the intraocular tension was sensibly diminished, showing the gravity of the lesion; and the sight (once normal) was reduced to a vague perception of light. The patient had never had syphilis, and she was of a good constitution, though of rheumatic and gouty tendency. The excessively serious state of the eyes continued from week to week, from month to month. Colleagues, the most competent and worthy of all confidence, recommended, nevertheless, an energetic course of antisyphilitic treatment. But the patient was strongly opposed to iodine, as well as to mercurial preparations. She contented herself with the hygienic rules which I had indicated to her, and a visit at a health resort beneficial to the gouty diathesis. Locally she employed mydriatics and poultices with a persistence and regularity worthy of all praise. She recovered completely and definitely without having taken a single grain of mercury; in fact, to-day I saw her for the first time for five years. Vision is excellent in both eyes; the dioptric media are perfectly transparent; there exist neither adhesions at the pupillary border nor choroidal exudations, nor even specks in the vitreous body. Nothing indicates the passage of the dreadful malady of which her uveal tract was the seat.

On another occasion a friend brought me his young wife. She had gradually lost the sight of her right eye in the space of a few weeks. It was scarcely possible for the patient to recognise the movements of the hand; a large portion of the retina was no longer functionally active, and produced a scotoma in the visual field. The ophthalmoscope revealed an optic neuritis of a most evident character, swelling of the papilla, serous exudation, in which the tortuous and gorged blood vessels were immersed. I did not hide from the husband the gravity of the affection. I explained to him that it depended probably upon a general disease, and that local treatment would not at all suffice, and I therefore sent him to the family physician. This colleague was a homœopathist; he gave infinitesimal doses of these remedies into which there does not enter an atom of mercury. Along with this, a state of hygiene, local and general, was strictly observed; and at the end of six months the neuritis had disappeared entirely, leaving the papilla sensibly pale. Vision, direct as well as indirect, has become normal, and things remain in this state still.

I have mentioned these cases because they are those in which mercurial treatment would seem to be most indicated. But to speak of affections of the lachrymal passages, of keratitis, of scleritis of a nature absolutely non-specific, of separation of the retina, of intraocular hæmorrhages—retinal or choroidal—of simple floating bodies, even in which the patient is exposed only too often to the grave troubles of mercurial absorption, it seems sufficient to point out this abuse to have it stopped. As for myself, convinced of the absolute inutilty of this treatment in the diseases cited, I consider it an imperative duty on the part of the physician to protect those who intrust to him their health against an agent which, an invaluable remedy in some cases, becomes in others a veritable poison.

DEATH DURING ANÆSTHESIA.

BY SURGEON-MAJOR EDWARD LAWRIE.
Hyderabad.

THE BRITISH MEDICAL JOURNAL of January 16th, 1892, contains an interesting article on chloroform by Dr. Lombe Atthill, in which it is stated that the Report of the Second Hyderabad Commission "affirms distinctly that death from chloroform is due to asphyxia." This is entirely a mistake. The Hyderabad Commission has affirmed over and over again that the only danger of asphyxia during chloroform inhalation is that it leads to gasping inspirations, and so to rapid and frequently irremediable overdosing. No doubt the nerve centres are more susceptible to poisoning with chloroform when asphyxia is present than when it is absent.

In the same issue of the BRITISH MEDICAL JOURNAL there is a letter on "Death during Anæsthesia" by Dr. Horatio C. Wood, of Philadelphia. Professor Wood says: "Denial of the existence of the other side of the shield has been persisted in by many an honest and capable man, but in the

long run the world learns for itself, and so I leave this controversy with the hope never to return to it." I trust sincerely Professor Wood will reconsider his decision, and fight it out like a man to the end. The Hyderabad Commission has never denied the existence of two sides of the shield. On one side are the true followers of Simpson and Syme,¹ Syme's cases and my own form a series of chloroform administrations extending over forty-five years without a single death. On the other side are Professor Wood, the Glasgow Committee, Professor Macwilliam, and their disciples the anæsthetists. On that side deaths under chloroform have been numerous, and have increased in frequency of late years in exact proportion as their teaching has gained ground.

We may well ask what is the difference between the two sides of the shield; and is it incapable of adjustment so as to make both sides alike? The main practical difference is this: The fundamental principle of chloroform administration on our side of the shield is that it is useless and dangerous to take the pulse as a guide. On Professor Wood's side, on the other hand, it is an essential principle of chloroform administration to watch the pulse continuously during the whole time of the inhalation. Our principles are founded upon uniform clinical and experimental data, and are characterised by uniform results; but on Professor Wood's side there is a conspicuous absence of uniformity in everything except the death-rolls from anæsthetics and antagonism to the Hyderabad Commission.

Our experimental data show that chloroform never affects the heart directly, and we are prepared to produce chloroform anæsthesia with uniform results in any laboratory or operating theatre in the world. If we can do this anybody can do it. The want of uniformity on Professor Wood's side is illustrated by Dr. Wood's statement that the heart is paralysed by chloroform; by Professor Macwilliam's statement that it is dilated by chloroform; and by the Glasgow Committee's finding that the great danger of chloroform is sudden stoppage of the heart through the vagus; while the anæsthetists tell us through their champion, Dr. Dudley Buxton, that these anatomical conditions—denoting cardiac enfeeblement by chloroform—are the counterparts of the procession of events which they themselves encounter again and again in the operating theatre when chloroform is administered in accordance with their own plans.²

At first sight these differences may appear to be irreconcilable; but in reality they are not so. The Hyderabad Commission has shown³ that there is always complete uniformity in all experiments with chloroform inhaled in the natural way, and that absence of uniformity is only characteristic of experiments where natural breathing is interfered with. This is precisely the point which our opponents have overlooked. In Professor Macwilliam's experiments the thorax was laid open and chloroform was pumped into the lungs with bellows, so that natural breathing was impossible. In those of the Glasgow Committee the chloroform was administered "by a cloth saturated with the agent being held over the mouth and nose," that is, with insufficient air,⁴ and vagus stimulation—which the Hyderabad Commission has since proved is a safeguard in abnormal inhalation—resulted. In Professor Wood's experiments there is an omission of all mention of the regularity or otherwise of the respiration.

In the *Medical Chronicle* of May, 1891, a friendly challenge was thrown down to Professor Wood, Professor Macwilliam, and the Glasgow Committee, of which they have hitherto taken no notice. It may be repeated here, in the hope that they will take it up and see for themselves if the two sides of the shield cannot be brought into accord and the chloroform question settled, in order that deaths during anæsthesia shall henceforth and for ever cease to occur. I therefore repeat my challenge to Professor Wood and his supporters—whether physiologists or anæsthetists—to produce an irregular tracing in the laboratory, or any irregularity of the heart's action in the operating theatre, in any case of chloroform anæsthesia in which the breathing is regular and natural.

¹ The true followers are to be distinguished from those pretenders who call themselves out-and-out followers of Syme, but nevertheless watch the pulse while chloroform is given, which Syme never did, *vide* Chloroform Report, pages 183 and 399.

² *Lancet*, December 13th, 1890.

³ The Report of the Hyderabad Chloroform Commission, p. 297.

⁴ *Ibid.*, pp. 229 and 245.

throughout the inhalation. If Professor Wood and his friends refuse to accept this challenge, judgment must go against them by default.

A NOTE ON AN EARLY DESCRIPTION OF INFANTILE HERNIA.

By J. MACREADY, F.R.C.S.,

Surgeon to the City of London Truss Society.

THE species of hernia, known as "infantile," was observed by Hey, of Leeds, in 1764, and up to the present time he has always been credited with its discovery. To question the claim to priority of this celebrated surgeon would almost seem sacrilegious, and yet there was another surgeon, earlier than Hey and no less famous, whose description of this disease might well entitle him to contest it. M. Méry,¹ in 1701, narrated a case which appears to be undoubtedly of this nature, but he did not stamp it with a name.

It may not be unprofitable, before quoting M. Méry's words, to recall the manner in which infantile hernia usually presents itself. When the coverings of the tumour are incised, it is not the sac but the tunica vaginalis which is opened; below is seen the testis, and above is the hernial sac projecting into the cavity. The sac is more or less free, so that it may have no attachment to the wall of the tunica vaginalis, except at the neck, or it may be united besides in its whole length to the posterior wall of the tunica vaginalis, and be joined also to the testis by a fold (plica vascularis) containing the spermatic vessels. The peritoneum of the tunica vaginalis invests the outer surface of the hernial sac, so that, when viewed from the interior of the cavity containing the testicle, it appears smooth and shining, and might at first be mistaken for intestine. This deceptive serous covering has to be divided, and afterwards the pouch of peritoneum lining the sac, before the bowel is reached. These characteristics serve to identify M. Méry's hernia.

A man, 70 years old, arrived at the Hôtel Dieu on August 20th, 1701. He had a right inguinal hernia as large as a goose's egg. The integuments were in a condition that betokened gangrene of the gut within, and as in those times gangrene of the gut was considered absolutely fatal, M. Méry thought the patient should be left to die. M. Petit, however, urged the operation so strongly that M. Méry consented. M. Méry incised the coverings of the hernia, and no sooner were they divided than a blackish, foetid fluid escaped, leaving a large cavity "in which I saw the testis, sound and naked." He expresses his astonishment at this, and then his still greater astonishment on seeing in this open cavity "*un intestin aveugle*," healthy, and not tense, instead of being gangrenous as he had anticipated. "It was pierced by a hole so small as would scarcely admit a pin." (He appears to have pricked the sac with his bistoury.) This *intestin aveugle*, "from the groin to the bottom of the tumour, was separate from the membranes of the scrotum; but it was so closely united to the ring of the abdominal muscles that, despairing of overcoming its adhesion without rupturing it, I proposed to M. Petit to leave it and to content ourselves with dilating the rings. Of this he did not approve. I then separated this supposed intestine from these parts of the muscles and returned it to the belly. I perceived that in returning it to the abdomen it was still adherent to the peritoneum." As he thought the fæces would be no longer obstructed, he dressed the wound. During the next four days the bowels acted and the vomiting ceased, but hiccup and delirium came on and the man died.

At the post-mortem examination a mortification of that part of the ileum which had been strangulated was found with a rupture of two-thirds of the circumference of the gut and extravasation of fæces. The gangrenous part was nowhere adherent. After careful examination of the parts in the groin, "I found," he says, "I had been mistaken, and that the part which I had taken for *un intestin aveugle* was only the peritoneum prolonged in the form of a *cul-de-sac* into the scrotum..... In ordinary hernia the prolongation of peritoneum (sac) is always found united to the membranes of the scrotum on the one side and to those of the testis on the other; but, on the contrary, in this hernia it (the sac) was entirely separated from the one and the other....."

M. Méry deprecates criticism on his case, and says surgeons had better try to resolve the questions (1) how to discern the peritoneal *cul-de-sac* from the intestine, and (2) how to discover the cause which was able to separate the *cul-de-sac* (sac) from the scrotal membranes and to expose the testis in the tumour. This case seems to admit but of one interpretation, and is given so clearly and circumstantially by Méry that it is surprising it has received so little attention from the profession. Even Mr. Lockwood, who has done so much to elucidate the mystery of infantile hernia, has made no mention of it. M. Méry's case appears to belong to that variety in which the sac

hangs free in the tunica vaginalis, and is only attached to it at the neck, in which, as Thompson Forster said, the sac is "pendent from the ring."

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

GENERAL SYMPTOMS PRODUCED BY ACCUMULATIONS OF CERUMEN.

CASE I.—A little girl, aged 8, suffered from incessant cough, bad nights, with frequent night terrors, almost complete loss of appetite, and emaciation. Her mother had been told that her lungs were much affected. A careful examination revealed nothing wrong in the chest, but, upon looking into the ears, one was found blocked with wax. The removal of this was followed by the happiest results—all symptoms rapidly disappearing. It is interesting to note that all the other members of the family also suffer from aural disorders—the father, mother, and one boy from catarrh with gradually advancing deafness, while another boy had a foul otorrhoea.

CASE II.—A gentleman, aged 81, complained of dreadful nervousness and restlessness with disordered digestion. His wife said he could not now settle to anything in the daytime, and that the disturbed nights were affecting her too. He had, during the few previous years, sought advice on several occasions without result, and he had now commenced to doctor himself with no happy results. Beyond a very furred tongue and considerable shaking, nothing could at once be observed which would suggest treatment. The temptation was strong, especially considering his age, to conclude that any advice would be no more successful than the former. It was noticed, however, that he was deaf, and, though he somewhat demurred, the ears were examined and found to be filled with large and hard masses of wax. These accumulations proved to be specially adapted to act as irritants, for embedded in the cerumen were large quantities of aural bristles, whose sharp ends projected like needles. It is remarkable that at such an age great improvement followed, and, at the end of a few months, the old gentleman sprightly declared himself "quite well."

CASE III.—A girl, aged 11, who had an exceedingly bad family history. Her mother and aunt had died of phthisis, her father suffers at present from lung disease, and an infant sister died of tuberculous meningitis. The facts demanded special care in the examination. The symptoms were rise of temperature and quick and irregular pulse. There were no head, eye, chest, nor abdominal symptoms, and her urine was normal. Her father, who had used a thermometer for some years, took her temperature for some days, and then sought advice. It ranged from 100° in the morning to 102° or 103° in the evening. She appeared to hear quite well, but more careful examination showed that the right ear was dull and filled with wax. This was very hard, and came away in two parts like small almonds. The temperature was normal the evening after removal, and has continued so since. The pulse also has gradually improved.

Edinburgh.

DAVID WM. AITKEN.

CASE OF VARICOSE VEINS IN THE FAUCES.

THIS was the case of a mechanic who had suffered for several years from an irritating hawking, with a mucous discharge from the back of his throat. I examined him, and found a mass of varicose veins projecting into the back of the throat, from the wall of the naso-pharynx on the right side. Its base sprang from the space behind the posterior pillar of the fauces, and extended upwards, so as partly to occlude the right posterior nares, while it invaded the back of the soft palate on that side. Running downwards it was attached by the side of the epiglottis and back of the tongue to the right aryteno-epiglottidean fold. The whole presented the appearance to the eye or laryngoscope of a mass of blackberries or a very long and wrinkled black snail. As the attachments were so extensive, and the walls of the mass—which hung out loosely from its broad base—were so very thin, it was not considered

¹ *Mém. de l'Acad. Roy. des Sciences* for 1701, p. 273, Obs. sur les Hernies. Observ. ii.