"shell shock" gets well—of the degenerate, work-shy, malingering borderline case, who did no work before the war, as little as possible during the war, and do not intend to work after the war. The Ministry of Pensions has taken the responsibility of these men; and it is our duty to educate ourselves and the public as to how to deal with them; they do much harm to our wounded and war invalids. The war found us well prepared as regards the prevention of infection, moderately prepared as regards the treatment of wounds, but in hopeless ignorance as regards the prevention and treatment of psycho-neuroses. We tolerated before the war in a supercilious manner some practitioners who specialized in this class of patient; a few—but still too many—of these were cranks themselves or quacks who battered on credulity and gave the bad name; but we ourselves were ignorant; we were guided by no scientific principles. The older surgeon looked with contempt on the bonesetter; he has now systematized the knowledge and experience of the bonesetter, and benefited the patient; the analogy is not too strained.

My object is to advocate the introduction of a simple elementary study of psychology, normal and pathological, into the wards of a general hospital, in order to formulate and systematize the instruction that is already given in a somewhat spasmodic and irregular manner; to train students and prepare them so that they will be able to benefit more fully by their attendance in the asylum, and be ready to take up this aspect of their professional life—the examination of a patient for responsibility of his actions, for testamentary capacity, and for the hundred small incidents that occur in our daily professional life, and the treatment of the minor mental ailments that form such a large part of general practice.

OBSTRUCTION BY A BAND IN A LARGE SCROTAL HERNIA.

BY

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INTESTINAL obstruction in a hernia, from causes other than constriction of the contents at the neck of the sac, is not of great rarity—I have heard of two such instances in the past year—but the following case presents features of unusual interest:

In September, 1919, I was asked by Dr. J. Thorpe Reckitt to see a case, apparently of strangulated inguinal hernia. The patient was a man, aged 69 years, who had a left inguinal hernia of remarkable size; its maximum length was about twelve inches and its circumference about eighteen inches while the patient was lying down in bed. The hernia had been present for forty years, and for many years—for how many the patient was unable to say—it had been irreducible and of its present size. No truss had ever been worn, but, in spite of its magnitude, the hernia seemed to have caused him singularly little inconvenience. He was able to lead an active life and attend to his business right up to the present illness. Some few years ago the swelling had been tapped by a medical man, presumably under the impression that the scrotal swelling was a hydrocele. No fluid was drawn off, but the patient was unable to say whether anything was injected into the sac.

His illness, which may be said to have started three days before I saw him, commenced with pain and tenderness in the hernia, followed by absolute constipation, neither faeces or flatus being passed. The symptoms at first were apparently not severe, so that he did not send for Dr. Reckitt until the third day, when the pain had extended to the lower part of the abdomen and he had commenced to vomit. When seen during the evening of that day his condition was very grave; the vomiting had persisted and he was then bringing up small quantities of foul brown fluid at frequent intervals. The pulse was not very rapid, being 100 per minute, but was of small volume; the tongue was furled but moist and the eyes were decidedly sunken. The lower part of the abdomen was tender and rigid, but, owing to the presence of much fatty tissue it was not possible to say if there was any distension. It was considered that the hernia was strangulated, with probably gangrene of some of the

contents. As it was thought that the patient's life might possibly be saved by relieving the obstruction and tying in a Paul's tube it was decided to operate.

Operation.

An anaesthetic was given and the sac exposed and opened in the usual way. The contents were chiefly small intestine, with a portion of the omentum and a small amount of foul blood-stained fluid. The neck of the sac was very large, and there was no difficulty in passing two fingers through it into the peritoneal cavity; the intestine showed no evidence of constriction, and it became certain that we were not dealing with an ordinary case of strangulated hernia. The omentum was ligatured and excised to allow of investigation of the bowel. It was estimated that about half the total length of small intestine was present in the sac; it was but slightly distended and the serous surface was hyperaemic. At the lower part of the sac a coil about 12 in. in length was found to be black and gangrenous. This was caused by a well-defined, rounded, fibrous band attached at each end to the mesentery, crossing and constricting both the proximal and distal ends of the coil, but having no attachment to the intestine. The gangrenous portion of the gut was sharply defined by the line of constriction, which was very tight, and, in addition, the whole of the affected coil was twisted through an angle of about 180 degrees. The band was situated at least 6 in. below the level of the external abdominal ring, and there was certainly no obstruction at the latter situation. The patient's condition was too bad to allow of a resection, so that, after the band had been divided, the gangrenous coil was drawn into the wound, incised, and Paul's tubes were tied in. The upper three-fourths of the wound were then closed and the patient returned to bed. However, he did not rally, and died in about three hours.

The nature of the band which caused the obstruction is doubtful. It was a definite, rounded, cord-like structure, attached at each end to the mesentery, but as it had no attachment to the intestine it can scarcely have been derived from a Meckel's diverticulum, though the gangrenous portion of intestine was probably ileum. It certainly had no connexion with the inguinal canal or the external abdominal ring, and there was nothing to suggest that it was derived from the omentum, which was not adherent to either the gut or the sac wall. No other bands or adhesions were noticed, and, indeed, I think that the reason that the hernia was irreducible was on account of its size and long duration, so that the capacity of the abdominal cavity was insufficient to accommodate its contents; at any rate there was hindrance to reduction at the neck of the sac, and no adhesion between the sac wall and contents.

One cannot help thinking that the band may have been inflammatory in origin, and that it may have followed upon the tapping which had been performed some years before. When I saw the patient there was no suspicion of a hydrocele, and at the operation there was only a small amount of fluid in the sac. Under these circumstances it is quite possible that the trocar and cannula may have inflicted some injury upon the mesentery, and that, as the result of the inflammation thus set up, the band was formed. In support of this view it may be pointed out that the situation of the band was about the level which would be selected for the introduction of the trocar and cannula in tapping a hydrocele. Whatever the cause of the band may have been, it is certainly a very unusual occurrence for a portion of the contents of a hernia to be obstructed in this way.

THE RADICAL CURE OF VARICOCELE.

BY

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SOME six years ago¹ I called attention to a simple and exact method of excising the eight or ten varicose spermatic veins (the pampiniform plexus) which are suspended, in loose areolar tissue, mostly in front of the vas deferens. It is essential to punctuate the fact that surgical intervention must be exclusively confined to removal of this bundle of veins, otherwise disastrous consequences are certain to ensue—for example, gangrene or atrophy of testis. I have seen many examples of the latter, and recently a very painful instance of the former—a gentleman who, just before embarking for Buenos Aires, was operated on by a well known English surgeon; on his arrival here he was suffering from marked toxæmia and a foul septic scrotum. I had to remove a gangrenous

testicle and found the cord itself tightly constricted in the ligature.

I cannot help thinking that operative textbooks are largely responsible for these mishaps by recommending procedures possessing needless magnification of perspective which often results in anatomical obfuscation—too much exposure and too much dissection frequently produce too much surgery. The essence of the thing is first to realize that the pampiniform plexus is situated anteriorly to the other structures of the cord, and then, before making the incision, to take care to secure it in that position—always remembering that the object is to remove a superficial bunch of varicose veins endowed with a definite topographical site, which may be easily confused by over-dissection and unnecessary manipulation of the part.

The operation which I have employed for some years past is as follows:

1. This clump of varicose veins is seized horizontally between the left thumb and left index finger. A pause is made, to be certain that the cord lies free and well posterior to the gripping fingers. This is verified by palpation with the right thumb and right index finger, and I generally demonstrate the position of the cord to some onlooker by rolling it close under the skin for inspection.

2. A two-inch incision is then made over the gripped projection; with a few horizontal strokes of the knife the infundibuliform fascia is divided, the offending plexus pops into the wound, and with a few more touches it is completely exposed through the whole length of incision.

3. These veins are then caught in mass by an artery forceps, which is handed to an assistant, who pulls it vertically upwards so as to bring the underlying connective tissue into view.

4. A stab of the scalpel makes an opening through this tissue sufficient for the introduction of the right index finger; this done, the left-hand grip is released, and the left index finger is instantly inserted alongside of the right one beneath the bundle of veins.

5. The pampiniform plexus is now freely separated from its bed by the two fingers (one working up and the other down) and as many inches as may be considered necessary are easily and rapidly isolated.

6. A catgut ligature is applied above and below, the intervening segment (usually 2 to 4 in.) of plexus is excised; the ends of ligatures are then tied so as to approximate stumps and to elevate scrotum, and the skin wound is united by a few catgut stitches, leaving room at the upper and lower angles for the passage of a slender wisp of silkworm gut—a precautionary haemorrhagic drain which I employ in all scrotal wounds.

The facility with which this little operation may be done can be estimated by the time occupied in its performance²—one to three minutes. The results warrant its commendation to others.

REFERENCES.

¹ *Lancet*, October 24th, 1914. ² "Operating to the Clock," *BRITISH MEDICAL JOURNAL*, December 21st, 1918.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

LIGATIONS OF THE LEFT SUBCLAVIAN ARTERY.

IN the *JOURNAL* of April 16th, under the above heading, the possibility is suggested that some surgeons may have performed this operation without having recorded the fact in print. That this supposition is correct in at least one instance is borne out by the following case on which I operated during the summer of 1918 in France. No doubt other surgeons during the great war had somewhat similar cases.

A soldier was received at a base hospital with the diagnosis of gunshot wound of the shoulder. He complained of pain in the neck. The wound was discovered only after careful search, and consisted of a tiny scab in the neck, above the inner end of the left clavicle, about an eighth of an inch in diameter. There was no other physical sign except some tenderness on deep pressure. Had he not consistently complained of pain, and at times given the impression of undoubted suffering, he would have been sent to rejoin his unit almost immediately. However, a few days after admission there appeared gradually a small red swelling, hard and tender to the touch, in the neck just behind the inner end of the left clavicle. There was no pulsation. The classical error

was committed, and "abscess" diagnosed. An x-ray plate revealed a tiny fragment of shell about the same size as the wound, deeply situated in the region of the swelling.

A small superficial incision was made over the red area, and a pair of artery forceps pushed deeply into the supposed abscess. No pus appeared. The finger was then introduced, and, the deep parts of a small cavity being disturbed, there followed an alarming gush of blood, easily controlled, however, by pressure of the tip of the finger on the pulsating artery, in the anterior wall of which there apparently was a tiny wound.

The remaining part of the operation was performed with the tip of the left index finger on the artery at the bottom of the wound, an assistant retracting and ligating, an orderly pulling the left arm downwards and the anaesthetist forcing the head firmly towards the right shoulder. A long incision was made transversely across the neck, just above the clavicle and including the original opening. The dissection which followed was naturally long and tedious, punctuated by various "alarums and excursions." The clavicular head of the sterno-mastoid was cut across. The suprascapular artery and various veins were ligatured and divided. The inner margin of the scalenus anticus and the thyroïd axis artery were recognized. The latter was followed to its origin from the subclavian, and the finger-tip on the puncture was just internal to the point of origin. With as little disturbance of the subclavian as possible, and after a little blunt dissection, two pairs of artery forceps were applied to the artery close together, and these occluded the puncture and controlled the haemorrhage. An aneurysm needle was passed round the artery, first immediately internal to and then immediately external to the forceps, and the vessel was ligated in two places with thick catgut.

The wound was stitched and a small drainage tube was left in position for twenty-four hours. The arm was wrapped in cotton-wool and placed in a modified Thomas's arm-splint in the horizontal position. No complications arose, the wound healed by first intention, and the patient was evacuated to England within three weeks.

Birmingham.

W. GEMMILL, F.R.C.S.

DERMATITIS CAUSED BY BITTER ORANGE.

OCCUPATIONAL dermatitis due to the handling of certain flowers and plants is well known, but cases are not very common, so that they may be rather difficult to recognize. In Sequeira's *Diseases of the Skin* is given a list of over forty plants which are known to have caused dermatitis. Among them is the bitter orange, and several cases of this form of dermatitis recently came under my notice among girls engaged in peeling bitter oranges in a jam factory.

The most marked case was that of a girl, aged 25, who suffered from a very acute dermatitis of the fingers, hands, and forearms, and also of the face. There was intense erythema and much swelling, especially of the hands and forearms, the parts most exposed to the juice. There were numerous small vesicles, a little larger than the size of a pin-head, all over the affected areas. I put the patient to bed for one week and applied a lotion of zinc carbonate, pulv. calaminae and aq. calcis, which proved very effective, the inflammation entirely disappearing after ten days. Idiosyncrasy evidently plays a considerable part in the condition, as in spite of all precautions the girl in question had ultimately to give up the work.

Glasgow.

F. ANDERSON MURRAY, M.D.

A STELE in memory of the internes of the Paris hospitals who died on active service during the war has been erected at the Hôtel-Dieu. On it are inscribed 72 names; it is ornamented by a bas-relief showing a first-aid post.

AT the meeting of the Congrès de Chirurgie at Strasbourg on October 3rd, the President, Professor E. Boeckel, will be presented with a medal in recognition of his patriotism during the German occupation.

THE tuberculosis mortality at Rio de Janeiro, which in 1903 was 4.43 per 1,000, rose to 5.53 in 1918, and is now 10 per 1,000. Amaury de Medeiros, general secretary of the Association for Combating Tuberculosis in Brazil, estimates the annual number of deaths from tuberculosis in Brazil at 60,000, and the number of cases at 600,000.