the right side. The tumour passed down into the scrotum, and was of the size of two closed fists. On the same side, there was a reducible femoral hernia of the size of one closed fist. Both tumours were easily reduced, but the slightest cough or movement brought them down again. As it seemed impossible to apply with success a truss, and as the patient was rendered quite unfit for his employment, I proposed to him to attempt his relief by operation. He at once consented, and on January 14th I performed the following operation. An incision about two-and-a-half inches in length was made half-an-inch above, and parallel to, the inner half of Poupart's ligament. This incision was carried through the muscles and fascia, so as to expose the necks of the sacs of both the inguinal and femoral herniæ outside the general peritoneal cavity. The epigastric artery was ligatured and cut across, as it was included in the incision. The object of my operation being to ligature the necks of the sacs with catgut as high up as possible, I first drew out the inguinal sac which was not adherent, and easily reducible. When this sac was drawn out though the wound, it measured about six inches in length, and closely connected with it was a second and partially obliterated sac. This second sac was carefully separated from the first, and, when examined, appeared to be the sac of what had been a direct inguinal hernia. Having made a small incision into the lower end of each of these sacs, and introduced my finger, so as to be sure that all their contents were reduced, I applied a catgut-ligature around their necks as high up as possible. I then prepared to act upon the femoral sac, but found that it had slipped up into the abdominal cavity. I could pass my finger by the wound readily into the femoral canal, down which the hernia came; and, while hesitating how best to secure the femoral sac, it occurred to me that the ligatured inguinal sacs might be drawn down into this canal and secured there, so as to plug it up and prevent the descent of the femoral hernia. Accordingly, having passed my finger down through the wound into the femoral canal, I introduced through the inner aspect of the thigh, at a point a little internal to and below the saphenous opening, a curved needle armed with prepared carbolised silk, and pushed it through the tissues until it reached my finger, when one end of the silk was seized and drawn through the wound, the other end being left protruding from the thigh and the needle withdrawn. The end which had been drawn out of the wound was then passed through the eye of the same needle, and run through and through the lower end of the ligatured inguinal sacs. It was now reintroduced through the wound into the femoral canal, being guarded by the finger and brought out again on the thigh close to its first point of entrance. By pulling upon the two ends of this thread, the inguinal sacs were drawn down into the femoral canal, and firmly secured there by tying these ends on a small piece of India-rubber cord. When the wound had been stitched up, the patient was made to cough, but neither of the herniæ protruded. The whole operation was performed under the spray; and antiseptic dressing, with an antiseptic pad, was applied over the wound. No bad symptom interfered with the good progress of the patient, and all the stitches were removed from the wound ten days after the operation. Two weeks after the operation, the silk thread which had been passed through the thigh and hernial sacs was cut, and came away quite easily after a little traction had been made upon it. On February 12th, a truss having two pads—one to press over the inguinal region, the other over the femoral region—was applied. On February 14th, the patient rose from bed wearing the truss; and although I removed the truss when he was in the upright position, and tested him in various ways, no protrusion of the hernial tumours took place. From this date he continued to walk about the wards freely with the truss; and on February 26th, he returned home quite relieved from his miserable condition, and able to walk and move perfectly. Before leaving, he was cautioned to wear the truss constantly: for, although no protrusion had taken place since the operation, it was too much to expect that an operation in such a case would be permanently successful unless the pressure of a truss were retained.

THE QUARANTINE OF PUERPERAL FEVER.

By A. D. L. NAPIER, M.B., C.M.

ABSENCE from home has prevented me from replying to a communication in the JOURNAL for April 1st by Dr. Braxton Hicks. I feel great diffidence in venturing to criticise what Dr. Hicks has written, as from his great acquirements, reputation, and position in obstetric literature, it is difficult fairly to encounter so formidable a writer. From what I have read of Dr. Hicks' publications, I am (perhaps erroneously) under the impression that he belongs to the school of "omnivorous puerperal

fever", if I may use the term; that he believes that, though there may be a primary vitiation of the blood, this is not necessary to create puerperal fever, but that any zymotic disease occurring in the puerperal woman will constitute puerperal fever. Therefore, while cordially agreeing with what has been written regarding the desirability of due precautionary measures against contagion, I would express my hope that eminent obstetricians will devote some of the great talents and opportunities at their disposal to a more satisfactory solution of the question. In the BRITISH MEDICAL JOURNAL for March 25th, Dr. Churchill has stated, that with forty years' midwifery experience he has been unable to connect two cases of puerperal fever. Dr. Braxton Hicks says, "although we cannot find any extraneous origin for a case of puerperal fever, we are not forced to assume it to be self-generated or epidemic". Defining puerperal fever as of specific entity distinct from traumatic causes or septicæmia, we have, according to a recent distinguished writer, four causes—epidemic influence, contagion, infection, and nosocomial malaria. Now, if after strict inquiry, we cannot blame contagion, it is very unsatisfactory to have it insinuated that, notwithstanding, it must be due to contagion: such at least is a fair interpretation of the statement quoted.

In conclusion, I regret if in what I have written I have misrepresented Dr. Braxton Hicks's opinions. I have only penned the above to bring under his notice a point in which there is apparently a difference of view between us.

CASE OF HYSTERICAL BLINDNESS.*

By JUNIUS HARDWICKE, L.K.Q.C.P.I., F.R.C.S.Eng., etc.,
Rotherham.

ABOUT seven years ago, I was called to visit a young lady, about sixteen years of age, with a pale face and flabby tissues, who was suffering from obstinate vomiting; so much so, that her mother informed me that she retained none of her food; still she was not apparently emaciated. This condition of things would occasionally return, together with pain for a day or two in the regions of the epigastrium and left hypochondrium, for about twelve months. She had never been sufficiently regular; the catamenia were often absent for months, and, when they did return, were always scanty; perhaps she would be slightly regular for six months, and not again so for some time; but she could always tell when the catamenia ought to have appeared by other symptoms. She had pain in the back on pressure.

The sickness and pain in the abdomen, owing to the fact of her father having died (as I considered) of carcinoma of the head of the pancreas, gave me much anxiety; and another physician saw her with me two or three times; but her youth and some peculiarities about her seemed to point more to hysteria than anything else. Up to this time, her mother had always thought her strong.

About twelve months after this, slight hæmoptysis ensued, which I did not consider to arise from any lung- or heart-disease.

About five years since, after having visited her in the morning on account of irritation in the stomach, I was suddenly summoned late in the evening, and informed that she could not swallow. This did not alarm me much, as I guessed what was the truth. I found her in bed, apparently asleep, with closed tremulous eyelids, no fever; pulse slightly excited, and no indication of throat obstruction. As I felt that she was fully persuaded that she was quite unable to perform the act of swallowing, and thereby rendered incapable of generating the necessary motor impulse, I spoke very firmly to her, also to her friends in her hearing, and threatened to send for a galvanic apparatus, and, if that did not succeed, for another instrument which I possessed which would soon make her swallow. Shortly afterwards, I induced her to make a vigorous exertion of her will; and she took some nourishment.

Upon my visit next morning, and since that time, I heard nothing more of this symptom. Her mother informed me that for months she would take nothing but tea. I omitted to state that she had occasionally violent hysterical paroxysms attended with screaming. From this period, with the exception of attacks of tic, she enjoyed fair health for a long time.

One evening in September 1875, whilst driving home from chapel, she complained to her mother of having an attack of tic again in the face; but on this occasion she attributed it to the brightness of the gas in the chapel, and said that she had been obliged to close her eyes during the service. She now said that the tic had also got to the back of her eyes.

The next day, she could scarcely see at all, but had to grope her way about the house. At this time, I was again sent for. I found very

* Read before the Yorkshire Branch.