This state of the brain has been well described by Sanson, but was, I believe, first pointed out by a distinguished London physician.

I have endeavoured, knowing the value of your space, to abridge the report of the cases as far as possible, without omitting necessary particulars.

CASE I. Concussion of the Brain; Slight Laceration; Small Ecchymoses of Blood in the Cerebral Substance; Effusion of Blood into the Cellular Tissue of the Orbit, from Fracture of the Facial Bones. This was the case of a gentleman who was thrown from his horse, and admitted into St. George's Hospital very shortly afterwards. He was then completely insensible. There were two very small wounds over the left eye, and one of them led down to the bone, which felt roughened. The left orbit was full of blood, pushing the eyeball forwards, and making the lids very tense. On opening the lids, the ocular conjunctiva was seen to be full, but not chemosed. There was no paralysis; the breathing was quiet; the pulse very weak, 84. The feet and legs were drawn up spasmodically every now and then. Next day, the ecchymosis in the orbit was increasing; and the jactitations had also increased; they affected the right arm more than any other part. The left arm was not moved, but the muscles retained their tone. The pulse was getting weaker, and was irregular.

It is unnecessary to go more minutely into the symptoms, which presented nothing further worthy of particular mention. As the weakness increased, the spasmodic movements became less violent, and soon ceased altogether. He died exhausted, on the fourth day after the accident.

On *post mortem* examination, no fracture of the skull could be traced on the most careful inspection. The source of the bleeding into the orbit was proved to be a fracture which had separated the angular process of the left malar from the frontal bone, and displaced it inwards slightly into the cavity of the orbit. A linear fissure extended also through the orbital process of the malar bone to the suture between it and the spheroid. There was a small extravasation of blood in the edge of the fornix, at its anterior part; and another on its posterior and under surface. A few minute extravasations were found in the superficial part of the optic thalamus. Some blood was poured out in the meshes of the pia mater, here and there; and the subarachnoid fluid was in great quantity. The brain was "wet", and its convolutions somewhat flattened by the fluid above mentioned.

CASE II. Severe Concussion; Ecchymosis of Blood in the Membranes of the Brain; Effusion of Blood in the Orbit, from Injury to the Face. The patient had sustained a severe injury of the head, by falling from a height of about forty feet. The lower jaw was fractured, and the face much bruised. He was quite insensible. There was abrasion of the skin in the neighbourhood of the right eye, and considerable ecchymosis in the right orbit; chiefly, however, confined to the lids. The pulse was very weak; the breathing regular; the pupils round, fixed, and of the usual size.

Next day the weakness was more alarming, but he had partly recovered consciousness. The effusion of blood had increased, especially at the right side of the neck; and the eyelids were very prominent. The pulse was extremely weak.

On the third and fourth days, he improved still more in consciousness; the ecchymosis was diminishing, and he could answer questions rationally. He had, however, occasional fits of restlessness, though no convulsions; and the pulse would sink from time to time in an alarming manner. The treatment consisted in the administration of small doses of calomel.

On the fifth day, he became less conscious; the pulse sank rapidly, and did not rally; and he died in the evening, comatose.

On *post mortem* examination, the extravasation of blood was found to be limited to the face and eyelids; there was no fracture of the bones of the skull or upper part of the face. Blood was effused on both surfaces of the visceral arach-

noid, but none was seen in the substance of the brain. There were several small scrofulous tubercles in the substance of the left cerebral hemisphere, two of which had become softened.

London, October 1855.

Taunton and Somerset Hospital.

CASE OF COMPOUND FRACTURE OF THE UPPER PART OF THE FEMUR: AMPUTATION AT THE HIP JOINT: DEATH ABOUT EIGHT HOURS AFTER THE OPERATION.

By HENRY ALFORD, Esq., Senior Surgeon to the Taunton and Somerset Hospital.

CASE. Robert Rugg, aged 20 years, May 19th, 1831, was admitted into the Taunton and Somerset Hospital under the following circumstances.

While driving a small wagon with one horse through the streets of Taunton, the horse ran away, and, in endeavouring to stop it, his left thigh was crushed between the nut of the wheel and a lamp post; the violence was so great that the post was loosened in the ground, and the framework on the top shaken off. He was immediately taken to the hospital. On examining the thigh there was found to be a comminuted and compound fracture of the upper third of the femur, with very considerable injury of the soft parts; the wound was on the inner edge of the anterior part of the thigh, about three or four inches from the groin; there had been a good deal of venous hæmorrhage; the wound, which was small, was enlarged sufficiently to allow a full examination of the injured parts, the muscles were very much lacerated and bruised, and in some parts almost reduced to a pulpy state, so as to allow of the finger being freely passed through the thigh, and moved about in all directions; the femur was fractured about three inches below the trochanters, and there were two loose fragments between the upper and lower portions; the integument, although not much injured itself, was extensively separated from the subjacent tissues, and a quantity of blood and air was infiltrated in the subcutaneous cellular tissue, as high as an inch or two above Poupart's ligament, causing swelling and a soft crepitous feeling to the touch; the hæmorrhage appeared to proceed from the saphena and some of the profunda veins.

When brought into the hospital he was in a state of collapse; the pulse feeble and rapid; countenance very pallid, shrunk, and anxious, with some restlessness; brandy was given him, and the venous hæmorrhage restrained by a compress and pressure.

On a consultation being held, it was determined to amputate at once at the hip joint, as the only probable means of saving the man's life; it was feared that he would not rally, and it was hoped that the stimulus of the operation, and the removal of the shattered limb, if it could be done without much hæmorrhage, might give him a better chance of recovery. From the state of the soft parts, amputation below the joint was impossible.

The femoral artery was first ligatured a little below Poupart's ligament; from the infiltration and swelling of the cellular tissue it would have been difficult to have effectually compressed it.

The operation was then performed after Larrey's method; a long catlin was thrust through the thigh, just internally to the lesser trochanter, and then cut out, making an internal flap about three inches long; the extensive injury to the soft parts on this side of the thigh prevented its being made longer; the rest of the soft parts were then cut through on the inner side of the joint, the capsular ligament divided, the head of the femur dislocated, and the knife being carried behind the head of the bone, and cut outwards, an external flap was made longer than the inner one; there was very little hæmorrhage; several ligatures were applied; the wound was kept open for a short time to

prevent the possibility of secondary hæmorrhage; the edges of the flaps were then brought together by sutures, and the stump dressed in the ordinary way. When the patient was put back in his bed, he did not appear more depressed than before the operation; he had taken brandy freely while it was going on; sixty minims of laudanum were given him immediately after, and two doses more of thirty minims each were given in the course of the afternoon; brandy and ammonia were also given to him at intervals, and he was allowed to drink freely of ale, as he complained of thirst, and asked for it. Restlessness and jactitation came on soon after he was in bed, and he gradually sank, and died at half-past nine, p.m., about ten hours after the accident, and eight after the amputation.

Thirteen hours after death the abdomen was examined. All the viscera were perfectly healthy and uninjured; the bones of the pelvis were also free from injury; a considerable quantity of extravasated blood was found between the peritoneum and muscles at the lower part of the abdomen, particularly at the left side; the injury of the soft parts at the upper portion of the thigh was very great, and some part of the inner flap was composed of torn muscular fibre; the femoral artery and vein were uninjured; but some of the profunda veins were torn through, and from them must have proceeded a great part of the hæmorrhage.

REMARKS. I am aware that the management of this case admits of criticism, and that the propriety of amputation at all, or, if that be admitted, of immediate amputation, during the state of collapse may be called in question. I am inclined to question the propriety of it myself, and I doubt whether, if such a case were to occur to me now, I should follow exactly the same mode of treatment; I was very young in practice at the time, and it is notorious that young medical practitioners, in every branch of the profession, underestimate *vis medicatrix nature*, and overrate the resources and effects of the remedial means afforded by their art. As age and experience advance, a gradual change of opinion takes place; we see more and more of the power and resources of nature, and more frequent instances of the failure of the best concerted remedial measures; we become more distrustful of our treatment, and tend more and more to the expectant plan of managing disease, until there is no small danger of our falling into the opposite error, and becoming altogether sceptics in the therapeutical part of our profession. I have often thought it probable that the fact of the practical part of medical education being almost exclusively conducted at public hospitals, has a tendency to produce the former error, which, by a natural principle of reaction, afterwards begets the latter. In hospital practice, little is left to nature, and from the very fact of hospitals being considered medical schools, every case is looked upon as a subject for therapeutic or operative treatment, and the pupil is taught to consider medical or surgical interference by active treatment as the great end and essence of the healing art, while his mind is hardly directed to observe the resources of nature in remedying all the lesions of the body. This however is a digression, and I will, in conclusion, mention the circumstances which, to the best of my recollection, influenced me in determining to operate in this case. A consultation was held on the case, and I had the unanimous sanction of my colleagues, which was alone sufficient to justify my practice. I had a full conviction in my own mind that the patient would not rally from his state of collapse if left alone, and that the amputation gave him the only chance of life. It has been held by many eminent surgeons, that the stimulus of the knife itself, under such circumstances, may be the means of arousing the almost extinct nervous energy. But that which had the most influence in determining my practice was the case of Mr. Huskinson, which had occurred about a year before, and which had been the subject of comments and animadversion in the *Lancet* of that year. The injury in his case was somewhat of the same character as in my patient, but more severe, though lower down in the limb; in his case amputation was not performed; a favourable reaction was waited for, which did not occur, and he

sank without rallying; the attending surgeons were blamed by some for not operating at once; they no doubt acted according to the best of their judgment, and probably acted right; but this case, with the comments on it, was fresh in my memory, and had no slight influence on my practice. We are all too apt to judge of a case by the result; and probably blame in both these cases may be undeserved. A surgeon can but form an opinion, according to the best of his judgment, from the facts before him, and act accordingly, and he ought not to be held responsible for the result.

Taunton, October, 1855.

St. Marylebone Infirmary.

CASE OF STRANGULATED FEMORAL HERNIA.

By HENRY THOMPSON, Esq., F.R.C.S., Honorary Surgeon to the Marylebone Infirmary.

Among the numerous elderly inmates of the adjoining workhouse, herniæ of the intestine is an extremely common affection; and besides the simple cases of strangulation which are frequently occurring, it is not uncommon to meet with those which are somewhat exceptional in their character.

I have recently had under my care a case, the particulars of which will, I think, prove interesting.

CASE. M. H., a woman, aged 73 years, was admitted into the Marylebone Infirmary October 8th, 1855, at 6 p.m. She had been suffering considerable pain for nearly three days from an unreduced femoral hernia, of old standing, on the left side. Vomiting had existed for thirty-six hours. There were present, tenderness and some swelling of the abdomen, and the powers of life were greatly depressed. Pulse 100, feeble. The patient's appearance was that of extreme distress, and she appeared old even for her advanced years. There was in addition a femoral hernia of the right side, but this was reducible. The taxis had been fully employed, and it was sufficiently obvious that operative measures only afforded any chance of relief, remote indeed as this appeared to be under the circumstances of the case. Accordingly, she was at once placed upon the table, a small dose of chloroform was administered, and I proceeded to operate without delay. An incision was made over the tumour in the usual way, and the integuments divided. It appeared desirable to open the sac, the contents of which proved to be in part omentum, and partly bowel. The intestine exposed was of a red colour, but not of that deep hue which is sometimes seen. The constricting membrane (Gimbernat's ligament) was exceedingly tight, and it was not without some difficulty that the requisite division was accomplished. This done, the contents of the sac were returned, the borders of the wound brought together by suture, a bandage applied, and the patient placed in bed. She was so much depressed after the operation, as to render the administration of brandy and water in small quantity desirable. She expressed herself then as free from pain, and greatly relieved.

October 9th. She has been restless during the night, and pain in the abdomen has been complained of this morning. Tongue dry; pulse 112. To have small doses of opium; beef tea for diet; hot fomentations to abdomen.

October 10th. Much the same. Pain and tenderness not localised at all, nor considerable, but generally diffused over abdomen. Wound looks well, uniting. Hernia of right side has descended, but is easily reducible.

October 11th. Symptoms as yesterday. No action of bowels. Takes milk freely, as she prefers it to beef tea. To omit the opium.

Her condition continued in all respects much the same for the next day or two, but vomiting occurred occasionally, and became more troublesome on the 13th; and she gradually became weaker, and died on the morning of the 14th instant.