saline mixture, with magnesia. She passed a tolerably good night, and the next morning the pulse was 90, and stronger, but there had been no evacuation from the bowels. The vomiting returned during the day, and continued at intervals until the 5th. The abdomen was tympanitic, and there was no relief from the bowels during this period; but on the 5th she had two free evacuations per anum, and a slight faecal discharge from the wound. The vomiting then ceased, and the swelling of the abdomen subsided. On the 6th an artificial anus was fully formed, and the whole of the faeces were discharged through it.

13. The slough of intestine came away this morning; she had a copious stool per anum in the afternoon.

17. Complaints of pain in the abdomen, which is distended, the bowels not having acted sufficiently. A dose of castor oil was given.

18. Has had a copious discharge of faeces per anum, followed by complete relief. The discharge of faeces from the groin has nearly ceased.

21. No discharge of faeces from the groin.

From this time the whole of the motions were passed per anum, but the wound was not sufficiently healed to enable her to bear the pressure of a truss until April 24, when she was discharged cured.

These cases appear to me of peculiar interest in relation to two important points of practice. The first is, the treatment of the intestine, when it is found in a gangrenous state. It appears from both the cases that a portion of intestine, in such a condition, may with safety be returned into the cavity of the abdomen, provided that the wound is left open for the escape of the contents of the bowels, when the dead portion is cast off. It has been remarked by Mr. Key, with reference to hernia that has been injured by a blow, that there is not much danger in reducing the intestine, as it seems disinclined to shift its position from the opening of the sac, its peristaltic movements, probably, either ceasing altogether, or being so enfeebled as to leave it in a helpless and passive condition where the taxis has placed it. The remark applies equally to a portion of intestine, the vitality of which is much impaired by severe or long-continued strangulation. The slough is insulated by the adhesion of the peritoneal surfaces around it, and thus effusion into the abdominal cavity is prevented.

I do not think, however, that this mode of treating a mortified portion of intestine is to be recommended. It should only be practised when the actual death of the part is not quite certain, and where there appears some reason to hope that it is not past recovery. When the intestine is clearly mortified, a free incision should be made into it, in order that the intestines above the strictured part may be evacuated without delay. The patient generally (even in those cases which terminate fatally) experiences immediate relief, the tension of the abdomen being removed, and the stomach becoming settled. Whereas, in those cases in which a portion of intestine in a state approaching to gangrene is returned, although the stricture is removed, it is incapable of performing its functions; several days may elapse before evacuations can be perceived, and in the meantime the patient may sink.

The second point to which I have referred is the

division of the stricture without opening the sac. There can be no doubt that, in the first of the cases I have related, a small portion of intestine had been included in the sac, and that it had been reduced after the division of the stricture, before the sac was opened. If I had been aware that I had returned the intestine, I should not have proceeded to open the sac, and in that case the patient must have died, because, when the slough was cast off, there would have been no exit for the contents of the bowels, which must, therefore, have passed into the cavity of the abdomen. I do not mean to infer, from the result of this case, that a strangulated portion of intestine can *never* be safely returned without the sac having been opened, but I am convinced by this, along with many others, that the cases in which it can be safely done are few.

CASE

OF

ANEURYSM OF THE THORACIC AORTA.

TO THE EDITORS OF THE PROVINCIAL MEDICAL JOURNAL.

GENTLEMEN,—If you think the following case of aneurysm of the thoracic aorta sufficiently interesting, I shall be glad to place it on record in your Journal.

I am, Gentlemen,

Your obedient servant,

FERGUSON BRANSON, M.D.,

Physician to the Sheffield General Infirmary.
Sheffield, June 10, 1843.

March 27, 1843. John Crips, aged thirty-five, a portmanteau-maker, and of intemperate habits, stated that ten years ago he had an attack of acute rheumatism, from which he recovered perfectly; three years ago complained of soreness at the epigastrium, with palpitation, and, as he expressed it, "felt as if something was tied tightly round his body;" nine months ago remarked a pulsation below the inferior angle of the left scapula, but is quite certain no tumor then existed. Three weeks ago, the beginning of March in the present year, he first perceived a small tumor at the point where he had previously felt the pulsation. The tumor increased rapidly, and, on the 27th of March, was the size of the largest orange, and pulsated strongly. A distinct aneurysmal murmur was heard over the swelling; heart's impulse increased; sounds normal; pulse 96, corresponding in both radials, and in character slightly thrilling; countenance pale and anxious; he complained of great pain in the back, especially at night, and was unable to lie on the right side; bowels confined; no discoloration of the integuments covering the tumor. On the 7th of April, the tumor having become much larger, he was admitted an in-patient of the Sheffield Infirmary. At this time the tumor measured twelve inches from the upper to the lower margin, and twelve inches from side to side. On the 13th a loud rasping sound, accompanying both beats of the heart, was heard extensively over the whole of the cardiac region, but most distinctly over the commencement and along the course of the aorta, below the left clavicle; it was heard also in the left supra-scapular space. The aneurysmal murmur could no longer be distinguished

over the tumor generally, though still very faintly heard over the superior margin of the swelling. Pulse 120; redness of the integuments over the most prominent part of the tumor. On the 15th of April the rasping sound was not heard in the cardiac region, nor below the left clavicle, though it was still faintly perceptible in the supra-scapular space; pulse 100. This disappearance and recurrence of the rasping sound was observed several times, and the intensity of the sound seemed to bear a direct relation to the rapidity of the circulation. The aneurysmal murmur was never again heard over any part of the swelling. The heart was displaced, the base being pushed downwards, and towards the right side. From this time to his death, which occurred on the 30th of May, he gradually became worse. The tumor appeared as an immense livid hump, extending from the eighth rib on the left side posteriorly, as far as the left lumbar region. The pulsations in the tumor were frightful, and shook his whole frame. He complained of constant severe pain in the left lumbar region, and was much exhausted by profuse perspirations, which harassed him day and night. Till within a week of his death the breathing was but little impeded, and the absence of cough very remarkable. The symptoms which immediately preceded dissolution nearly resembled those so graphically described by Mr. John Bell, as occurring in persons who die of aneurysm of the thoracic aorta without hæmorrhage. "Frequently," says that writer, "before the awful and fatal hæmorrhage has had time to occur, the patient perishes of sufferings too great for nature to bear. The aneurysmal tumor so fills the chest, so oppresses the lungs, compresses the trachea, and curbs the course of the descending blood, that the system, with a poor circulation of ill-oxydated blood, is quite exhausted. And thus, though the patient is saved from the most terrible scene of all, he suffers great miseries; he experiences in his chest severe pains, which he compares with the stabbing of knives; terrible palpitations; an awful sense of sinking within him; a sound within his breast, as if of the rushing of waters; a continual sense of his condition; sudden startings during the night, fearful dreams, and dangers of suffocation, until, with sleepless nights, miserable thoughts by day, and the gradual decline of an ill-supported system, he grows weak, dropsical, and expires." The treatment was, of course, only palliative, and consisted in gradually increased doses of tincture of digitalis and morphia.

Examination of the Body Thirty-six Hours after Death.

Decomposition had commenced about the neck and face. Anteriorly the chest was well formed, whilst posteriorly nearly the whole of the left side of the chest was occupied by a large projecting tumor, which extended as far as the left lumbar region, and measured thirteen inches from above downwards, and seventeen from side to side. The most prominent part of the swelling was inflamed and livid, and the skin in some places abraded. On removing the anterior walls of the chest, a considerable quantity (several pints) of bloody serum escaped from the left pleural cavity. The right lung was healthy, the left remarkably small and wasted. The heart was displaced; a line drawn from the base to the apex would have

crossed the sternum diagonally, the base of the heart being pushed considerably towards the right side. The pericardium contained two or three ounces of pale serum. The size and muscular structure of the heart was natural, and the surface of the right ventricle was marked by several white patches of lymph. The mitral, tricuspid, and aortic valves, were rather more opaque than natural; the pulmonary artery was healthy. On removing the left lung and the abdominal viscera, with the exception of the kidneys, the tumor was found to occupy nearly the whole of the left side of the chest; the diaphragm on the left side was pushed downwards, and the left kidney pushed forwards and inwards by the tumor. On slitting up the aorta, the vessel was seen to communicate with the tumor a little below the arch. The communicating opening was about an inch in diameter, in shape irregular, with a thickened margin, and situated on the posterior side of the artery. There was no dilatation of the artery opposite the opening. The coats of the artery were unruptured at this point, and could be traced for a short distance into the cavity. From the margin of the aneurysmal opening, superiorly and externally, the coats of the artery extended into the tumor to a distance of about three inches; but internally and inferiorly, from the same margin, they could be traced only to the distance of an inch. The aorta throughout its whole length was very much thickened; there was an extensive atheromatous deposit beneath its internal coat, and one round plate of bone, nearly half an inch in diameter, was found very close to the aneurysmal opening. This was the only ossific deposit in the course of the aorta. On removing the whole of the tumor, with the vertebræ and ribs, to which it was firmly attached, it measured twenty-eight inches in circumference longitudinally, and twenty-five inches transversely; it was, however, somewhat irregular in shape, as if fresh pouches had been successively formed. On opening the tumor, it was found to consist of two large chambers; the posterior chamber was globular, and formed the principal part of the external swelling; the narrow opening into this chamber was formed by a constriction of the walls of the tumor at the point where the aneurysm had forced its way through the ribs. The other chamber was irregular in shape, and consisted of several pouches; from the lower part of this chamber a long, narrow, burrowing sinus, extended by the side of the vertebræ as far as the third lumbar vertebra. The posterior globular chamber was completely filled with masses of coagula, not arranged concentrically, but traversed in all directions by semi-organised membranous layers; portions of these membranous layers presented a reticulated appearance. Fibrinous concretions, and what seemed false membrane, adhered to the inner surface of the tumor, which was generally extremely rugged and uneven. Not the smallest trace of the coats of the artery could be distinguished in this division of the tumor. The anterior chamber into which the artery opened was filled with half-coagulated dark blood, and one small patch of ulceration was remarked. The walls of the tumor adhered firmly to the sides of the vertebræ, the principal portion of the bodies of the vertebræ being within the tumor, and thus forming part of its walls. The bodies of the seventh, eighth, ninth, tenth, eleventh, and twelfth

dorsal vertebræ, were within the tumor, denuded, carious, and deeply excavated, the intervertebral substance remaining nearly entire. The tenth dorsal vertebra was more deeply excavated than the rest. The seventh, eighth, and ninth dorsal vertebræ, were in some degree protected by a mass of fibrine lying upon their anterior surfaces, and which materially strengthened the walls of the tumor at this point. The ninth, tenth, eleventh, and twelfth ribs, were also more or less absorbed. The ninth rib was denuded and carious, and from it a plate of bone was detached, and pushed upwards. The tenth rib had nearly disappeared, two small portions only remaining, one attached to the cartilage, the other to the vertebra. The eleventh rib was only less injured than the tenth, the remaining portions being considerably displaced, and pushed downwards. The twelfth rib was completely divided near the vertebra, but not otherwise extensively diseased. The walls of the tumor were at every point entire. The remaining viscera presented little remarkable.

STATISTICAL REPORT
OF
190 CASES OF INSANITY
ADMITTED INTO
THE RETREAT, NEAR LEEDS,
During Ten Years, from 1830 to 1840.
By **SAMUEL HARE, Esq.**
(Concluded from p. 236.)

C.—Influence of the Duration of the Disease.—Judging from the result of the cases, as exhibited in Table XVIII, and without modifying circumstances being considered, it would seem that the previous

duration of insanity had less influence on the proportionate number of recoveries than is usually believed, because these did not, in the more recent cases, very remarkably exceed those which took place in the cases of a more chronic kind. Nevertheless, I am fully convinced that the former are far more under the influence of treatment than the latter, and that the time required for their cure is also considerably less. The reason why the proportionate number of cures in the more recent cases does not appear greater is simply that, some of the patients being much relieved, were removed by their friends before they could be considered completely well, and that they were, therefore, put down in the report merely as relieved. That friends should be more anxious to remove patients from an establishment when the case is recent, is easily comprehended, because, as in these cases, the patients frequently becoming quite manageable in a short time, their friends often desire that the remainder of the recovery should take place at home.* Of the more chronic cases, those whose insanity had existed more than twelve months, the recoveries, considering this circumstance, were very numerous, amounting to no less than 39 out of 90. This circumstance I attribute to the great pains taken to improve the general health, and the close attention paid to the state of the digestive organs; for I have often had the evidence before me, and have been more and more confirmed in the opinion by each succeeding case, that the first step to be attained in the cure of mental disorder is to put the chylopoietic viscera into as sound and healthy a condition as possible, and that the alleviation of the mental disease may usually be dated from the period when this desirable object is accomplished.

TABLE XVIII.
Exhibiting the Influence of the Duration of the Disease upon the Recoveries, &c.

Duration of the Attack.	Discharged.															Remain- ing, June 30, 1840.	Grand Total.							
	Recovered.						Relieved.	Not Relieved.	Died.	Total.														
	Recovery complete.			Recovery not confirmed.																				
	M.	F.	T.	M.	F.	T.					M.	F.	T.	M.	F.					T.	M.	F.	T.	
First attack of three months' duration, or less	9	5	14		1	1	6	5	11		2	2	2	1	3	17	14	31	1		1	18	14	32
Do. of from three to twelve months' dura- tion	7	7	14				7	1	8	5	3	8	3	1	4	22	12	34	1		1	23	12	35
Second attack of not more than twelve months' duration	4	1	5				2	2				1		1	5	3	8		1	1	2	6	4	10
Attacks of more than twelve month's dura- tion	20	19	39	1	7	8	9	11	20	9	4	13	7	3	10	46	44	90	8	6	14	54	50	104
Attack and duration not stated	2		2				1	2	3	1		1	2	1	3	6	3	9				6	3	9
Total	12	32	74	1	8	9	23	21	44	15	9	24	15	6	21	96	76	172	11	7	18	107	83	190

* It may also be remarked, that some of the cases which were reported by the patients' friends as of only three months' duration, were, probably, of considerably longer standing, the insidious approach of the disease being often, in its early stages, altogether overlooked.