absorption of the plastic effusion into the canal, upon which the success of the operation so largely depends.

In the treatment of bubonocoele a difficulty may be found from the fact that sufficient of the fundus of the sac does not protrude from the external abdominal ring to permit of efficient torsion, or when the sac is very small, and reduces with the hernia, it may be quite impossible to twist it. Upon two occasions this difficulty has occurred to me, but it must be remembered that in this class of cases it is only under exceptional circumstances that the operation for radical cure is called for; a truss usually perfectly controls the rupture. It is the very large and bulky hernia that are the real test of any operation of the kind; and in these cases torsion of the sac answers admirably, and I believe that the only contra-indication to operation on account of size is that very rarely met with condition in which the abdominal cavity has become so contracted that the hernia is incapable of being replaced within it.

A modification of the above procedure is obviously necessary in the case of congenital hernia, and upon four occasions I have treated this form successfully; the sac is divided circumferentially close to the testicle, and the serous lining of the upper portion is stripped off from the inside, separated well up to the internal ring, and twisted as before.

In my first case I sutured up the lower portion to form a tunica vaginalis; but, as it was followed by acute hydrocele and suppuration, I have discontinued the practice, and now only take care that the drain communicates with it. In the first case upon which I operated there was, in addition to a very large right inguinal hernia, a bubonocoele upon the left side, and I was very much surprised to find that the twisting of the large hernia effectually cured the one upon the opposite side; this I consider to be the most conclusive proof of the far-reaching effect of torsion. Dr. Lentaigne tells me that he has had a similar experience.

When both the hernia descend into the scrotum, it is, of course, too much to expect that twisting one will prove sufficient. I have only operated upon one such case, and the first operation decreased decidedly the hernia upon the opposite side; at a subsequent period the second rupture was also twisted. I do not think that there would be any objection to performing both operations simultaneously. In a single instance the hernia was complicated with a large hydrocele upon the same side. This was radically cured by the drain being brought through the hydrocele at the same time that the hernia was twisted.

Of inguinal hernia in the female I have also but a single case to record. The operation is much simplified by the ease with which the sac can be isolated; but in other respects the steps do not differ from those detailed for the male sex.

In umbilical hernia I have as yet no experience of the operation of torsion, but I have no doubt of its easy performance and probable success.

The addition of "radical cure" to the usual operation for the relief of strangulation, besides preventing recurrence, tends largely to the success of the operation by practically shutting off the peritoneal cavity from the wound; but of course it should not be adopted where any evidence of gangrene of the intestine exists. For statistical purposes these cases must be kept absolutely distinct, as a much higher death-rate is manifestly to be expected when the case is complicated by strangulation. I have twisted the sac three times after relieving strangulation. Two of them, examples of inguinal hernia, did remarkably well, while the third, which was a case of femoral hernia in a patient suffering from kidney disease, died on the tenth day. The specimen, removed at the *post-mortem*, lost much of its characteristic appearance when taken from the body; but even still the far-reaching effect of torsion of the sac is tolerably manifest.

In conclusion, it may, I think, be fairly claimed that the effect of torsion of the sac in closing the hernial canal and tightening up the peritoneum is greater than in any other operation, and that in the relatively few cases in which it fails—so far that a light truss is necessary subsequently—no other procedure would have been more successful.

BIRMINGHAM MEDICAL INSTITUTE POST-GRADUATE LECTURES.—Three courses have been arranged for the present winter session. The first of the series, consisting of three lectures on some of the Diseases of the Skin, was delivered by Dr. R. M. Simon at the Institute during the month of November. The lectures were illustrated by plates, microscopic specimens, preparations used in treatment, and by the exhibition of living cases. The attendance was very good, and afforded evidence of the satisfactory treatment of his subject by the lecturer.

HORNED MEN IN AFRICA: FURTHER PARTICULARS OF THEIR EXISTENCE.

By SURGEON J. J. LAMPREY, Army Medical Staff, F.R.G.S.

In a paper read before the Royal Irish Academy on December 11th, 1882, by Professor Alexander Macalister, F.R.S., of Cambridge, upon the existence of "horned men in Africa," several interesting details are given of one case, which was the only one regarding which he had information. As it has been my good fortune to see and carefully examine three persons from different localities in Western Africa having the same physical peculiarities, I proceed to give particulars of them.

As far back as the year 1877, whilst serving on the Gold Coast, I had the opportunities of making drawings of these individuals, each of them showing a very remarkable development of the infra-orbital ridge of both maxillary bones, which appeared to be a congenital malformation.

The first horned man (Fig. 1) I had an opportunity of observing was a Fantee, named Cofea, aged about 32 years, from the little village of Amaquanta, in the Wassan territory. He had a prominent clearly-defined bony development of the infra-orbital ridge of both maxillary bones. The skin, which was perfectly healthy, was quite free over these knobs, and was not abnormally stretched. I failed twice to take a cast of his face, but I made the following sketch of him which is here reproduced.

The second horned man (Fig. 2) I saw was a long-faced youth, aged about 18 years, named Quassie Jabin, from the town of Bontocco, in the Gamin territory, and not a kinsman of the first one. He also, as the drawing here shows, possessed a well-marked bony exostosis or knob-like growth of the infra-orbital ridges of the maxillary bones. The state of the skin over this horn or prominence was normal and in no way attached, nor was there any impairment in the sense of smell. From a statement made by him through a Fantee interpreter, I gathered that this horn-like growth had been in existence as long as he could remember.

The third and last case of a horned man (Fig. 3) was that of Cudjo Danso, aged about 20 years, whom I sketched early in the month of December, 1877, at Cape Coast Castle. He also was a long-faced negro, having a well marked bony growth of the infra-orbital ridge of the maxillary bones. He stated, through an interpreter, that, as far as he was aware, this horn-like knob had grown of itself; it certainly had grown larger as he became older. It gave him no inconvenience;

he could see and smell perfectly. The skin over this exostosis was perfectly free, and in no way adherent to the bones of the face. He was not aware of any others possessing a similar deformity, nor had

he received a wound or blow in the face. It grew of itself, and had not been artificially produced.

I have not observed a similar fulness in others; and from inquiries which I have made, no information tends to confirm the statements that any large number, or tribe of persons similarly affected, are to be found in Western Africa, or the conjecture that any artificial means have been used to produce this deformity.

In a good many negro skulls a kind of ridging of the zygomatic process of the maxilla may be observed, but not reaching to the length

of the brim of the orbit, and involving the bones of the nose, as exists in these cases, and forming an exostosis of the infra-orbital ridges of the maxillary bones.

SUTURE OF DIVIDED ULNAR NERVE AFTER SIX MONTHS.

By SURGEON F. J. JENCKEN, M.B.,
Army Medical Staff, Limerick.

PRIVATE W. D., L.—Regiment, was admitted into hospital on July 24th, 1886, in the following condition:—

The little finger and ring finger of his right hand were cold and paralysed; both fingers were vesicated, and he stated that he had a whitlow on the little finger; but though there was pus beneath the skin, the coldness of the surface and absence of pain excluded the idea of its being an ordinary whitlow, but rather suggested suppuration, from want of vitality, such as was called "blue foot" in the surgical history of the American war, when it occurred in the lower extremity.

The history was that he had received two or three cuts on the front and ulnar side of his forearm near the wrist seven months before. The wound had severed the ulnar artery and nerve, and the scars were quite evident. The palm of the right hand, seen from the front aspect, was broadened out to a triangular shape, with the apex at the metacarpo-phalangeal line of articulation and the base at the wrist, the broadening being due to loss of tone and substance in the interossei and lumbricales muscles of the ring and little fingers (see Fig. 1). There

Fig. 1.

was complete loss of surface sensation over the front of the little finger and the ulnar half of the front of the ring finger, and the corresponding portion of the palm, so much so that he would often allow these parts to remain in contact with the flame of a lamp or gas jet until the skin was burnt, for the amusement of his comrades. When first seen by me they were black, vesicated, and cold. The skin at the top of the little finger was very thick, the nail deformed, and pus could be squeezed out of the top of the finger and from under the nail. He was quite unable to grasp with the affected hand.

On July 30th, 1886, I operated antiseptically, making an incision over the course of the ulnar nerve, at the wrist, passing through the old cicatrices. After a long and difficult dissection, owing to the matting together of the tissues, I found the divided extremities of the ulnar nerve, separated by an interval of about an inch. I refreshed them, but it was only by flexing the wrist forcibly that I was enabled to unite them, which was done by horse-hair sutures. I then closed the wound, and dressed it with carbolic oil and tenax, keeping the hand forcibly flexed over a pad. On August 2nd (four days afterwards), I opened the wound under the spray, and removed a few skin sutures, and put in two new ones. There were only a few drops of pus. No smell, no sign of inflammation, and there never was any rise of temperature. Sensation had returned to the affected fingers in great part. Dressed as before, still keeping the hand flexed over a pad of lint, as at first, the wound had quite healed in a fortnight, and sensation had