infantile hernia. Demmeaux has suggested that whether the sac first present in the scrotum be congenital or acquired, the press of intestine on a weak and loosely supported neck may cause a diverticulum slowly to develop. Such pouch may be in front or behind, to the inner or outer side.

If rupture of the neck of a femoral sac occurs the bowel may pass into the subperitoneal tissue. Callisen recorded in 1777 a case where, owing to rupture of the sac below the neck, the bowel had escaped and made for itself a lodgment between the pectineus and psoas muscles.

These conditions may be represented in tabular form thus:

REDUCTION IN MASS.	
True.	False.
1. Reduction into a pro-peritoneal sac; rarely an interstitial sac.	1. Rupture of the sac at the neck or elsewhere, with escape of fluid only. The hernial swelling becomes considerably smaller, but the bowel remains strangled.
2. Reduction of the whole sac, with contents, within the abdomen, outside the peritoneum, the mutual relations of sac and contents being undisturbed.	2. Reduction of part of the hernial contents. A small portion remaining in the canal, paralysed and stiff with inflammatory products, undergoes a "secondary" strangulation.
3. Rupture of the neck of the sac or its division during operation and extravasation of the hernial contents into the subperitoneal tissue.	

A CASE OF EXPLORATORY OPERATION FOR DILATATION OF THE STOMACH.

By ERNEST A. T. STEELE, M.R.C.S., L.R.C.P.,
Surgeon, St. Mary's Hospital for Sick Children, Plaistow, E.

In connection with the question of operative interference in cases of gastric dilatation which form the subject of Mr. Bennett's admirable clinical lecture, published in the *BRITISH MEDICAL JOURNAL* for February 3rd, the following case, which has lately been under my care, may be of interest.

History.—A woman, aged 38 years, consulted me on January 5th of this year, giving the following history. For five years she has suffered from attacks of vomiting, with occasional remissions. During the attacks absolutely nothing could be retained by the stomach, and the patient would be reduced to a state of complete exhaustion. At no time between the attacks of vomiting has she been able to take ordinary diet, her food being administered in the form of soups and farinaceous messes of various kinds. She has been an in-patient of two of the metropolitan hospitals, and has undergone every variety of medical treatment, prolonged rectal feeding, lavage, etc. At the last hospital the question of exploration was considered, and the patient was prepared and placed on the operation table, but at the last moment it was decided not to operate. The patient was a dark, neurotic-looking woman, with an aspect of constant suffering, considerably wasted, but not extremely so. She told me that for a fortnight she had been unable to keep anything down, and that she had been using rectal feeding. An examination of the abdomen revealed a certain amount of tenderness about 2 inches above the umbilicus and a little to the right of the middle line, the area of stomach resonance was much increased, but there was no tumour to be felt. As every kind of treatment short of an operation had already been tried, I advised this latter, and sent her home with instructions as to rest and rectal feeding until I had a bed vacant for her.

Operation.—On January 11th, however, she had become so much worse that I saw her at home in consultation with her medical attendant, Dr. Banning of Shoburyness. She was then in a state of extreme exhaustion, and retching about once an hour. The nutrient enemata were not being retained so well, and it was evident that unless something could be done for her relief without delay she would die very shortly, so on the following morning she was moved up to St. Mary's Children's Hospital, Plaistow, and admitted into one of my beds for women. The same evening (January 12th) I opened the abdomen. The stomach was much dilated, but contracted visibly after exposure: the great omentum was slightly adherent in the right iliac region, and thus formed a band which, extending from the iliac region to the pyloric end of the stomach, tended to fix that portion of the organ in an abnormal position, and might possibly have led to kinking under certain conditions of distension of the stomach. These adhesions having been separated, palpation of both anterior and posterior surfaces of the stomach revealed nothing abnormal. The pylorus was thicker than normal, so I decided to examine it from the interior. The stomach was accordingly opened about one and a-half inch from the pylorus, the orifice of which just admitted the tip of the little finger. The pyloric opening having been dilated, the remainder of the stomach surface was examined for any further abnormality, but nothing else was discovered. The stomach and parietal wounds were then closed in the usual way. The patient stood the operation remarkably well, and kept a good pulse throughout.

After-Course.—So far as the operation was concerned the case was promising, as the vomiting and retching entirely ceased, and there was no pain. On January 15th she took peptonised milk and a prepared food by the mouth, and retained it without trouble, but her condition was one of intense exhaustion. The next day slight diarrhoea occurred, which just seemed to turn the scale against her, and she died somewhat suddenly, with symptoms of cardiac failure, on the morning of January 17th.

I feel sure that if the operation could have been undertaken before the patient became so worn out by the constant

retching, the result would have been entirely favourable. I much regret that permission for a necropsy could not be obtained.

A MODIFICATION OF THE OPERATION OF INGUINAL COLOTOMY.

By R. COZENS BAILEY, M.S.LOND., F.R.C.S.,
Senior Assistant Surgeon to the Metropolitan Hospital; Demonstrator of Operative Surgery at St. Bartholomew's Hospital.

In the following case I adopted a novel method of performing inguinal colotomy, and, as the result realised my expectation, I think I am justified in publishing the case, though an isolated one:

S. A. D., aged 47, spinster, was admitted into the Metropolitan Hospital under my care on February 18th, 1897, suffering from carcinoma of the rectum. The growth was removed in the ordinary way, and she was discharged convalescent on April 7th. She was taught to pass a bougie, and instructed to do so three times a week; but in spite of this considerable trouble was caused by contraction of the scar. On May 23rd, 1898, she was readmitted with a tightish stricture, above which a mass of recurrent growth could be felt.

Description of Operation.—Before again attempting removal it was decided to perform inguinal colotomy, which was done on May 31st in the following manner: The abdomen was opened by a 2-inch incision at right angles to a line drawn from the left anterior superior iliac spine to the umbilicus, at its outer point of trisection, and a loop of sigmoid flexure drawn out. So far the operation had been conducted in the usual way. The proximal arm of the U-shaped sigmoid loop was then stitched all round to the edges of the incision in the external oblique muscle by a row of sutures which penetrated the external coats of the bowel only. A second incision a little over 1 inch in length was then made, parallel with the first and about 2 inches below it. This, which was placed just above Poupart's ligament, exposed the surface of the external oblique. The band of skin and subcutaneous tissue between the two incisions was next freed from the subjacent structures with the handle of the scalpel and the loop of intestine drawn out through the lower wound, where it was subsequently kept in position by a glass rod passed through the mesentery. The upper skin wound was closed.

After-History.—On June 8th, the bowel was opened, and the patient did uninterruptedly well. June 15th, the patient was examined under an anæsthetic with a view to removing the growth, but this was found to be so extensive that nothing was done. Owing to the irritation caused by the passage of fæces being now removed, the local condition improved so much that, after consultation, a further operation was decided upon.

Operation for Removal of Growth.—Accordingly on July 6th a clean sweep of everything was made, including the lower part of the sacrum, the coccyx, and the posterior vaginal wall. Into the details of this latter operation I need not enter, as I only wish at present to call attention to the manner of performing the colotomy.

After-History.—On August 23rd the patient was discharged convalescent, wearing an instrument, designed somewhat after the shape of a left inguinal truss, which made pressure over the colotomy wound and also over the bowel lying between the skin and the external oblique.

The photograph on p. 441, taken at the end of August, 1899 (15 months after the operation) shows well the position of the two incisions. The object of the operation as described was to allow the pad to make pressure upon a portion of the length of the wall of the viscus as well as upon the opening itself, and thus to obtain more efficient control, as in Frank's method of performing gastrostomy.

The aponeurosis of the external oblique seems to be a sufficiently resistant structure to afford efficient counter-pressure, but should this not prove to be the case, I see no reason why, in suitable cases, the gut should not be brought out below Poupart's ligament, or even over the crest of the ilium, except, perhaps, that the situation of the opening would be more inconvenient than the ordinary one. If greater control were obtained, however, a little extra inconvenience would be amply compensated. Of course in some cases the meso-sigmoid will not be long enough to allow of the procedure, but in most, if the intestine is first drawn well down and then well up, a sufficient length will be available.

If it were thought desirable to open the intestine immediately, the extra undermining of the skin would perhaps render the wound more liable to contamination than after the usual operation.

MEMORANDA:

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

FREQUENT DISLOCATION OF THE RIGHT SHOULDER.

THE following case, if not unique, is so unusual as to be worth recording. On February 24th, November 9th, 1894, March 26th, August 8th and 10th, December 2nd, 1895, April 1st, July 7th, 1896, I reduced a dislocation of the right shoulder joint in a man, aged 54. The same joint was dislocated and reduced at least four times by other surgeons. The first time the accident happened he refused to give the joint sufficient rest. The capsular ligament is very lax, and there is possibly a shallow glenoid cavity. He is a stout, well-built man, and the muscles of the shoulders are well-developed, large, and powerful. The only time I ever succeeded in effecting reduction, without anaesthesia, was on the first occasion, when he was too drunk to offer any resistance to my efforts. If he throw his hand above his head, or if he receive a slight blow on the shoulder, out goes the head of the humerus, sometimes into the axilla, at other times under the pectoral muscles. In June, 1896, I was called to reduce it, but before reaching his house his daughter met me, and said "the bone went back of itself." I supposed there was a mistake as to the nature of the injury; but in the light of what follows perhaps she was correct. On August 29th, 1896, he accidentally struck his right shoulder against a door, and the head of the humerus was thrown into the axilla. Failing to effect reduction without anaesthesia, I put him to bed, because as he had only just finished a hearty dinner I feared to administer chloroform until after the lapse of three hours, at least. After my departure he drank a good deal of whisky, and during his restless sleep he flung his arm about so much that in some manner spontaneous reduction took place. This I found, to my astonishment, when I returned to reduce it under anaesthesia, as usual.

Stillorgan Castle, co. Dublin.

P. O'CONNELL, M.D., M.Ch.

FOREIGN BODY IN THE MALE URETHRA.

THERE are many cases on record of foreign bodies inserted in the male urethra, but I think the following instance, which came under my notice a short time ago, possesses a few points of special interest:

I was called one evening to a seafaring man who had been drinking heavily, and was then under the influence of alcohol. He informed me that he had passed a lady's bonnet pin up his urethra, that it had slipped from his grasp, and that he was unable to recover it.

I found the point of a black pin just protruding from the fleshy part of the glans penis, having perforated the mucous membrane; while the head, consisting of a large glass bead,

could be felt deep in the perineum, grasped firmly by muscular contraction.

He was unable to bear any manipulation for its removal, so I decided to administer an anæsthetic. When under the influence of this the point of the pin was seized in a pair of strong toothed forceps, and the pin drawn through the urethra until its head rested against the urethral puncture; the pin was then rotated through a segment of a circle, and I was thus enabled to push it out of the urethra head first.

The pin was an ordinary black bonnet pin, $6\frac{1}{2}$ inches in length. The patient, on recovering from the anæsthetic, immediately rejoined his vessel, and had no subsequent inconvenience.

Hackney, N.E.

HORACE WILSON, M.R.C.S., L.R.C.P.

FRACTURE OF BOTH CLAVICLES.

REFERRING to the case of simultaneous fracture of both clavicles, recorded by Mr. Battersby in the BRITISH MEDICAL JOURNAL of January 13th, I may say that I had a similar case, due to a similar accident, a few years ago, when in practice at Accrington. A shunter was caught by the shoulders between the buffers of two gently colliding waggons, and sustained simple fracture of both clavicles in the middle third. The force seemed to have been just sufficient to snap the clavicles, and nothing more. Like Mr. Battersby, I was under the impression that my case was probably unique in its method of production.

Aberdeen.

THOMAS MILNE, M.D.

WHEN IS CANCER CURED?

THE following case is interesting as showing how long after operation and apparent cure a cancer may return.

In November, 1890, I removed a scirrhus growth (the identity of which was proved by the microscope) from the axilla of a lady. She continued perfectly well until the autumn of last year, when she noticed a small lump in the neighbourhood of the old cicatrix. This I removed, together with the breast to which it was attached, last month—that is to say, nine years and two months after the first operation. This secondary growth was examined by the Clinical Research Association which, reports as follows: "This specimen shows a secondary scirrhus carcinoma in the fat of the axilla. It is not contained in lymphatic glands, but has evidently been deposited along the course of the lymphatic vessels."

Hearing, as we do, so much in the present day of a "time limit," I think this case worth reporting.

York.

W. H. JALLAND, F.R.C.S.

THE BROMIDE SLEEP.

IN connection with Dr. Neil Macleod's paper in the BRITISH MEDICAL JOURNAL of January 20th, a case which came under my notice at the Kensington Dispensary a week or two ago may be of interest.

A youth, aged 16 years, was discharged from the navy for epilepsy, returned home, and took employment as stable boy. His mother, acting upon the advice of a neighbour, purchased seven pennyworth of potassium bromide at a chemist's. I ascertained that $2\frac{3}{4}$ ozs. would be sold for this amount. The whole of this she dissolved in a pint of water, and directed her son to take a wineglassful, at stated times. The boy, however, dosed himself liberally out of a tumbler, and between Monday and Wednesday morning had taken three-quarters of the pint—that is, nearly two ounces of the salt in forty-eight hours. On the Thursday and Friday he was stated to be very drowsy, and, his parents becoming alarmed, his mother brought him to the dispensary on the Saturday. It was then three days since he had taken the last dose of the drug. He could only just manage to keep awake as he sat on his chair; he had a somewhat plethoric appearance, and that was all one noticed wrong with him until he was asked to walk, when he presented the staggering uncertain gait of a drunken man. He had no rash. His mind was clear, and his answers sufficiently accurate when he roused himself to reply to questions. His pupils were moderately dilated and reacted normally. His knee-jerks were normal. I ordered him some bitter tonic, and in three days he was practically