to an operation. But it will happen that a patient, ignorant of the exact state of his case, and inconvenienced by the fistula, is anxious for its removal; even here it is our duty to explain to him the probable consequences before we comply with his wishes.

PROPOSITION THE SIXTH.

"The best Treatment of Diabetes."

I have attended eight cases of this disease within the last three years, and seven of these have died apparently from tubercular disease of the lungs. I am disposed to consider that the pulmonary disease is consequent upon the diabetes, as in three of the cases that I saw in the earlier stage of the diabetic disease, there was no evidence of pulmonary derangement till after the diabetes had been from four to six months in existence. I have generally found that diabetes attacks individuals of the strumous development; and from the very constant connection of diabetes and phthisis, I think we are justified in considering diabetes as one of the various ways in which tubercle develops itself, although we have not as yet been able to detect the proximate cause of the diabetes.

The medicines from which I have found most (*although but temporary*) relief are, Dover's powder in moderate doses at bed-time, the carbonate of ammonia in ten-grain doses three times a day, and occasionally the vapour bath; I have also used quinine, acetate of lead, and alum, but with no appreciable benefit. As regards diet, it will be desirable to avoid saccharine and farinaceous articles as much as we can; but in actual practice it will be found that we can exercise but very little influence over our patients in the matter of their diet. From what I have seen of the use of cod-liver oil in strumous disease, I should be disposed to expect considerable benefit from it in diabetes, if we have an opportunity of administering it in the onset of the disease. It deserves attention, both for its medicinal and dietetic properties; it ministers powerfully to nutrition, and by its alterative properties appears to modify the whole character of the strumous habit. I have not had an opportunity of testing its merits in this disease since the remedy attracted my attention; but I shall indeed be very much deceived if it does not prove of great benefit, even should it not altogether cure the disease.

Colchester, Dec. 15, 1846.

CASE OF DISLOCATION OF THE HIP-JOINT,

COMPLICATED WITH FRACTURE OF THE FEMUR,
BUT AT FIRST TREATED SIMPLY AS THE LATTER.

By W. H. BAINBRIGGE, Esq., F.R.C.S., Surgeon to
the Northern Hospital, Liverpool,

Mrs.—, aged 38, a married lady of a highly scrofulous habit, had a scirrhus tumour of the breast, for which she underwent an operation, which left her in a state of cachexia so extreme, that she was for two years confined to her room, and totally unable to move about. She was reduced to such a state of emaciation as to appear a mere living skeleton. At the expiration of this time her health began slightly to improve, and she was able, by the aid of a crutch and stick, to take a little exercise in her room; but on one occasion, in attempting to walk round the room, the following accident happened:—

With one hand resting on the table which served as a support to the left side, and the other arm assisted by a stick, she tried to walk round the table, when suddenly losing her balance, the weight of the trunk was momentarily thrown on the left leg, round which, as on an axis, the body performed a semi-revolution, and fell with force on the floor. Medical aid was immediately summoned, and the femur, on examination, was pronounced to be fractured near its upper third. The fractured limb was found to be from one inch and a half to two inches shorter than the other. Without entering into details, it will suffice here to state, that her medical attendants, by forcible extension, brought the injured limb to match the sound one in length, and kept it in that state by means of the long straight splint.

In this position she remained full five months, suffering, as she informed me, the most excruciating pain, and without any progress being made towards the re-union of the fracture. When called in, I found her in the above deplorable state, and observing, from the great pain she endured, that she could not then bear the slightest movement of the limb, I merely removed the roller and felt for the fracture on the inner side of the thigh, when I discovered, to my surprise, that the ends of the fractured bone were fully three inches apart. It struck me that the best, indeed the only thing I could do, was to remove the extension and suffer the muscles to resume their normal condition. This being done, the patient experienced immediate relief. I was not at this time aware of any lesion beyond the fracture, though I suspected, from the space I had discovered between the ends of the bones, that there must have been also dislocation of the hip-joint. This done, I left her for the present.

A day or two after the pain had so far diminished that I was enabled to make a full examination, and turning the patient slightly on her right side, I immediately detected a dislocation of the hip-joint of the fractured limb on the dorsum ilii. I found also that a large deposit of CALLUS, about the size of the fist, had been thrown out opposite the fracture, and was attached to the upper portion of the bone at its fractured end, and now the case in all its bearings stood clearly revealed before me.

Forcible extension had been established and persevered in for five months, under the impression entertained in the first instance by her medical attendant that it was simply a case of fracture, and that the shortening of the limb arose from muscular contraction. This *forcible extension*, instead of approximating the ends of the fractured bone, only dragged them farther apart, and their distance which at first was from one inch and a half to two inches, now became doubled. The unnatural and long-continued extension of the muscular fibre had produced the intense suffering under which the patient laboured. The callus, or as the patient termed it, the excrescence, was regarded as a cancerous tumour, and the cause of the intense pain—a supposition, apparently favoured by the fact of her having had a scirrhus tumour of the mamma two years before, and her scrofulous habit of body.

The non-union of the fracture had also been ascribed to the same causes. The real nature of the accident had been wholly mistaken.

What now remained to be done? After the lapse of

five months it was out of the question to think of reducing the dislocation. To promote the union of the ends of the fractured bone became therefore the great point to be aimed at. No difficulty was experienced in accomplishing it. The removal of the long splint enabled the contraction of the muscles to bring the ends of the bone into apposition. I now applied a short splint to the inner part of the thigh, and left the limb quiescent on pillows. No splint could be placed on the outer side in consequence of the callus, which, however, soon became absorbed. This, together with the requisite treatment for the improvement of her general health, was the course pursued, and I had the satisfaction of finding the fracture reunited in about six weeks. At the end of two months the patient was quite restored with the exception of the deformity of the limb, resulting from the dislocation of the hip-joint, which had formed for itself new relations.

The details of the above case impress upon us the paramount importance of careful, patient, and deliberate examination in the first instance. One error at the commencement may not only prove mischievous and embarrassing *per se*, but lead to others equally, if not more so. Once a fixed principle is laid down, such is the blinding effect of a first-formed decision, that although results may develop themselves in the sequel, so marked and plain as to expose the original error to any unbiassed judgment, yet it is still persevered in, and leads to many more. An iron formula of procedure is established, and every new fact is screwed into adaptation with it.

Here we observe nature's extraordinary attempt to bridge the chasm which had been widened by the process of extension of the limb, stigmatized as an aberration—her friendly indications unheeded and misunderstood, and her crowning efforts baffled by the injudicious interference of art, resulting from an erroneous estimate in the first instance, of the real nature of the case. It is with a view to guard against the repetition of such errors that I have thought it my duty to give the details of the above case to the profession.

CLINICAL REPORTS OF SURGICAL CASES UNDER THE TREATMENT OF WILLIAM SANDS COX, ESQ., AT THE QUEEN'S HOS- PITAL, BIRMINGHAM.

By PETER HINCKES BIRD, one of the Resident
Medical Officers.

CASE XVI.

OBLIQUE INGUINAL HERNIA.

Henry Wagstaff, aged 41, a nailor, admitted into the Queen's Hospital, on July 11th at four o'clock p.m. He states that about 12 a.m., while lifting a heavy weight of iron, he suddenly felt something give way, attended with sudden pain across the abdomen, and a tumour appeared on the left side, which protruded in a short time into the scrotum; he was very sick, and vomited the contents of the stomach; the bowels were opened before the accident happened. When admitted he was rather sick, merely ejecting the contents of the stomach without any admixture of faecal matter; [troubled at times with

eructations; he complained of great pain across the stomach. On examination there was found an oblong swelling, extending obliquely inwards and downwards above Poupart's ligament, then descending into the scrotum; the tumour was elastic, giving an impulse to the hand on coughing, rather tender to the touch; tongue slightly coated; pulse 86, feeble. The taxis was applied, and in a short time the bowel returned, affording great relief to the patient.

To have one ounce of saline mixture every four hours.

12th. Bowels open; tongue clean; feels quite comfortable.

13th. To have a truss. Discharged cured.

In this case the patient was afflicted with a recent hernia, without any symptoms of strangulation, but it is very probable that had he not come to the Hospital and had it reduced, it would have strangulated, and would have put the patient's life in considerable danger. Mr. Lawrence* correctly observes, that the danger is greatest when a rupture is strangulated at the moment of its formation. According to Mr. Guthrie† a hernia of recent formation cannot remain in a state of incarceration, ending in strangulation, for a longer period than ten hours, without placing the patient's life in great jeopardy.

Spontaneous herniæ, and those which arise from predisposing weakness, seldom become strangulated, for as the parts concerned are weak and relaxed, the stricture in such cases is never close, nor are the symptoms violent.

The opening through which the parts protrude is narrower in some situations than in others, more so in recent than in old herniæ; the progress of the case will therefore be more rapid, and the danger of the patient more urgent. Thus femoral, inguinal, and umbilical ruptures are more dangerous than the ventral, perineal, or vaginal kinds.

The disorders for which inguinal hernia may be mistaken are, hydrocele, bubo, varicocele, and orchitis. Inguinal hernia may in general be easily distinguished from hydrocele of the tunica vaginalis. The tumour of hydrocele is more pyriform, it increases from below upwards; it is usually translucent and fluctuating, but never tympanitic. It is rare for sufficient serum to be effused into the hernial sac to impart the sense of fluctuation, and still rarer for it to allow of any translucency, while it is sometimes tympanitic. Hydrocele does not vary in size from pressure and position, which hernia frequently does; the gradual formation of the swelling, its not giving an impulse on coughing, together with the absolute impossibility of feeling the testicle at the bottom of the scrotum also prove the disease to be hydrocele. With regard to translucency, as a sign of hydrocele, Mr. Teale‡ cautions his readers against laying too much stress upon it, and cites two cases in point in which a hernia was mistaken for a hydrocele. Hydrocele of the spermatic cord may be more easily confounded with hernia, and cases are sometimes brought to the hospital with trusses applied. When the tumour is situated below the ring we are enabled to grasp the cord as in its normal state, and its want of

* On Ruptures, Ed. 4th, p. 75.

† On Inguinal and Femoral Hernia, p. 24.

‡ A Practical Treatise on Abdominal Hernia.