and by and bye ulceration occurs and perforation, with, it may be, a general peritonitis. In certain cases, however, and this seems to be one, the coats become thicker as the dilatation proceeds, and the secretion is retained while the cyst attains very large dimensions. The thick colloid contents represent the mucous secretion of the glands of the appendage.

CLINICAL REMARKS ON A CASE OF STRANGULATED FEMORAL HERNIA.

By T. H. BARTLEET, F.R.C.S.,

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FOR the following brief notes of the case, I am indebted to Mr. Shipworth, Resident Surgical Assistant.

Thomas Jones, aged 43, married, a smith, was admitted November 10th, 1874. He had had a swelling in the right femoral region, which occasionally disappeared, for the last seven years. On November 1st, the swelling increased without any special cause. His bowels were constipated; and he took aperient medicine, which produced two motions. On November 2nd, he vomited several times. On the 3rd, the vomiting continued, and he was unable to pass flatus. On the 4th, he described the vomiting as being faecal. Constipation and faecal vomiting continued until his admission on November 10th, when he was found to have a small painless hard tumour in the right femoral region. There was no impulse. The belly was distended, but not painful or tender. The patient's aspect was distressed; his temperature was 99 deg., and his pulse 85. The taxis was tried with great care, but ineffectually. Under chloroform, a transverse incision of one and a half inches was made over the neck of the sac, down to which the intervening tissues were divided on a director. The seat of stricture was the falciform margin of the saphenous opening, a few fibres of which were divided; and the contents of the sac were returned, the sac itself not being opened. The sac, which seemed likely to be drawn up by violent respiratory efforts, was held to the wound by a hare-lip pin passed through the edges of the latter, and including a piece of areolar tissue attached to the sac. The wound was dressed and rolled in the usual way.

November 10th. Vomiting had continued two or three times after the operation. He took twenty minims of tincture of opium, which relieved the vomiting, and was followed by a good night. He had passed flatus. Temperature normal; pulse 75. He had no pain.

November 13th. There was slight discharge from the wound. He had passed a firm and very copious motion.

November 28th. The wound had been dressed with tenax, and was all but healed; it measured now barely an inch.

REMARKS.—The case seems to me to present the following points of interest: the length of time during which symptoms of obstruction had lasted; the lengthened duration of faecal vomiting; the mode of operation; the after-treatment.

Symptoms of complete obstruction had lasted for nine days. The condition of the hernial tumour did not justify the opinion that strangulation had lasted thus long. I believe that the hernia was, at the beginning at all events, *incarcerated*, not *strangulated*. Now, what is an incarcerated hernia? It is a hernia in which the constriction affects only the calibre, and not the walls, of the gut; that is, the passage through the intestine is entirely closed, but the intestinal walls are not sufficiently constricted to stop the circulation through them, and consequently to cause them to sphacelate.

Faecal vomiting was present for four days. This symptom, though a common one in long standing cases of strangulated hernia, is justly considered one of serious importance. It is supposed to be due to the long continued and ineffectual peristaltic action of the intestine above the stricture, inducing a backward current of the contents of the bowel in the centre of the tube.

The Operation.—I have for some time given up the long vertical incision over the whole or greater part of the sac. I make a short transverse incision over the neck of the sac, by pinching up the integuments and transfixing; the incision being rarely as long as two inches. I divide the tissues on a director until I am able to insert a nail under the stricture. I find it rare, even in old standing and in inguinal herniae, to be unable to relieve the stricture without opening the sac. Occasionally the stricture is caused by a few fibres in the sac; and these I have, in one or two cases, very carefully divided from the outside instead of from the inside of the sac.

Herniotomy without opening the sac is an operation free from danger. No important tissues are cut through or displaced. The danger, as far as the operation is concerned, is due to the opening of the sac; for we

then make an open track for the admission of air, and sometimes of fingers, into the peritoneal cavity. I think needless alarm is often felt about the condition of the bowel, or of its strangulation by a band or by omentum, when the sac is not opened. In cases of recent strangulation, it seems to me as great a mark of unwisdom to open the sac to examine its contents, as it would be to trephine the skull to look for a possible clot underneath, in every case of injury of the skull with insensibility. Opening the sac is a *certain* risk; leaving it unopened is an *uncertain* risk. Moreover, in recent cases of strangulated hernia, it is customary to attempt reduction by taxis. Now, if it be safe to reduce a strangulated hernia by taxis, it is surely safe to do so by an operation which is as safe and simple as is extraperitoneal herniotomy. I am aware that the present case is not one of recent strangulation. The symptoms of obstruction and even faecal vomiting had lasted many days. It may be fairly asked why I did not deem it necessary to open the sac and examine the condition of its contents. My examination of the hernia before and during the operation did not favour the belief that it was gangrenous. Pain was not, and had not been, complained of. The integuments were not emphysematous, oedematous, or red; the sac was not flaccid. Had the sac or its contents been long gangrenous, the superficial tissues would have resented the presence of dead matter, as of any other foreign body. Unfortunately, there is no way of telling whether or not the contents of the sac are *just dead*; and I consider it better, in the absence of definite symptoms, to face this risk rather than that of peritonitis, so frequently consequent upon opening the sac. After I had returned the contents of the sac, the violent efforts of vomiting seemed likely to draw the sac itself up into the abdominal cavity. This was undesirable, since, had symptoms of strangulation still continued, I might have wished to open the sac and to bring into view the intestine or omentum it had contained, and which, in the paralysed state of the intestines, would almost certainly be found lying near the crural ring. I therefore kept the sac near the wound by transfixing a tag of areolar tissue attached to it (not the sac itself) by a hare-lip pin, with which I closed the wound. The necessity did not arise in this case, but the manœuvre might be useful in other cases.

With regard to after-treatment, one dose of tincture of opium relieved the sickness, and gave a good night, which the novelty of the patient's position in hospital might have prevented. After this, he had no medicine—above all, no aperient. He was kept to milk and broth diet until his bowels were open, which they were on the fourth day after the operation and the fourteenth day of constipation. The wound was dressed with tenax—an excellent dressing for these deep wounds, as it prevents the accumulation of pus, and consequently favours the contraction and healing of the wound.

THE SLEEPING SICKNESS OF WESTERN AFRICA.

By ALBERT A. GORE, M.D., F.R.C.S.I., SURGEON-MAJOR.

SOME time since, I read, in the "Notes and Queries" of a contemporary, a few brief remarks on this rare disease. As the subject is one of some interest to those who may travel in these distant regions, and to the medical officers who have to treat our West Indian soldiers, I have jotted down the following *résumé*, which may probably contain a summary of all our present knowledge on the matter.

Lethargy, from the Greek terms *λήθη* and *ἀργία*, is placed by the older writers under their division *Neurotica*, and defined as a "mental and corporeal torpidity, with deep quiet sleep". The occasional causes being congestion or effusion in the brain by violent mental commotion, as that of fright or furious anger; by retrocedent gout, or repelled exanthems; but more generally by long continued labour of body or severe exercise of mind, cerebral exhaustion. Celsus regarded it as a nervous affection; Forester and Cheyne as chiefly dependent upon plethora or congestion. According to Mason Good, it is not unfrequently a strictly nervous affection connected with an irregular or debilitated state of the mind. The common causes of sleep, therefore, whether natural or morbid, are in many cases causes of lethargy. The older writers classified the disease under three heads.

(a.) *Lethargus absolutus*, or genuine lethargy, without intervals of sensation, waking, or consciousness.

(b.) *Lethargus cataphora*, or remissive lethargy, with short remissions or intervals of imperfect waking, sensation, and speech.

(c.) *Lethargic vigil*, or imperfect lethargy, perfect lethargy of the body, but imperfect lethargy of the mind, wandering ideas, and belief of wakefulness during sleep.

The first variety of the ancients is the later "constitutional lethargic slumber" of Blanchet and other French observers. Examples have