keeping the friends quiet, will amply occupy your time. It is also conducive to the end you have in view, to shave the head and apply cold lotions to the skull.

After reaction has returned, you will find advantage in the application of ice to the head; it is physiologically correct, and is often a great relief to the patient. You may remember that this poor woman used the first power of speaking that returned to her in begging me to continue the ice: whenever it was applied, it induced sleep, and was most agreeable. What a strange state a person must be in for ice to the head to be agreeable! But so it was.

When, then, you are called in to a case of apoplexy, let these considerations pass through your minds:—

1. Does it depend on destructive softening of the cerebral substance? If so, I must not let anything persuade me to bleed.

2. Has the effusion taken place so long ago as to be, if blood, coagulated? If so, again, I had better abstain.

3. If it be fluid, bleeding is very much to be desired; it may prevent increase of the effusion and relapse.

4. But, to make bleeding most useful and least hurtful, the proper time must be selected; namely, the time when the heart regains its strength.

5. The best guide is the circulation. The sharpness and hardness of the pulse and heart, as felt by you, are a faint picture of the sharpness and hardness of the pulse, as felt by the patient's brain. With your fingers on the wrist, let your mind travel into the interior of the skull.

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

BRISTOL ROYAL INFIRMARY.

FIVE CASES OF INTESTINAL PERFORATION.

By EDWARD L. FOX, M.D., Physician to the Infirmary.

CASE I. Joseph Hollier, aged 32, policeman, was admitted into the Royal Infirmary, on July 18th, 1860. Typhoid fever had broken out a short time before in a quarter of the city much inhabited by the police. He had seen one of his brother officers of the force in violent delirium from fever. The symptoms were very slight all through his illness; but from the first moment he was convinced he should die. He was taken ill on July 14th, and died on August 7th.

Many of Peyer's patches were found ulcerated. The cæcum was covered with a very large quantity of circular ulcerations. One of these, about three inches from the valve, had perforated all the coats of the intestine, and fecal matter had escaped into the cellular tissue behind, but not into the peritoneum.

CASE II. Thomas Hollier, aged 28, policeman, brother of the last patient, had seen several of the police in fever. He was taken ill on September 3rd, 1860, and died on October 14th. There was scarcely any diarrhoea throughout his illness, and the symptoms always seemed slight. He, however, had the same unfortunate conviction that he should die.

There was a little fluid in the abdomen. The coils of small and large intestine were matted together with flakes of yellow lymph. A mass of lymph under the parietal peritoneum just above the sigmoid flexure. About a foot and a half above the ileo-cæcal valve was an ulcerated patch, and another a little lower down. Immediately above the valve was a space, about the size of the top of a stethoscope, entirely covered with ulcers, in which, however, there was no yellow matter, and which seemed to have been in process of repair. Close below the valve, in the colon, was a large ragged ulcerated patch, in which perforation had occurred in two places: in one spot the perforation was as big as a pin's head; in the other, which was close to it, the perforation was as large as a small filbert. These perforations had been closed up by a band of lymph, which was torn across in opening the viscera. There were only two or three ulcers besides in the colon.

CASE III. Mary Ann Wookey, aged 18, was admitted into the Infirmary, on October 11th, 1860. She had just been discharged from the wards as an incurable epileptic; and, during her sojourn there, had occupied a bed next to that of a fever-patient. On admission, she had the coated tongue, abdominal tenderness, and rose-coloured spots of typhoid fever, but there was no diarrhoea. She gradually became convalescent, and was allowed some meat on November 3rd. On November 8th, she suddenly felt great pain over the ascending colon, the abdomen became tympanitic, and she perspired profusely. This condition, accompanied with total constipation and a thready pulse of 132, persisted until the 24th. On that day, the bowels acted of their own accord; and from this time, a slow convalescence commenced, interrupted, however, by several slight renewals of the peritonitis. She was not discharged until February 10th, but had become very fat during the latter part of her illness. The pulse, even at the time of her discharge, remained over 100. The treatment consisted of turpentine fomentations to the abdomen, and opium and gallic acid internally, with some stimulant.

CASE IV. Adolph Kruge, aged 21, sailor, was admitted into the Infirmary, on April 24th, 1861, in a dying state. He had come from Havana, and had been ailing when he left that place. His captain had tried no remedy, except that he had endeavoured to bleed him several times, but without success. The crew had been very short of vegetables, and had had no lemon or lime-juice. The patient had had no diarrhoea during the voyage. On admission, he was found to be a mere skeleton, very filthy, and having his chest and abdomen covered with dark purple spots, not like petechiæ, but suggesting the idea of typhoid spots in a patient with scurvy. The abdomen was very tender. He died on the second day.

The ileum presented two ulcerated patches in its upper part. About eight inches from the valve was a large long patch, in which there were no less than seven perforations—two of large size, the rest very small. Nearer still to the valve were several groups of ulcerated patches, in most of which the ulceration had extended entirely, or almost entirely, to the serous coat. The valve itself was healthy, as was the ascending colon. The rest of the colon as far as the rectum exhibited the appearances seen in acute dysentery; viz., much ecchymosis, with ragged ulceration of the mucous membrane, and a very considerable smearing of thick yellowish mucus.

CASE V. James Mills, aged 70, sailor, was admitted into the Infirmary, on November 7th, 1860. He had not been to sea for ten years; had been a drunkard, and had been now ill for eight weeks. His bowels were open twenty times in the twenty-four hours, and the motions were bloody. Under astringents and opium, he seemed at first to improve; but at the end of the

month the symptoms recurred, and he died on December 12th.

The small intestines were quite healthy. The large intestine, in its whole extent, was much thickened from inflammatory deposit. The mucous membrane in many places was shreddy, and fell off on being touched, leaving the muscular fibre exposed beneath it. Just under the ileo-cæcal valve, and in several other places along the colon, there were small ecchymoses of blood. In the colon there were five perforations: two of them were round holes, the ulceration having proceeded in a direct line through all the coats: the three others were more oblique, the ulceration having first proceeded through the mucous and muscular coats, and then taken an oblique direction, perforating the serous coat at the distance of an inch or an inch and a half from the original ulcer.

The above cases may illustrate the following points.

1. Mental depression has a most fatal tendency in fever. Both the first cases were fine strong men, well able physically to fight with the disease; and the autopsy of the second showed how little the intestine had suffered.

2. Diarrhœa may be and often is absent, when the ulceration is proceeding even to perforation. In fever, probably the amount of diarrhœa affords little or no evidence of the amount of intestinal mischief.

3. Perforation is by no means necessarily a fatal occurrence. My third case was, without doubt, one of perforation, healed naturally. This mode of natural cure was seen at the autopsy of the second case, in which a band of lymph entirely occluded the orifice of the perforations. The condition, which was found in the first case, may also occasionally render such an occurrence comparatively harmless; the fecal matter having escaped into the cellular tissue behind the intestine. In this situation, a circumscribed abscess may be formed. I believe my colleague, Dr. William Budd, has seen a case of this kind, in which the abscess opened externally.

4. Typhoid fever and dysentery may coexist.

5. The coexistence of scurvy with typhoid fever may modify the peculiar character of the typhoid eruption.

Original Communications.

ON INCISIONS FOR STRICTURE, COMPARED WITH DILATATION.

By JOHN GAY, F.R.C.S., Surgeon to the Great Northern Hospital, etc.

PERHAPS there are few subjects of graver import connected with surgery than stricture and its treatment, seeing that the disease itself is not only most troublesome to the patient, and often most perplexing to the surgeon, but that it is a very constant cause of premature and rapidly supervening death in old persons.

The question of the value of incisions in some forms of obstinate stricture appears to be yet *sub judice*; some able surgeons, amongst them Mr. Henry Smith,* contending that their value is of small account; whilst others, and amongst them Mr. Henry Thompson, recommend them in certain cases, not only as palliative in most, but curative, in its widest sense, in some. I am led to agree very much with Mr. Smith in his estimate of the value of the incision method, compared with other modes of treatment, especially that by dilatation; believing that the advocates of the former found their

verdict upon its immediate and transient, rather than upon its ultimate and substantial, results.

Some years since, one of the most justly eminent surgeons of our age proposed external division in certain kinds of permeable stricture. Before that time, surgeons resorted to this course only in cases of impermeable stricture; or as an adjuvant in the treatment of permeable strictures, when complicated with perineal fistulæ. Mr. Syme's judgment and experience led him to propose this operation, or (as it has been called) "the perineal section" as "a simple remedy, and sufficient to accomplish a cure, quickly, safely, and surely" in cases of extremely irritable stricture, or those in which the stricture is so contractile as to resist repeated attempts at dilatation. Coming from such a source, this proposal was received with, as it was entitled to, the greatest respect; and it had not been long enunciated ere it began to be carried into practice somewhat vigorously. But whether the cases chosen for this mode of treatment by all the disciples have been scrupulously such as the master would have approved, is, to say the least of it, questionable; and if, therefore, it has not been attended with the amount of success prognosticated for it, the failure cannot honestly be charged at his door.

The records of this operation, given in Mr. Thompson's excellent work, inform us that the results have been as follows: viz., a large proportion of cures, some failures, and a few deaths.

The *cures*, from the unqualified manner in which they are spoken of, may be supposed to be such, in the Johnsonian sense of the word; but the prevailing opinion (probably as near an approximation to the truth as the statistical evidence by which the contrary view is supported) is that they are not quite "cures", inasmuch as, in the great majority of cases, the patients find the use of the bougie or catheter as much and perseveringly needed after external incision, as after any other mode of primary dilatation; for without it the stricture will as inevitably and invariably return. Perhaps it may be objected that this is but an opinion or impression. I do not see how we are to arrive at a much more satisfactory conclusion; for it would, obviously, be a matter of extreme difficulty to obtain the ultimate results in a number of cases, sufficiently large to form the basis of a practical inference that might be depended upon; whereas it is easy to obtain the immediate, which are, I am persuaded, the most favourable of the two. Cases constantly turn up in the course of practice, which have grievously disappointed the hopes of the patient, over which, at an earlier period after the operation, both patient and operator indulged the most sanguine expectations. I cannot but think, therefore, that the term "cures," in reference to this operation, has been used in somewhat too latitudinarian a spirit; and that, at least in some of the cases thus represented, the patients were only temporarily benefited.

It is true, that Mr. Syme, Mr. Thompson, and other gentlemen, whose statements or motives cannot for a moment be doubted, testify to some instances in which external incision has been followed by a positive and permanent cure of the stricture. The cases in question have been subject to observation for years. But this success is not a feature of this mode of treatment exclusively; for it follows catheterisation as well in some few, and those even of the most severe, cases.

The *deaths* have been computed at six per cent. This, of course, is a correct computation as far as its elements go; but I am inclined to believe, from evidence which it has been my own lot to obtain in the course of my professional duties and intercourse, that the deaths have not been so scrupulously registered as the escapes.

The following case which occurred some few years ago, made a deep impression on my mind; and I narrate it in order to shew that the risk attendant upon

* See, in "Transactions of Medical Society of London," a paper by Mr. Smith.