cases of neuralgia and of diabetes mellitus, and I am sincerely glad that the imperfection of the *British Pharmacopæia* pill has been so early shown.

Among the propositions made for modifying the present pill, I find the suggestion that soap should be added to the mass to render it more soluble. This I trust will not be done, as the alkali in the soap will form a compound with part of the phosphorus, and, to say the least, render the preparation uncertain in strength. I shall be glad if you can find room for this note in your JOURNAL, as the *Pharmaceutical Journal* does not reach the hands of the profession generally.

CURE OF A LARGE IRREDUCIBLE FEMORAL HERNIA BY OPERATION.*

By JOHN CHIENE, F.R.C.S. Edin.,
Assistant-Surgeon, Edinburgh Royal Infirmary.

My object in reading this note of the cure by operation of a large irreducible femoral hernia, is to illustrate the value of antiseptic treatment in a class of cases on which surgeons, as a rule, hesitate to operate.

I might have detailed several examples of irreducible herniæ, both inguinal and femoral, which I have had under observation, and in which I have used palliative measures, following the rules laid down in surgical text-books. Such cases are by no means rare; and, as all present have, I doubt not, had ample experience of examples, I will pass at once to the narration of the case in which I operated successfully for the relief of the irreducibility.

A. R., aged 43, domestic servant, was admitted to the clinical surgical wards of the Edinburgh Royal Infirmary on May 24th, 1876, suffering from a large swelling in the right groin, which had existed for four years. It had gradually increased in size, and seldom gave much uneasiness except after severe exertion. She had never been able by pressure to reduce its bulk, and says that it had rapidly increased in size of late. She was now unable for her work as a housemaid, and was anxious that something should be done for her relief; all palliation had failed to prevent its increase. She had always enjoyed excellent health.

There was now a fluctuating tumour in the right inguinal region, measuring vertically six inches, transversely four inches. It occupied the greater part of Scarpa's triangle. On palpation, it was partly fluid and partly solid. It was either an irreducible femoral hernia or a cystic tumour. Pressure made no diminution in its size. As the history gave no assistance in coming to a conclusion, the swelling was punctured on May 25th with a fine trocar and cannula under antiseptic spray. Eleven ounces of a clear straw-coloured fluid were drawn off. It was impossible to remove all the fluid. After its withdrawal, hard masses were distinctly felt, which were either hardened masses of omentum or solid portions of a cystic tumour. Pressure was applied by means of cotton wadding and an elastic bandage. The fluid, on examination, was highly albuminous, and the sediment consisted of bodies similar to white blood-corpuscles.

The fluid having reaccumulated, chloroform was administered on June 4th, and an incision made in the long axis of the tumour as far as possible from the middle line, so as not to interfere with the antiseptic management. The cyst was then easily separated from its connections, except in the region of the crural canal, where the existence of a distinct neck showed that the case was one of hernia. The sac was then laid open, and the hard masses previously mentioned exposed to view. They were found to be condensed masses of omentum, adherent to each other and to the inner surface of the sac wall. In consequence of inflammatory changes and adhesions, none of the contents could be returned into the abdominal cavity. The omentum, as it passed into the sac, was firmly adherent at the neck anteriorly; posteriorly, there was a communication with the peritoneal cavity; and, by dragging on the omentum, more could be withdrawn from the abdomen. There was no bowel in the sac, and no strangulation of its contents. The masses of omentum were now carefully separated, and the adhesions to the inner surface of the cyst cut across after ligature. The pedicle of the omentum was then ligatured in small portions by ligatures of chromic-acid gut. In all, fifteen ligatures were applied. The sac was then cut away, and carefully stitched with chromic-acid gut over the remains of the omentum. Two drainage-tubes were then inserted, and the wound stitched with catgut. Protection was applied over the wound, and a large sponge squeezed dry out of one to forty carbolic lotion laid over the protective to soak up the discharge. The usual antiseptic dressing was then ap-

plied, which was kept in position by an elastic bandage. The operation was performed under the spray.

The patient's progress was uninterrupted. The pulse never rose above 80, and the temperature was once 101 deg. on the day after the operation; it then sank to the normal. She never had any uneasiness in the wound. One drainage-tube was removed on the fourth day, the other on the eighth day; on the eleventh day, the superficial stitches were removed. On the twenty-first day, the wound was firmly healed. A small hard lump was then to be felt in the region of the crural canal. This was, in all probability, the remains of the sac. There was no impulse on coughing. She went to the Convalescent Hospital on July 3rd, one month after the operation. She was supplied with a weak Salmon and Ody truss, which she is to wear as a precautionary measure. Six weeks after the operation, she expressed herself as perfectly well. There is now nothing abnormal at the seat of the operation, and no impulse whatever on coughing.

REMARKS.—Percival Pott says, of irreducible herniæ, that "such cases are capable of no relief from surgery but the application of a suspensory bag". These words, written many years ago, still express the opinion of the majority of surgeons. Lawrence says "an irreducible hernia may be left in great measure to itself". Birkett, in Holmes's *System of Surgery*, says "irreducible crural rupture, of course, requires a hollow pad, whether epiplocele or purely entrocele". Palliation in one form or other is at present the rule in surgery; and in Syme's words we may sum up the treatment of such cases: "By strict attention to the state of the bowels, by abstinence from all violent exertion, and by the support of a bag truss"; it is preferable to palliate the complaint "than to endanger life by trying to effect a radical cure with the knife".

Irreducible herniæ contain either bowel or omentum, or both bowel and omentum. The case I now record contained omentum only. I am aware that in some rare cases it may not be possible to complete the operation if the irreducibility be due to adhesions between the sac and the bowel, so firm that they cannot be overcome. The patient should, therefore, be informed of this possibility, because the exact nature of the contents cannot be foretold with certainty. The probability, however, of such adhesions is, I believe, comparatively rare as the primary cause of the irreducibility, which, as a rule, is due to an increase in the size of the omentum, and to its condensation following inflammatory attacks and to inflammatory thickening of the neck of the sac; causes which can be relieved by such an operation as I now propose. In those cases in which the operation cannot be completed, the necessary exploration with antiseptic precautions can be performed with such safety that I believe it justifiable in all cases in which the hernial tumour interferes with the usefulness of the patient, and in which the usual means by evacuations, starvation, and long continued rest in bed have had a fair trial without success.

The importance of being able to cure by operation such cases has a very important bearing in relation to insurance. No cautious medical man will recommend for insurance anyone suffering from irreducible rupture; if these cases can be cured by operation with safety, then many will submit to the operation in order that their lives may be accepted at the usual rates, a matter often of great importance to their families.

The result of this case encourages me to give the method further trial. Mr. Syme, in speaking of irreducible hernia, says: "Operations have occasionally been performed, but their almost uniformly fatal result ought to deter all prudent surgeons from repeating such attempts." These words, I beg to submit, have, by the use of antiseptic precautions, lost their significance; and I trust that I have shown that a change will soon be accomplished in the treatment of irreducible hernia.

ON A NEW METHOD OF CURING PHYMOSIS.

By G. DE GORREQUER GRIFFITH, M.D.,

Senior Physician to the Hospital for Women and Children, Vincent Square.

SOME years ago, a patient came to me with a very slight stricture of the foreskin. I did not then perform any of the usual operations, but dilated the aperture in the prepuce by means of a forceps something like the ordinary uterine dressing forceps. The pain was very trifling.

My next patient was a young schoolmaster who had contracted gonorrhœa or balanitis, or both together, I was unable to decide which, as the preputial orifice was so small that I could not see that of the urethra for some time, and till I had subdued the inflammation. Then through the exceedingly narrow opening in the foreskin I got a glimpse of the entrance of the urethra. It was of importance to him to get well quickly as he was about to be married, but he had a very

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