"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