My patient had suffered from ague twenty-three years previously to the commencement of the attack of anæmia which proved fatal. He also came from a district in Cambridgeshire in which ague used to prevail, but in which it is now almost unknown. It is highly improbable, therefore, that exposure to paludal miasma was the cause of his illness. The blood had not the appearance described by Eichhorst as characteristic of this affection, as I have stated in the notes. Dr. Grainger Stewart has failed to discover these appearances in two well marked and ultimately fatal cases which occurred in his practice (BRITISH MEDICAL JOURNAL, July 8th, 1876). In some cases of this disease, fatty degeneration of the heart has been observed; but, in my case, the heart was somewhat hypertrophied and the muscular tissue was firm and of a good colour.

The patient's illness commenced with so-called "bilious attacks", of which he seems to have had several; some at considerable intervals. After his admission, no evidence of jaundice could be detected beyond the sallowness of the skin, which was the sallowness of anæmia, and not that of jaundice. This hue of the skin has been noted by other observers. The giddiness, somnolence, and epileptiform attacks which occurred towards the termination of the illness, bear out the theory of cerebral anæmia being the proximate cause of these conditions. The only hæmorrhage the patient had was that from the nose a few days before his death. There were no ecchymoses of the skin or mucous membranes, but slight ones of the right pleura and of the membranes of the brain, over a circumscribed spot on the left hemisphere, were found at the necropsy.

With regard to the treatment of the case little need be said. Iron had been given before his admission, and was tried the first week after it, but without the least apparent benefit. It is true that at first large doses were not given; but this was done purposely to avoid irritating the stomach, an effect which was produced when drachm doses of the perchloride were given on the day of his death. Iron seems to have no curative effect in this form of anæmia. Phosphorus was the drug next resorted to. I was induced to give it upon the recommendation of Dr. Broadbent, who, in the *Practitioner* for January 1875, has recorded two cases of this disease treated successfully by this drug. As to its *modus operandi*, but little is known. It would seem, however, when given in medicinal doses, to influence favourably the processes of blood-formation and nutrition. The patient was a little better for the first few days after its administration, but the improvement did not continue, either from the dose being too small or the disease having progressed too far before the phosphorus was tried.

Transfusion was thought of, and a consultation was held by Dr. Humphry and myself as to its advisability. The results recorded by Professor Pepper and Gussow were not, however, thought sufficiently encouraging to induce us to operate. Besides, it was felt that the only real use of transfusion would be to prolong life whilst some remedy was fairly tried, and, phosphorus having apparently failed, it was difficult to tell where to look for another.

IRREDUCIBLE FEMORAL HERNIA: OPERATION: RECOVERY.

By C. F. MAUNDER, F.R.C.S.,
Surgeon to the London Hospital.

THE publication in the JOURNAL of October 7th of the report of an operation for the cure of an irreducible femoral hernia, leads me to record an instance of a similar kind which occurred in my practice ten years ago.

S. A., cook in a gentleman's family, and forty-five years of age, had been the subject of a lump in the right groin for about eight years. This gradually enlarged, latterly somewhat quickly, associated with local pain, especially on lifting a weight. Also, she often suffered from pains in the stomach and "spasms". The swelling interfering with her comfort and occupation, she consulted Mr. E. W. Tait of Highbury Park, who asked me to see her.

The tumour, of the size of an egg, but somewhat irregular in shape and indurated, occupied the site of a femoral hernia.

Operation, June 1866.—The patient having been chloroformed, a longitudinal incision was made along the centre of the swelling and the structures divided till the sac was reached, and was found to contain a small quantity of fluid and a mass of omentum, thickened and nodulated. On tracing the tumour to the crural ring, it was found to be continuous through this with the structures within the abdomen by a slender pedicle. This pedicle or stem having been tied with a silk ligature, the tumour was cut away. The ends of the ligature were brought out at the lower angle of the wound, and the latter was closed by suture.

Very little suppuration occurred; the ligature came away in due time; and the patient made a good recovery.

In very many instances of herniotomy necessitated by strangulation, I have, after reducing the bowel, cut away large masses of omentum without unfavourable consequences. In one instance in which the omentum was firmly adherent to the bottom of a scrotal sac, I placed a double ligature on this structure and divided it between them. This plan allowed the lower portion to subside into the scrotum, while the upper, being lodged at the ring, enabled the patient to wear a truss after his restoration to health.

If, from any cause, omentum cannot be reduced, or it be deemed undesirable to reduce it, it should be treated by one of the above methods, in order to enable the patient thereafter to wear an effective truss, upon which his future comfort and safety will much depend.

CASE OF INTUSSUSCEPTION SUCCESSFULLY TREATED BY INFLATION: WITH REMARKS.*

By THOMAS EASTES, M.D., F.R.C.S., Folkestone.

THE following are some notes I took of an interesting case of intussusception recently under my care.

August 6th. I was called at 10.30 A.M., to see W. T., a boy aged 3. I found him lying down, apparently in pain. His mother informed me that he had been quite well until 2.30 A.M., except that for two or three days he had had slight diarrhoea; but this had not been sufficient for her to seek medical advice for him. Between 2 and 3 A.M., he woke up complaining of great pain in the abdomen; this pain was not constant, but it troubled him again very frequently until my arrival. At 5 A.M., he was sick; there was no food in the vomit, and it consisted chiefly of greenish glairy mucus. At 6 A.M., his father procured some castor-oil, and it was immediately given him. At 6.30 A.M., the bowels acted, and a fairly natural motion was passed. At 7 A.M., or soon after, blood and glairy mucus passed from the bowel with much straining, and twice again before 10.30. The pain was paroxysmal and very severe, making the boy twist and roll himself about all over the couch, and scream to his mother for relief.

On examination, the pulse was a little accelerated; the abdomen was flaccid, and easily examined thoroughly. In the right inguinal region, a firm sausage-shaped swelling was felt, not apparently more than an inch in diameter, and two or three inches long; it was directed upwards, parallel with the side of the abdomen. Three drops of liquor opii sedativus were given to the child; and the mother had strict orders to give him nothing but a tablespoonful of milk every half-hour, and a little ice to suck; and to save everything passed or vomited.

At 1 P.M., the swelling was felt as before in the right inguinal region; but there was now a much firmer and rather larger sausage-shaped mass in the left inguinal region. Its apparent diameter was about two inches, and it could be traced up to the splenic flexure of the colon and partly across towards the median line. It was lost there, and could not be felt again till the swelling previously noticed in the right inguinal region was reached. Each lump was tender, but especially that in the left inguinal region. The symptoms had not improved, except that the child had had some sleep from the opiate, but the pain had been as bad as ever since the sleep, and blood and glairy mucus oozed from the bowel frequently. Three more drops of opiate were given, and only small quantities of milk and ice allowed. At 4 P.M., the parents were told of the very serious nature of the child's illness, and it was explained to them that, if the bowel could not be returned to its proper position, death was almost inevitable; also that I intended, with their consent, to try to remedy the state of things by blowing air into the bowel with a pair of bellows, and, if that did not succeed, to resort to the graver operation of opening the abdomen and pulling the small bowel out of the greater, into which it had been drawn.

At 4.45 P.M., my brother, Mr. George Eastes, who was then staying at Folkestone, kindly met me at the house and administered chloroform to the child. When the child became insensible, I examined the rectum with the forefinger, and could reach well into the commencement of the sigmoid flexure; and with the other hand could press down the mass on to the tip of my finger, but could not actually touch the end of the invaginated part without two layers of bowel-wall intervening. I now, with the help of the father, proceeded to force air into the rectum. The apparatus used consisted of an ordinary pair of bellows, over the nozzle of which I fastened one end of a yard of India-

* Read before the conjoint meeting at Rochester of the East and West Kent Districts of the South-Eastern Branch.

rubber tubing, the other end of this tubing being slipped over the end of a gum-elastic tube, such as is usually sold with Higginson's syringes. This gum-elastic tube was then passed into the rectum. It had at its base an ivory plate of the size of a halfpenny, which helped to retain the air in the rectum. After blowing the bellows for about four minutes, the sigmoid flexure and descending colon became inflated, but there was no great distension for a quarter of an hour; this was chiefly due to imperfect action of the bellows, which I then attended to, and was able to improve temporarily; but there was also what one might call a safety-valve action of the rectum, so that, when the distension of that part of the bowel was too great, some of the air escaped by the side of the tube, and blood and mucus were forced out with it. The distension now became more visible; and, after about half an hour, it was evident that the air had passed through the intussuscepted part and through the ileo-caecal valve, and that the small bowel was partly distended. The process of inflation took about forty minutes altogether. From time to time, the action of the bellows was stopped, and the abdomen manipulated gently to help the return of the bowel to its natural state; but the air was never all allowed to escape, until the end of the operation, when it was desirable to make as perfect an examination of the abdomen as possible before allowing the child to recover consciousness. Within ten minutes of commencing the inflation, the mass had retreated upwards from the left inguinal region, and soon it could not be felt. When the abdomen was quite flaccid again and the child still insensible, there was a slight feeling of resistance in the right inguinal region, probably due to the swollen state of the extremely congested part of the bowel that had formed the deeper and more advanced part of the intussusception; and I had strong hopes that we had accomplished the desired object, and saved the child's life without running the risk of opening the abdomen.

At 9 P.M., the child was sitting up in bed, comfortable and laughing, and would not admit that the abdomen was tender, but I was careful not to press very heavily. The pulse was 122 per minute; there had been sickness once, and an attack of slight pain once since the operation, and a considerable quantity of blood and mucus had been passed.

August 7th, 11.30 A.M. The child had been very comfortable indeed; his pulse was 92; there had been no further action of the bowels, but a little vomiting on two occasions, the vomit consisting of some of the milk and ice-water that he had taken, and having a slightly green tinge. He had had one very slight pain in the night. The abdomen was not so flaccid, but not at all tender, and no lump or swelling could be felt on either side. His diet still consisted of milk and ice.

8.30 P.M. The pulse was 100, and the boy was comfortable; there had been no further sickness; no tenderness nor swelling was discoverable. The bowels had acted naturally at 8 P.M.; no blood nor mucus being passed. There had been no more pain; and from this time the boy continued to improve rapidly, having no other bad symptoms.

REMARKS.—*Cause.* I believe that the increased and irregular peristalsis accompanying diarrhoea is a common cause of intussusception; and this is in agreement with the fact that intussusception is much more common in the summer months than in winter.

Diagnosis.—The case could not be mistaken after a careful examination of the abdomen, and the history alone made one strongly suspect its true nature; the mother's account of slight diarrhoea for a few days, then sudden severe colicky pain and vomiting recurring at intervals, followed in rather over four hours by the passage of blood and mucus, with much tenesmus, in a child under six years, made the existence of intussusception highly probable; and the presence of the tumours rendered it quite certain. It seems to have been a case of the ileo-caecal variety of intussusception, such as is much the most frequent in children. There is a little uncertainty as to the real character of the tumour in the right inguinal region. When first I saw the child, it was probably part of the bowel involved that was felt there; and, having once felt it unmistakably, I, perhaps, did not afterwards pay so much attention to it as to the mass in the left side of the abdomen. For, when the intussusception was plainly felt in the left inguinal region, the tumour in the right could only have been the portions of meso-colon and mesentery corresponding to the intussuscepted bowel stretched extremely tight.

Prognosis.—This, apart from the chance of successful treatment, was very bad. Recovery of children by separation of the invaginated part is a rare result. Under treatment, the prognosis was good, because the intussusception was not probably of more than fourteen hours' duration when inflation was practised, and, therefore, so much the more likely to be reduced by that process.

Treatment.—I think there can be no doubt that, when once intussusception is diagnosed, an anæsthetic should be given, and inflation tried as the most successful treatment known; and, if that be entirely unsuccessful, the tumour not changing its position at all, I believe that, where the diagnosis is certain, the proper step to take is to open the

abdomen at once, and draw out the bowel from its enclosing sheath of neighbouring bowel as carefully as possible, and close the wound. This, of course, applies especially to cases seen early; for there is no doubt that immediate treatment is of the greatest importance. By delay, the intussusception will probably increase; if not, adhesions may form, or strangulation of the enclosed bowel proceed to a dangerous degree, both complications lessening the chance of successful treatment so much that, after awhile, it is wiser to trust to the small chance of recovery by gangrene and separation of the intussuscepted portion of bowel than to attempt to return it to its normal position. In thirteen cases (referred to in the New Sydenham Society's *Biennial Retrospect of Medicine and Surgery for 1873-74*, page 341), in which the abdomen was opened for intussusception, five recovered. This is an encouraging result; and, I believe, far above the number that recover after the separation of the bowel.

CASES ILLUSTRATING THE SUCCESSFUL TREATMENT OF SUFFOCATIVE GOITRE WITHOUT EXCISION OF THE THYROID GLAND.*

By LENNOX BROWNE, F.R.C.S.ED.,

Senior Surgeon to the Central London Throat and Ear Hospital; Surgeon and Aural Surgeon to the Royal Society of Musicians; etc.

At the meeting of this Association in Edinburgh last year, Dr. Heron Watson related some cases of excision of the thyroid gland on account of goitrous enlargement, and received the support of Professor Lister, who showed a gland which he had removed in the method advocated by Dr. Watson. This gentleman had taken precautions against the most obvious danger of such a procedure—hemorrhage—by previously tying the thyroid arteries; and he had undoubtedly had greater success than any other surgeon who had performed the operation. Nevertheless, one fatal case had occurred in a series of seven, and others in which alarming hemorrhage had to be reported. I ventured on that occasion to express my opinion very strongly to the effect that the operation was totally unnecessary, because there were other remedial measures involving no danger whatever, and completely removing the enlargement, and with it the distressing and dangerous symptoms to which the disease frequently gives rise. I further stated that the procedure I advised was so simple that the patient was not required to remain in bed a single day, or even to cease from work; and that the after-disfigurement was very much less than could be the case, even under the most favourable circumstances, when an incision had been made "from the thyroid cartilage to the sternum".

The two particular procedures to which I referred as suitable for the form of goitre under consideration were, the injection of tincture of iodine into the substance of the gland after the plan of Lücke of Berne, and the introduction of a seton; and I stated that I had had several cases in my own practice: and had also seen many others treated with great success by colleagues.

As many members of the Association appeared sceptical of the benefits to be derived from treatment so simple, I determined at the next annual meeting to relate some cases. I shall on this occasion recount but six, all of which have been sent to me by, or have otherwise been under the notice of, independent practitioners. In these cases, also, relief has been sought for and afforded on account of distressing symptoms, and no case is included in which treatment was adopted solely to remedy a disfigurement.

It is somewhat difficult to say in exactly what cases one may expect benefit from the iodine, and in which the seton may be indicated beforehand as preferable. The effect of the former is to produce absorption of the cellular portion of the gland; but the fibrous tissue is often bound more tightly together by such absorption, so that, though the whole lump is reduced, it is more dense, and a varying number of more or less hard fibrous nodules remain. The after-marking from use of the injection-needle is, however, *nil*; and in the softer forms of goitre this treatment is most successful, especially if suppuration, which is never excessive, be produced, so as to cause breaking up of the fibrous as well as of the cellular portion of the tumour.† This is what always takes place by use of the seton. The after-marking by this method is extremely slight, and can, in the case of a female, be easily covered by a velvet ribbon round the neck.

* Read before the Surgical Section at the Annual Meeting of the British Medical Association in Sheffield.

† Since I have read this paper, Dr. Webb of Wirksworth, a very bronchocelous district, informs me that he has had great success by injection of a solution of iodine, four times stronger than that of the *Pharmacopœia*: this has been, however, in polycystic goitres. He agrees with me, that in the denser forms the area of inflammation produced by the iodine injections is often very limited.