why that lesion is unlikely to happen frequently. Be it noted, that the displacement observed was primary, taking place at once in the original injury, and of such a kind as could scarcely be produced after lodgment of the head of the humerus in the upper part of the axilla, without injury to the thoracic walls or the shoulder-girdle. While the patient was walking on crutches, his right crutch slipped; he lost his footing; and, the whole weight of his body being thus thrown on the left crutch, the head of that crutch glided outwards from the axilla, and raised his elbow as he fell to the ground. This is the patient's story. The head of the crutch was the fulcrum on which the dislocation took place; and, as it glided outwards, it gave more and more leverage to the forces by which the head of the humerus was depressed—viz., the action of the latissimus dorsi and pectoralis major muscles in the commencement of the process, and the weight of the patient's body throughout. But, in the ordinary dislocation forwards and downwards, the elbow or hand comes into contact with the ground while the head of the humerus is at a higher level, with the weight of the body over it; and the latissimus dorsi and pectoralis major muscles, which are important agents in producing the dislocation, likewise draw the arm and the trunk together, and pull the head of the humerus to the deep part of the armpit. Now, in the present instance, although these muscles doubtless aided in withdrawing the head of the humerus from the glenoid fossa, they were immediately thereafter with great rapidity opposed by the descending weight of the body, which, pressing the acromion against the displaced neck of the humerus, caused the head of the bone to pass between the insertions of the muscles in question, undoing the fold in the tendon of each, and reversing, or more probably destroying, the action of both.

HYPODERMIC INJECTION OF MORPHIA IN A CASE OF FIBROID TUMOUR OF THE UTERUS.*

By SAMUEL MILLS, Esq.,
House-Surgeon to the County Hospital, Lincoln.

It is perhaps worthy of mention that great relief was afforded during life by means of the hypodermic method of injection of morphia to a poor woman (S. G., aged 40) who was lately an in-patient in this hospital, suffering from a very large and irregular fibroid tumour of the uterus. One of the main features of the case, and in fact the one which I am anxious to bring before this meeting, is the pain which she suffered during the last fortnight of her existence; pain of the most dreadful and agonising character during its continuance, and apparently caused by efforts on the part of the uterus to expel the fibroid mass from its interior. The pain was almost of daily occurrence, and, unless speedy relief was afforded her, would continue unabated for six or eight hours at once. In these attacks, she presented more the appearance of a woman in very severe labour than any other state with which I could compare her. She complained of the pain being always either in "her body" over the seat of the uterus, or in her back—most frequently in her back, which latter part, in her agony she often cried out, "must break in two."

Various opiates, amongst others from half a drachm to forty minims of chlorodyne, were given by the mouth; but they all appeared either to disagree with the stomach, or give little or no relief to her suffering, so that I was obliged to resort to the hypodermic administration of morphia, which was first commenced by injecting one-third of a grain of morphia under the skin of the abdomen, over the seat of the uterine tumour. In exactly three minutes (as timed by a watch) from the time of injecting, she was quite free from pain, and certainly presented a sudden contrast to her former state of agony. She was left in a perfectly quiescent state, and breathing tranquilly. She stated that the injection first made her feel very "lightheaded," and then acted like a charm in sending her to sleep. The first injection kept her free from pain for twenty-four hours, after which she had a recurrence in every way as severe as before, but this time the seat of pain was entirely in her back, in the lower dorsal and lumbar regions. The same quantity (one-third of a grain) was injected into the thick cellular tissue of the back, under the skin of the lower dorsal region. The relief was equally significant as in the former instance, and was afforded in four minutes from the time of injection. The pain, principally in the back, recurred almost daily for the space of a fortnight, when she became completely exhausted and worn out by it, and sank, as it were from sheer exhaustion. The quantity of morphia injected was obliged to be increased towards the latter part of her existence, as the system gradually became used to it, but never more than one grain was injected at a time, and this dose had to be repeated occasionally as often as twice in the twenty-four hours. No injurious local effects were ever produced by the injecting process.

* Read before the Lincoln Medical Society, January 1868.

REMOVAL OF FOREIGN BODY FROM THE LEFT BRONCHUS.

By JOHN WALTERS, M.B., Reigate.

T. W., aged 40, tailor, twelve years ago had tracheotomy performed for disease of the larynx and glottis, following fever. He had worn the same tube ever since, not being able to do without it. The voice had been distinct, but husky.

On March 22nd, 1867, at 8.30 A.M., while he was attempting to remove the tube for cleansing, the rim came off, and he could not get hold of the cylinder. When I saw him shortly afterwards, I could see the tube at the bottom of the wound. I went down stairs to get instruments from the carriage, and to ask Dr. Holman to assist me. When I returned, the tube had slipped down the trachea, and could only be felt by a bent probe at a distance of five inches from the external opening, to the right. Respiration was imperfect over the right side of the chest; perfect on the left. Attacks of dyspnoea were at times moderately severe, and cough very troublesome. Inversion was tried, with smart blows on the back and front, without altering the position of the tube. At 3 P.M., having obtained a pair of long curved forceps, we resolved to make further attempts to remove the tube. A stilette, bent at the end, was first introduced, and caught something which seemed like the tube; but, on making traction, smart bright hæmorrhage came rather freely from the tracheal wound, so the hook was disengaged and withdrawn. Chloroform was then administered over the mouth and trachea; it excited him much at first, but he soon went under its influence. The long forceps was then introduced; and the tube was felt, but it could not be caught. Bloody mucus came freely from the mouth and wound, and he retched freely. The respiration became so much impaired, that the chloroform had to be given up, and time given him to eject the accumulation in his air-passages, this condition being somewhat perilous. When he had sufficiently recovered, I made a fresh examination, and found the tube rather more than five inches down and to the left. After one or two failures, the tube was seized with the long forceps, and drawn to the wound, where it stuck; and, while Dr. Holman was enlarging the opening to admit its removal, it slipped back. I managed, however, to catch it again immediately—fortunately, this time in the long axis; and it was readily removed, and found to be filled with mucous membrane. After the removal, he complained merely of being wearied, and of some soreness of the chest.

He did not suffer pain during the attempts at removal—merely distress from obstruction to the breathing. His recovery was very rapid, and in a few days he was able to resume his work.

ON OPERATING FOR STRANGULATED HERNIA.

By G. OLIVER, M.B.LOND., M.R.C.S., etc.

I OPERATED on two cases of strangulated hernia during the past year. The fibrous structures which caused strangulation were dilated by a simple manoeuvre of the tip of the forefinger, after which proceeding the bowel was easily reduced. The hernia-knife was not used. The operation was so simple, and yet so successful, that I am induced to record it.

My patients were both females; and in each case a single reducible femoral hernia had existed for several months before it became strangulated. In one case, symptoms of strangulation existed twenty-four hours, in the other case four days, before the operation was performed. In the latter case, there was persistent and profusely stercoraceous vomiting.

The structures covering the seat of strangulation were incised in the usual way. A wound of about two inches in length was produced, which passed in a direction outwards and slightly upwards across Poupart's ligament. The forefinger exploring the wound felt some firm fibres encircling the neck of the tumour. The knife was dispensed with, and the tip of the forefinger was insinuated under the constricting fibres; and these, as well as firm tendinous bands at the crural ring, were forcibly stretched by firm pressure of the finger in a direction away from the bowel; this, now free from constriction, was easily returned to the abdomen by gentle pressure. The wound, closed by metallic sutures, was healed in a few days. Both patients recovered uninterruptedly.

Since the above cases occurred to me, I have learnt that Baron Seutin successfully dilated the stricture of strangulated hernia by insinuating the tip of the forefinger into it, and by stretching it forcibly.

(Ranking, vol. xxiv.) But Seutin's method, though *prima facie* so simple, does not appear to have been followed generally by surgeons. These, among other objections, may be urged against it: the want of exactitude and precision in the forcible dilatation of the stricture through the skin, fat, etc.; and the liability on the part of the operator to injure the bowel by clumsy or badly directed and forcible pressure; and, perhaps, in certain cases, with the greatest care, the bowel would be injured; and, until a cutting operation is performed, the uncertainty as to the cause and conditions of strangulation.

A preliminary incision enables us to proceed with greater certainty and precision in the dilatation of any structures which cause strangulation, than when such incision is dispensed with, as in Seutin's method.

PENETRATING WOUND OF THE PELVIS OPENING THE BLADDER.*

By EDWARD CROSSMAN, Esq., Hambrook, Bristol.

The subject of the accident I am about to relate was a healthy farm-labourer, aged 36.

Between seven and eight o'clock in the morning of the 26th of June he was driving a mowing machine, and, in passing over a large ant-hill, was jerked off the driving-seat. Still maintaining a sitting posture, he fell on to the handle which puts the machinery in and out of gear. This handle is iron, about the size and shape of an ordinary break on a carriage, and stands perpendicularly to the left, and a little below the level of the driver's seat. For a moment he balanced himself on this point, and then succeeded in throwing himself clear of the machine on to the ground, the knives working on the opposite side. From an examination of the machine, it appeared that the handle had penetrated to a depth of four inches. The seat of his breeches was saturated with urine. A catheter passed into the bladder only drew off a few drachms of bloody fluid; and the discharge from a wound situated between the tuberosity of the ischium and the anus, on the right side, had a distinctly urinous odour. Under these circumstances it was deemed expedient, for the moment, not to explore more fully the wound, for fear of adding to the mischief already done. He was carefully removed to our village hospital, placed in bed in a half-sitting posture, and his position so arranged as to secure a perfect drainage from the wound. Ten drops of Battley's liquor opii was given him every two hours. A milk diet was ordered, and no stimulants. During the day he was seen by three of my colleagues. It was universally agreed that his chance of recovery was but small, and that the danger to be anticipated was from extravasation of urine. In the evening he was inclined to shiver; his skin was hot; pulse 120; and he complained of pain in the right iliac fossa, increased on pressure. But the next morning these symptoms had not increased; his pulse remained the same, and he had dozed a little during the night. When turned to one side, some flatus passed through the wound, and the drainage of urine appeared perfect. The same amount of opiate was continued: viz., 10 minims of Battley's solution every two hours, and he was given half-a-pint of beef-tea every four hours. The following day the feverish symptoms had diminished; his pulse had fallen to 90; and the urine continued to pass freely through the wound, accompanied by some fecal matter. On the third day, in company with one of my colleagues, I made a careful examination of the wound. Externally, between the tuberosity of the ischium and the anus, on the right side, was an irregular punctured wound, about an inch and a-half in diameter. The finger passed into the rectum traced this; it penetrated the right wall of the gut about two inches above the sphincter, passed through the anterior wall, ruptured the urethra immediately in front of the prostate, and thence entered the bladder. My finger, following the wound, passed readily into the neck of the bladder. Having ascertained the extent of the injury, I passed a catheter and secured it in the bladder; but through this for the first three days little or no urine passed, the escape still taking place through the wound, through which also liquid feces continued to pass, while nothing passed the anus. On the third day after the catheter had been secured in the bladder, urine began to drop regularly through it, and the fecal matter passing through the wound became harder. The urine thus collected contained a large admixture of pus, and his strength began to fail so much, as to necessitate a liberal allowance of brandy. Five days after the first examination, I again passed my finger into the rectum. The urethral wound had closed considerably, and I could no longer pass my finger into the bladder. Nearly all the urine was then passing through the catheter, which was changed once in twenty-four hours. Each catheter when removed was useless; the portion in contact with the bowel

being entirely denuded of its outer coat. At the expiration of another week (fourteen days after the receipt of injury) all urine had ceased to pass through the wound. A few days later the feces ceased to pass also. Three weeks after the accident, the catheter was removed, and from this time all treatment was at an end. He passed urine in a full stream and without impediment. The external wound was closed, and he was able to walk about. Six weeks after the accident, he was again at work.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, JANUARY 28TH, 1868.

SAMUEL SOLLY, Esq., F.R.S., President, in the Chair.

ON A CASE OF VESICO-INTESTINAL FISTULA, FOR WHICH COLOTOMY WAS PERFORMED; WITH REMARKS. BY THOS. BRYANT, F.R.C.S.

THE case was one which Mr. BRYANT was asked to see by Dr. Habershon in Guy's Hospital in March 1867. The patient was 49 years of age, married, and the father of ten children. Twenty-seven years previously he had been in the West Indies, where he had yellow fever and ague. He returned home after five years in good health, and remained well for twenty-one years, or till two years before his admission, when he was seized with a violent attack of purging, and the passage of a quantity of blood. From that time he had passed at uncertain intervals slime and blood in small quantities with his motions. Eight or nine months since he passed some ounces of blood from the bowel, and seven months since he began to have pain across the hypogastrium and about the anus. Six weeks after noticing this pain, he observed flatus and a small quantity of blood and feces pass with his urine. Of late he had suffered from difficulty in defecation, and frequent desire; but the act had not been associated with pain. His motions had, however, never been well formed since his illness. He had never had syphilis. When coming under observation, his abdomen was natural; no swelling or tumour could be detected in it. The urine was loaded with feculent deposit, and the act of micturition was most painful. On making a local examination of the rectum, extensive ulceration of the lower bowel was readily made out, and an apparent stricture high up. This ulceration was, however, free from all adventitious deposit. As the case appeared to be one of simple ulceration of the bowel, with a fistulous communication with the bladder, colotomy was suggested and performed on April 27th, with the view of affording a free outlet for the intestinal contents above the seat of the disease, and the hope that the fistulous vesical communication would subsequently close, and the ulceration of the bowel heal; the certainty existing that relief to the patient's suffering would be afforded for a time, if not permanently secured. The operation was performed without difficulty, Mr. Bryant making an oblique incision from above downwards and forwards, its centre passing across the middle of the external border of the quadratus lumborum muscle; the object of this incision being to give plenty of room. Immediate relief was experienced by the patient. In two days the urine became clear, and was passed without pain. An abscess subsequently formed in the perineum, which was opened by a deep incision; but this soon healed, and everything went on well till June 20th, when a change took place. Abdominal pains appeared in the region of the bladder, and some constitutional disturbance. On June 25th, these symptoms were relieved by a sudden rush of feces into the bladder, and their passage with the urine. The feces were thin, and evidently from the small intestine. From that time the man's power gradually gave way, and he sank on August 27th, four months after colotomy had been performed, and two after the reappearance of feces in the urine. After death it was discovered that the bladder, large intestine, and small intestine communicated with an abscess at the base of the bladder, and that all signs of ulceration of the intestine had disappeared, with the exception of the fistulous opening into the abscess. The left kidney was completely disorganised, and was full of thick greenish pus, as were the ureter and bladder. Mr. Bryant said the case tended to support the conclusions which Mr. Holmes had drawn from the consideration of his own and other cases. It supported the conclusion "that ulcerated openings sometimes take place between the bladder and either the large or small intestine, many of which have no connexion with previous stricture of the gut, still less with disease; that in those cases in which the feces discharged into the bladder came from the lower gut, and are consequently more solid, great suffering is produced;" and "that in such cases as are not dependent on malignant disease, colotomy, by diverting the feces from the fistulous channel, may enable the latter to close, and thus relieve the patient's sufferings, and restore him to a condition of

* Read before the Bath and Bristol Branch.