The history of pain, the sudden appearance of the tumour, and the sanguineous nature of its contents, have already been pointed out. The change in the colour of the fluid is also worthy of note. At first it was deep reddish-brown, afterwards the colour of *café au lait*. It seems possible that this change of colour may progress until the cyst contents fail to give evidence of their former sanguineous nature, and the origin of the pancreatic cyst in a hæmorrhagic effusion be thus overlooked. The cessation of pain after the appearance of the cyst is a curious feature that has occurred in other cases. The patient is cured of pain that may have existed for months or even years before the development of the swelling. A long-standing disease culminates in a severe manifestation that, instead of proving disastrous to the health of the patient, results in the removal of the distressing symptoms. This fact increases the obscurity of the origin of these cysts, but a discussion of its import is beyond the scope of this brief record; it may, however, be remarked that the great point of interest seems to be how far the pancreas is involved. In fatal cases of hæmorrhage in the region of the epigastrium the pancreas may be extensively affected, but we can hardly suppose that a patient would improve in health and gain in weight after destruction of that important gland.

OBSTRUCTION OF THE BOWELS CAUSED BY AN INCOMPLETELY REDUCED LEFT INGUINAL HERNIA.

LAPAROTOMY: DIVISION OF INTERNAL ABDOMINAL RING FROM WITHIN THE ABDOMEN: RECOVERY.

By W. C. EVERLEY TAYLOR, F.R.C.P. EDIN., M.R.C.S.,
Surgeon to the Scarborough Hospital.

ON April 13th, 1893, I was asked by Dr. Wilkinson, of Cloughton, to see G. H., a man aged 53, living at Scalby. The patient had for many years suffered from hernia, which was kept in position by a well-fitting truss. On April 7th, after retiring to bed and taking off the truss, he sneezed violently, which caused the hernia to descend. He attempted to reduce it himself without success. On the following morning he sent for Dr. Wilkinson, who found a manifest left oblique inguinal hernia. With gentle manipulation the hernia seemed to be easily reduced, with apparent great relief of the pain. During the next two days there were no remarkable symptoms, save that no flatus passed. On the morning of April 11th the patient complained of wandering colicky pains, which during the day increased in intensity; obstinate vomiting set in, and the general condition became alarming.

I saw him on the afternoon of April 13th, at 4.30 P.M. The patient was much exhausted; the pulse was 120, rapid and running; the tongue small and red; the temperature 100° F. The abdomen was distended and tender; there was no dulness nor increased pain on pressure over the site of the hernial apertures. There was nothing to be felt in the inguinal canals. The patient's condition was desperate; the stercoraceous vomiting had existed for forty-eight hours, and there had been no action of the bowels or passage of flatus since April 7th. I was of opinion that either the gut had been incompletely returned or that there was strangulation by a band.

Ether having been administered, a median incision was made. The intestines were much distended. I passed my hand to the site of the left internal ring, and found a knuckle of the small intestine tightly grasped by the inner margin of the internal ring. A very slight incision liberated the gut; about two-thirds of the lumen of the gut had been involved in the constriction; it was dark chocolate colour, but shining; there was no evidence of any peritonitis. The abdominal contents were as little disturbed as possible, and no "toilet of the peritoneum" was attempted. The peritoneum and muscles were sutured separately with silk, and the skin wound with silkworm gut; three carbolised catgut sutures were unfortunately used in the superficial wound. The patient rallied well from the operation; flatus was passed within six hours; the vomiting ceased immediately; the progress to recovery was only retarded by some stitch abscesses set

up by the carbolised catgut sutures, and the patient is now "as well as ever he was" in his life.

The remarkable points in the case are the abeyance of symptoms for forty-eight hours after the gut was thought to be returned, the desperate condition of the patient when operated upon, and the great ease with which the hernia was dealt with from within the abdomen.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

LYING-IN HOSPITAL, MADRAS.¹

A CASE OF SYMPHYSIOTOMY.

(By Surgeon-Lieutenant-Colonel A. M. BRANFOOT, M.B.)

THE patient, Velliammah, Hindu girl, 15 years of age, was admitted into the delivery ward on September 16th, 1893, in labour with her first child. It was stated that she had been in labour for eight hours previous to admission, but she had all the appearances of having been much longer than this. The uterus corresponded to full term of gestation, and was somewhat rigid. Fœtal heart audible on the left side below the umbilicus. Bladder was distended, and 20 ounces of urine drawn off by catheter. In general appearance the girl was small. *Per vaginam* head presenting in the brim with a large scalp tumour, membranes absent, and the rim of the cervix could just be felt. Pelvis markedly small, and of apparently infantile type. Chloroform was administered, Simpson's axis-traction forceps applied and traction made, but considerable traction force failed to move the head. It was therefore determined to perform symphysiotomy.

Operation.—The abdomen was washed with antiseptic lotion and the pubic hair shaved. An incision 2½ inches in length was made from above the symphysis downwards in the median line, dividing skin and tissues down to the top of the symphysis. Symphysis was exposed and a blunt-pointed bistoury pushed into the joint; but the separation of the pubic bones could not be completed, and it was found necessary to complete the division with a small Hey's saw, when the pubic bones separated to about half an inch, the hips being firmly supported by an assistant. Pressure from above failing to deliver, Simpson's ordinary forceps were applied and delivery readily effected. During delivery the bones separated to about 2½ inches. The head was delivered with the occiput posterior. The bones were then approximated by pressure and the periosteum united by two deep silk sutures. The wound was closed by silk sutures and a small drainage tube inserted at the lower angle. The placenta was expressed, the wound dressed with antiseptic gauze, and a firm bandage placed round the pelvis. The child, a male, weighed 212 *tolas*—just under 6 lbs.; length 18½ inches. It was alive and has since thriven well.

Convalescence after delivery was uneventful. The wound healed almost by first intention, except at the lower part, from which a little pus escaped. The patient was kept on her back until September 29th (twelfth day), when she was allowed to lie on her side. On October 1st the following notes were taken: Temperature, normal; pulse, 88. Vaginal walls natural; the finger can be passed along both sides of the pubic arch, and the symphysis appears united. There is still a small sinus at the lower end of the wound externally. On October 9th patient sitting up. She has some cough. October 18th patient is able to walk by herself. No pain complained of over the symphysis. Slight rise of temperature due to bronchial catarrh. When walking there is slight incontinence of urine occasionally; this is apparently due to debility. When convalescent patient's height found to be 4ft. 6½ inches, and weight 65 lbs.

A careful examination of the pelvis was made. External measurements, A.S.S. 8½ inches, Cr. IL., 8½ inches. External ante-posterior 5 inches. Promontory of sacrum reached by

¹ Communicated to the South Indian Branch