view, I incline to the doctrine that this salt is a valuable therapeutic auxiliary to other measures when we have to contend with certain forms of bronchial distress. I am sure of its capability to do good service in the proper asthenic bronchitis of old people. I claim for it no higher virtue, because I know our proneness to call any drug a *specific* which we know particularly well how to work with.

I would beg special attention to the absolute mortality of the smallest quantity of opium, and to the still more destructive effects of morphia.

If a patient be teased by residual catarrhal sputa, a short mercurial course will clear it away; and after that (or even at the same time) an iron tonic will help to restore the general health.

Great care must be taken at all seasons of the year that the skin is properly protected.

To recapitulate: I would specify the following points as deserving notice in the clinical history and management of Acute Capillary Bronchitis:—

1. The extraordinary pulse and breath-ratio, and the intense dyspnoea.
2. The pathological origin and character of the sputum.
3. The quasi-cyanosis of the skin, together with the so-called "collapse."
4. The occasional indistinctness of the diagnosis from acute tubercle.
5. The necessity of a supporting and alcoholic treatment.

ON DIVISION OF THE STRICTURE IN STRANGULATED HERNIA.

By THOMAS DARBY, F.R.C.S.I., Bray, Ireland.

THE mode of dividing the stricture when performing the operation for the reduction of strangulated hernia has been much dwelt upon, and we are cautioned not to divide it too freely; but I am not aware that it has ever been suggested to not divide it at all. Having succeeded in reducing the hernia without dividing the stricture in six cases after the sac had been opened, I beg leave to submit a short account of three of those cases so treated by me.

CASE I.—Stephen Manly, aged 80, was admitted to the Rathdown Union Hospital, on August 22nd, 1862, suffering from a strangulated hernia in the right groin. I operated; when the sac was opened a considerable quantity (probably not less than from ten to fifteen ounces) of brownish serum gushed out, and a knuckle of small intestine was exposed to view in the bottom of the sac; I introduced a director into the stricture, and as I passed it round the neck of the hernia, the bowel returned into the abdomen without further manipulation. It is here necessary to state that, for forty-eight hours after admission to hospital, Manly refused to submit to the operation, and that during this interval he had been placed under the influence of chloroform, had the tobacco enema administered, and the taxis carefully applied without avail. He recovered.

CASE II.—Jane Barrett, aged 70, the subject of old reducible femoral hernia on both sides, was admitted to Hospital June 10th, 1863, with the hernia in the right groin strangulated. Taxis having failed, I laid open the sac, and exposed a portion of omentum and a considerable coil of small intestine in a state of strangulation. I carried the director completely round the neck within the stricture (a practice recommended by the late Dr. Hutton of Dublin), and by careful manipulation, succeeded in returning the entire mass to the abdominal cavity. This woman recovered.

CASE III.—Anne M'Loughlin, aged 30, was admitted to hospital on October 4th, 1865, with a strangulated hernia in the right groin. I opened the sac, and reduced a coil of small intestine without dividing the stricture, although it was so tight that considerable difficulty was experienced before I could pass the director round the constricted part. This woman also recovered.

It is not merely on account of these cases having recovered after operation that I have selected them for this paper, but rather because each case differed from the other in some feature of practical interest; for example, in Manly's case, it is not easy to understand why symptoms of strangulation presented, or why the elaborate attempts at reduction should have failed in a case where the bowel, after the sac was opened, may be said to have returned of its own accord; in Barrett's case, the contents of the sac were large, solid, and complex, yet no great difficulty was experienced in returning them; and, in M'Loughlin's case, where the constriction was very severe, it was found possible to return the bowel without dividing the stricture.

That instances will occur where old adhesions, gangrene, or some other circumstance may render the division of the tendons necessary, there can be no doubt; and in such cases it will be also necessary to open the sac. If, therefore, we take into account that the sac *must* be opened in the worst cases; that peritonitis is not the cause of death in the majority

of those cases which terminate fatally after operation; that the fear of peritonitis does not deter surgeons from opening the abdominal cavity in the treatment of other diseases; and, on the other hand, if it be borne in mind that all danger of wounding an artery is avoided; that the tendons are left uninjured by the surgeon; that the operation is much simplified; and that in cases of recovery the patient is in all respects as well and as little liable to inconvenience from the rupture as he was before strangulation took place, the advantages of reducing hernia without dividing the stricture—the practicability of which is sufficiently proved by the foregoing cases—will be made manifest.

THE CURABILITY OF LATERAL CURVATURE OF THE SPINE.*

By WILLIAM ADAMS, F.R.C.S.,
Surgeon to the Orthopædic Hospital.

THE curability of lateral curvature of the spine is, at the present time, one of those unsettled questions which urgently demand the attention of the profession; and I now venture to submit some conclusions at which, from observation and experience, I have arrived, in reference to the curability of this affection.

In order to bring this subject forward in a definite manner, I propose the two following questions; viz., 1. In what cases is lateral curvature of the spine curable? and 2. What are the directly curative means?

As a starting point, I would particularly insist upon the fact, that no confirmed or persistent curvature of the spine, however slight, can exist merely as a functional affection; but that in every instance a spinal curvature is necessarily associated with, and dependent upon, certain structural changes, proportionate to the degree of curvature and its duration. It is of the utmost importance to recognise this fact, because lateral curvature is generally described as being, at least in the early stage, a functional affection depending upon muscular debility, or the undue action of certain muscles which have been called into play by some occupation, or some acquired habit. There can be no doubt that, in such cases as these, there is often some appearance of curvature, such as may be produced by any person in certain attitudes; but a careful examination will show that no persistent deviation of the spine exists. There can be as little doubt, however, that such cases have often been treated as cases of lateral curvature, and of course with great success under various methods of treatment.

A broad and distinct line must be drawn between any such functional conditions—or, as they may be called, functional or physiological curvatures—and the confirmed or persistent curvature of the spine, which, however slight, is necessarily associated with structural changes. A ready and certain means of diagnosis is of the utmost practical importance, in reference both to the treatment and the prognosis of the case.

The ordinary method of examination for forming a diagnosis is by passing the finger down the spinal column, and tracing the apices of the spinous processes; but this is fallacious, as the spinous processes may deviate laterally in a case of simple debility, without actual curvature; and on the other hand may remain in a straight line, whilst the bodies of the vertebræ have deviated to a considerable extent, so as to form a large internal curvature, associated with considerable alteration in the relations of the ribs in the dorsal region, and of the transverse processes of the vertebræ in the lumbar region.

In all cases of the so-called lateral curvature of the spine, the primary and essential deviation takes place in the bodies of the vertebræ, which are found to move laterally in the direction of horizontal rotation, so as to give a spiral twist to the portion of the spinal column involved. The result of this is to cause a projection backwards of the angles of the ribs in the dorsal region, or bulging on the side of the convexity of the curve, and a corresponding depression or receding of the ribs on the concavity of the curve. In the lumbar region we have also a projection backwards of the transverse processes of the vertebræ which render prominent the lumbar muscles on the same side; and on the opposite side the transverse processes are depressed, so as to leave a hollow in the lumbar region, and allow a prominence of the crest of the ilium, and an apparent enlargement of the hip.

Upon these conditions I rely as a positive test of the existence of those deviations and structural changes which essentially exist in all cases of persistent or confirmed lateral curvature, however slight. In slight cases, these deviations will be made more apparent by placing the patient in a stooping position, and in practice I always adopt this mode of examination.

* Read before the Harveian Society of London.