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.

AUTOPSY, twenty-six hours after death. Abdomen considerably distended; the small intestines and greater part of the colon filled with flatus. A small part of the ilium, congested, but which has evidently been in process of recovery, is observed lying free near to the situation of the internal left femoral ring, and is obviously the portion which was released at the operation. On opening it, there is no lesion of the mucous membrane. The transverse colon has a very peculiar position and appearance; it is greatly distended, and lies obliquely across the abdomen; the part which should occupy the right hypochondrium being dragged down into the right iliac fossa; and it is bound down there by very firm fibrous bands to the mouth of the sac of the right femoral hernia. It is apparently constricted by these bands, and by a portion of omentum, which forms part of the contents of that hernia; and there is much congestion of the coats of the bowel about this spot. Above the point of obstruction described, there is some accumulation of semi-fluid faecal matter, intermixed with many scybala. The remaining part of the intestines contain flatus only. This is evidently the part at which, after the release of the left hernia, the fatal obstruction existed.

REMARKS. Respecting this case, it may be observed, that the indication presented, when it became evident that permanent relief had not followed the operation, was undoubtedly to search for the existing cause of obstruction. The contents of the left hernial sac had been satisfactorily returned, and no signs were present to lead me to connect with this spot the source of difficulty, nor to explore in that direction by opening up the wound afresh. The right hernia also was easily reducible. The condition of the patient was low, and her age considerable; and already as much had been done as her powers might be expected to sustain. Weighing all these circumstances, I decided, that to administer opium, and to support life, without hazarding interference either by purgatives, enemata, or renewed operation, would be the safest course to adopt; and the result justified this course of action. The event proved that no surgical interference with either hernia could have availed to remove the obstruction. The pathological conditions may be regarded as the following:—First, constriction of the ilium at left femoral ring, to which relief was afforded; and subsequently, or perhaps at about the same time, the occurrence of constriction in the transverse colon, by means of the old fibrous bands and omental adhesions, which had evidently long confined it in the abnormal position described; and which constriction, it is probable, may have been occasioned by some means connected with the disturbed condition of the other intestines, altered as they were by extreme inflation and constant movement during the period of hernial obstruction.

London, October 1855.

ORIGINAL COMMUNICATIONS.

SOME OBSERVATIONS ON OSTEIOD CANCER.

By RICHARD QUAIN, Esq., F.R.S.

THE manner of considering any morbid growth or tumour depends, in a good measure, upon the point of view from which it is observed; and there is no diseased formation in reference to which the proposition is more true than that which forms the subject of this communication.* Osteoid cancer is a rare disease. It is only in late years, and starting from the observations of Müller, that its nature has been somewhat completely made out, and its pathological importance recognised. The effect of the disease of the system; the structure of the tumour; the mode of its growth; the manner of its propagation to other parts; its

relation to other commoner forms of cancer—these are all matters of deep interest. To the pathologist, as such, they are full of material for attractive inquiry. The surgeon, too, has to investigate more or less the same points in the history of the disease; but all the results of the investigations are, in his mind, brought to bear, as far as it can be done, upon the single question respecting the propriety of removing the tumour by a surgical operation. I say a surgical operation, for the disease being malignant, in the present state of our knowledge, unhappily, the expectation of removal by other means may not be entertained. The subject which I have to discuss is the surgical question alluded to in reference to certain forms of osteoid cancer. I shall adduce two examples of the disease, and shall then endeavour to interpret the facts of those cases in so far as they bear on the question of operation—the point to which I desire all the facts and the inferences from them to converge.

CASE I. William Allen, aged 17 years, was admitted into the hospital 12th March, 1850. A slender active boy; does not remember to have ever had any illness except that which he now suffers from. There is no evidence of serious disease in any of his family. Has been employed as an errand boy, and has been in the habit of walking twelve or fourteen miles a-day.

Three months and a fortnight before his admission to the hospital, he "first felt a great pain strike into his left knee." The part kept growing larger, and after a long day's walking he used to go to bed exhausted. The swelling began at the inner side. About two months ago he took to his bed, and underwent treatment, including leeches and blisters, to subdue local inflammation.

Upon admission, he was found with pale countenance and lips; tongue furred; skin cool and moist. He appeared emaciated, and is said to have lost flesh lately. The left knee is kept semiflexed. There is considerable enlargement of the lower part of the thigh, with a bulging above both the condyles of the femur. The outline of the patella is not distinguishable, except by the touch. The swelling is greatest at the back part and sides of the limb. It is firm to the feel, with, however, a little elasticity over the condyles, while some fluctuation is distinguished around the patella. Measurement of the limbs gives the following results. The diseased limb exceeds the sound one over the patella by three inches, and at a hand's breadth above the patella, by five inches. The glands of the groin are swollen, and very tender. There is a raw surface at each side of the knee, the effect of blisters. A large artery is felt pulsating at the inner side of the popliteal space. There is constant pain about the joint, with, at short intervals, intense shooting pains. From the patient's extreme suffering, and his rapidly declining health, the immediate amputation of the limb was necessary. The enlargement of the glands I looked on as inflammatory, the result of the cutaneous inflammation excited by the blisters. They were smooth, and acutely sensitive to the touch. Glands affected by the specific disease are commonly somewhat rugged as well as hard, and less tender. Moreover, the disease of the bone would involve rather the deep than the superficial glands. My expectation was that the swelling of the glands would subside after the operation.

The tumour, which was fully double the size of a closed hand, and is identified with the femur at its back part, was, in the recent state, of greyish colour, and full of large blood-vessels. Throughout it is permeated with bone. The osseous structure is most abundant near the femur; while towards the circumference of the growth it appears in the form of spicula. The morbid deposit is likewise seen in the interior of the bone.

The boy had a good though slow recovery; and when he showed himself at the hospital in July of the same year, he had gained flesh largely, and was, in fact, in vigorous health. The glands of the groin had now resumed their natural size.

Subsequently, he travelled about the country as a pedler, retaining good health and vigour for three years after the

* These observations were communicated to the North London Medical Society at its first meeting in the present session.