOVERY.

By T. SAVAGE, M.D., M.R.C.P.Lond., F.R.C.S.Eng.,
Senior Surgeon to the Birmingham Hospital for Women; Consulting Obstetric Surgeon to the Kidderminster Infirmary.

DR. CLEMENT DUKES of Rugby sent for me on July 12th, 1882, to see with him a patient whom he had been attending, and had seen a few hours previously in consultation with Dr. Heslop of Birmingham. The case was an urgent one, and it was considered that it would be necessary to give some relief of a surgical nature, and that without much delay. The following are the notes which I took at the time. Mrs. H., aged 25, was married on January 4th, 1882. Her catamenial history before marriage was normal; she had three periods after marriage, the last one ending on March 18th. Soon after this, she had vomiting and constipation.

She first consulted Dr. Dukes on June 30th, having pain on lying down, and a slight blood-discharge. He examined her the next day, and found a tumour on the right side of the abdomen, of pyramidal shape, and most prominent between the umbilicus and the iliac crest. It was very hard, dull on percussion, and non-fluctuant. It extended also well over into the left side. Neither the patient nor her husband had noticed any enlargement until shortly after menstruation had ceased in March; and they then thought it was to be attributed to pregnancy. She had had no rigor, nor rise in temperature, but had been a good deal troubled with painful micturition.

When I saw her, I found the condition as above described. Her face was flushed; temperature normal; pulse 108. The tongue was white (aphthous?). She had been taking morphia for the pain, which had been very severe, and was increasing in intensity. She had no rest nor sleep, and for some days had been almost constantly vomiting. Her face had the aspect of much suffering, and she was becoming thinner daily. The tumour was very hard, and rose to the level of the umbilicus. It was very prominent on the right side, having almost the appearance of an abscess that wanted to be opened. It was dull and non-fluctuant. It gradually flattened over on to the left side. The prominent part of the tumour was very tender indeed, especially on its right side. Both flanks were resonant; and the tension of the abdominal wall was most extreme. Through the vagina, the cervix was felt very high up on the left, soft, and a little open. On the right side, through the vaginal roof, the swelling projected downwards, and was felt to be in direct relation with the abdominal tumour; and it was quite immovable. The uterus appeared to be quite distinct from the tumour; there was a sulcus between it and the cervix, and pressure from above did not affect the cervix.

In considering the diagnosis, hæmatocele and pelvic abscess were excluded; but it seemed likely that it might be an extra-uterine gestation, a myoma, or an ovarian tumour with the addition of intra-uterine gestation. It was quite clear that relief of some kind must be afforded to the patient without delay; and one of two courses seemed open for that purpose. The first was, to induce abortion; this would relieve the tension, and therefore the pain, though only to a very slight extent, not enough to be of much service, and would still leave the tumour, the cause of the trouble, untouched. The operation itself would also not be unattended with risk. The second course would be to make an exploratory incision, with a view, if possible, of removing the tumour. After taking into account the hardness and the rapid growth of the swelling, as well as the intense pain of the last fortnight, the inability to take food, and the emaciation, it was agreed to recommend an abdominal section, to which both the patient and her husband assented, after having had explained to them the objects and risks of the operation.

On the following morning therefore, Dr. Dukes giving ether, I made an incision nine inches long, the upper portion extending nearly two inches above the umbilicus. The tumour was found to be a large solid fibro-myoma growing out, and forming part of the right side of the uterus. The cavity of the uterus was found to contain a foetus, and was pushed upwards and to the left. The right ovary and Fallopian tube were in front of the tumour, and almost black from compression between it and the abdominal wall.

It was thought that it would be safer and easier to remove the whole mass, which was accordingly done, rather than attempt removal of the tumour alone. The stump was secured by a wire clamp, and its serous outer surface was attached by silk to the abdominal wound. Two thick silk ligatures were also tied round the stump for security. Very little blood was lost, and much care was taken to prevent any from being left behind the bladder, or on the vaginal roof, which appeared to be considerably dragged upwards by the clamped stump. A glass drainage-tube was inserted just above the stump, and perchloride of iron was applied to the end of the stump. After the operation, which lasted about an hour and a half, the finger passed into the vagina detected the cervix high up, but otherwise normal, showing that the wire had encircled the uterus at about the level of the inner os, and had not included any of the vaginal roof with danger to the ureters. Only about four ounces of ether were administered. The mass removed weighed nearly 9lbs., and contained the foetus with membranes intact. The recovery after this formidable operation was uninterrupted, and is very largely to be attributed to the care and skilful treatment of Dr. Dukes who had the sole charge of the patient after the operation. She may now (August 25th) be said to be quite well. The breasts secreted milk on the fourth day. The clamp came away on the twenty-first day.

This is the second time that Porro's operation has been successfully performed in this country, so far as I have been able to learn. The first case was, very curiously, done by Mr. Knowsley Thornton at the Samaritan Hospital the day before this one (see BRITISH MEDICAL JOURNAL, July 22nd); and it seems to me that it ought to be more generally successful than the records from abroad show it to have been. Dr. Alexander Simpson's compiled table shows recoveries 41.6 per cent., and deaths 58.3 per cent.; and in Italy, where it has been done 38 times, the deaths were 24, or 63 per cent., and the recoveries 14, or 37 per cent. Experience and observation up to the present time incline me to think that the extraperitoneal method of treating the stump will be found to be the best, more frequently than the intraperitoneal.

PRELIMINARY IRIDECTOMY IN EXTRACTION OF CATARACT.*

By FRANK H. HODGES, F.R.C.S. Edin.,
Ophthalmic Surgeon to the Leicester Infirmary.

ON my appointment as Ophthalmic Surgeon to the Leicester Infirmary, five years ago, I sought the advice of Mr. Critchett and Dr. Snellen of Utrecht, as to the safest method of extracting cataract. Both were emphatically in favour of performing an iridectomy some weeks prior to the extraction; Mr. Critchett remarking, "If my eternal salvation depended upon the success of a single case of cataract, I would do a preliminary iridectomy;" and Dr. Snellen, "Were I to operate on my own father I should do a preliminary iridectomy." Dr. Snellen further informed me that his custom was to tell his patients that the usual operation at one sitting (Graëfe's method) was a very successful procedure, but that dividing the operation by doing an iridectomy first, and extracting the cataract later on, was somewhat safer, though necessarily the cure was a little delayed; then leaving the choice of operation to the patient.

With regard to the interval that should elapse between the iridectomy and the extraction, Dr. Snellen's rule was "not before six weeks, preferably eight." I have hitherto maintained the latter interval, though I think the rule that my friend, Mr. Priestley Smith, adopts, of doing the extraction as soon as any vascularity in the region of the iridectomy wound has subsided, is perhaps better than any arbitrary fixed interval.

Of the comparative advantages of this method of extraction, if any, over the more usual methods, I have no personal experience, having during the last five years performed preliminary iridectomy in all cases of extraction of senile cataract. Experience of it, however, leads me to claim several conspicuous advantages; and of these I would place first, "absence of hæmorrhage from the iris at the time of the extraction." In my first case in private practice, the subject of which was a gouty old lady, on division of the iris the anterior chamber filled with blood, which occupied six weeks in absorption. A sharp attack of gout came on four days after the iridectomy, but fortunately did not affect the eye. At the extraction eight weeks later, another attack of gout occurred, and this time the iris became involved, but yielded promptly to leeches and atropine, with colchicum internally. The old lady made an excellent recovery, and can now read No. 1 fluently. The cataract had a small hard nucleus with abundant soft cortical substance, which I

could not completely remove, and I believe that the preliminary iridectomy turned the scale from failure to success; for, had the complication of hæmorrhage in a chamber with cortical substance been added to the existing one of gouty iritis, it is highly probable the eye would have been lost.

Besides the greater safety to the eye from the absence of blood in the anterior chamber, it is a manifest advantage to the operator not to have the parts obscured in the important stages of laceration of the capsule and extraction of the cataract. Another advantage of dividing the operation is the experience gained at the first as to how the anæsthetic is borne. My practice is to always to give an anæsthetic for the iridectomy, ether or ethidene bichloride for patients under sixty, and chloroform for those over*; and then, if this be badly borne, or cause much after-sickness, for the extraction either to give no anæsthetic or substitute another. Of the minor advantages, I would instance the tranquility of mind with which a patient awaits the extraction after a painless iridectomy followed by the usual rapid recovery. I have had several patients, who prior to the iridectomy were dreadfully nervous about it, or more usually the anæsthetic; who, upon suffering no inconvenience from the anæsthetic nor pain from the iridectomy, submitted calmly to the subsequent extraction. Again, cataract not unfrequently happens to people in excellent health, who have never been laid up for a day, and to whom confinement is necessarily irksome. The little preparatory training which they get for the iridectomy stands them in good stead for the all-important extraction, and accustoms them to the new sensation of having the eyes bandaged, and of lying on only one side or the back, and to the maintenance of perfect quiet. These latter may seem trifles, but success in eye-surgery often depends upon scrupulous attention to many minor points of detail.

CLINICAL MEMORANDA.

NOTE ON THE AURICULAR PULSATION OF MITRAL STENOSIS.

AS I finish the perusal of Dr. Balfour's paper in the current number of the BRITISH MEDICAL JOURNAL for August 12th, and the discussion thereupon, which took place at the late annual meeting, I am moved to write, while the subject is in memory, to say that I am quite in accord with the views enunciated by Dr. Broadbent, that any pulsation on the chest-wall, and tracings derived therefrom, can hardly own an auricular source. I say this upon the strength of a good deal of observation. Dr. Balfour's writings on this as on all subjects, interesting and pregnant as they ever are, arrested my attention long ago, as also did Dr. Gibson's paper and tracings when they were first published; and, so far as opportunity has offered since that time, I have taken occasion to ascertain in the deadhouse the relations existing between the left auricular appendix and left auricle at the surface, in cases of mitral constriction; and, though I have seen many cases where the auricle and the auricular appendix have been dilated, neither has ever come so near to the surface as to make it at all probable, to my mind, that any pulsation could be appreciable enough to record upon the chest-wall. I have never seen even the most dilated left appendix which was not a considerable depth below the surface; and, discounting the dead for the living position, I still am more than in doubt. On the other hand, three or four cases have occurred in which, during life, a marked pulsation has been observed in the second left interspace, and in all, it has been adequately explained by the existence at the necropsy of a much dilated pulmonary artery. Dilatation of the pulmonary artery is a condition which occurs under diverse circumstances, and it is not uncommon. Its not unfrequent occurrence disposes, I think, of Dr. Balfour's objections to the basic murmur being of pulmonary origin, viz., that there is no possible cause of murmur in the pulmonary artery which is not equally operative at the aortic orifice, or indeed more so. Given high tension in both systemic and pulmonary circulation, I believe the pulmonary artery dilates readily, and the aorta much less so.

I should be sorry to think that the existence of curable dilatation of the left ventricle in chlorosis, so ably maintained by Dr. Balfour, was in any way endangered by a disbelief in the auricular impulse; but, whether it be so or not, I am of opinion that the pulsation observed in some of these cases, and the *bruit* heard in many are probably due to waves in a dilated pulmonary artery, the dilatation being consequent upon mitral regurgitation, and to the resulting obstruction to the pulmonary circulation.

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* Read before the Annual Meeting of the Midland Branch.

* In deference to the opinion of Mr. Jonathan Hutchinson that, for patients over sixty, chloroform is the safest anæsthetic.