to obviate the necessity of a second opening. The tendency to heal is so great, that it is advisable, for the first thirty-six hours which follow the operation, to introduce into the wound a small, twisted string of lint, so as to prevent immediate union of its lips. As an example of the rapid closing of these abscesses, I may mention the case of the patient lying in the eighth bed of the second ward, in whom a week had sufficed to heal up an abscess of this nature, seated in the phrenic region.

In the prostatic portion abscess has a great tendency to ulcerate the urethra. Cases are not rare in which such collections of matter have been opened in the urethra by the mere passage of a catheter. This is not an unfavorable termination, the condensed prostatic structures effectually preventing dispersion of urine in the cellular tissue.

3. Retention of urine frequently accompanies acute gonorrhœa. This complication may be the result of inflammatory swelling of the urethra, or of spasmodic contraction of the membranous region.

It is evident that, as long as the introduction of a catheter can be dispensed with, although the passage of urine may not be altogether free, it will be right to avoid this fresh cause of phlogosis; but when the retention is complete, when the bladder is distended, there is no other course left, and middle-sized instruments should then be employed, and with the utmost caution. It must be remembered that inflammation has now rendered the membrane more liable to be torn, and, therefore, the operation must require great prudence. It is obvious, for this reason, that small-sized catheters must be rejected, as well as the large ones, praised by Mayor on the following startling principle:—"The narrower the stricture, the larger should be the instrument!"

If catheterism has been necessary, and the instrument be firmly retained by the swollen urethra, as a second operation of the kind may be unsuccessful, or, at least, attended with much difficulty and irritation, the catheter should be allowed to remain in the bladder; under contrary circumstances, it should be withdrawn.

4. Hæmorrhage, when arising from exhalation, is generally trifling in abundance, and requires no special attention; but, if caused by a rupture of the urethra, or laceration, it may be desirable to arrest it. For this purpose injections of cold water, or compression behind the seat of the hæmorrhage, will frequently suffice. Should they fail, a catheter may be introduced, and a circular bandage applied round the penis will stop the bleeding. Great prudence in the application of this kind of compression, and close attention to the patient, are necessary, as it may, and has been seen to, produce gangrene.

5. Incontinence, as well as retention of urine, may occur from irritation of the neck of the bladder, and the best means of subduing this troublesome complication will be free cauterisation of the prostatic region with lunar caustic.

TWO CASES

OF

STRANGULATED HERNIA, FOLLOWED BY ARTIFICIAL ANUS.

By WILLIAM HEY, Jun., Esq.,
Surgeon to the Leeds General Infirmary.

CASE I.—Anne Wood, aged 66 years, was admitted into the Leeds General Infirmary on the 11th of August, 1841, at three, p.m., on account of a large femoral hernia of the right side, which had been strangulated forty hours. Having tried the usual means of reduction without success, I proceeded to the operation at half-past seven, p.m. In compliance with the suggestion of my colleague, Mr. Teale, who assisted me, I divided the stricture without opening the sac, and then again attempted to reduce the hernia, but did not succeed in doing so, nor was I sensible of any diminution in the bulk of the tumor. I, therefore, of course opened the sac, in which I found a considerable mass of omentum, but *no intestine*. I concluded that the symptoms had been produced by the strangulation of the omentum. A considerable portion of it, which appeared to have been long protruded, and was indurated, was removed, and the wound closed. On the day but one following, in consequence of some appearance of inflammation, the dressings were removed, and, as the wound showed no disposition to unite, the stitches were cut out, and a poultice applied. The wound continued to present a sloughy appearance until the sixth day, when a copious discharge of thin feculent matter took place from it. For some days the whole of the fæces were discharged through the artificial anus, and afterwards partly through it and partly through the natural passage, until September 3, when the artificial anus was closed (seventeen days after its formation).

Sept. 24. The wound was healed, and the cicatrix sufficiently firm to bear the pressure of a truss, when the patient was discharged cured.

CASE II.—Elizabeth Smith, aged 61 years, was admitted on the afternoon of Wednesday, the 1st of March, 1843, with a small femoral hernia of the right side, which had been strangulated since eight o'clock in the morning of the previous Monday. She stated that she had had hernia for twenty-five years, but had never wore a truss, and had always been able to reduce it until the Monday morning. At the time of admission the extremities were cold, pulse very feeble, pain in the abdomen severe, vomiting frequent, and slightly stercoraceous. The tumor was very tender, and the integuments covering it somewhat firm and adherent, from effusion into the subcutaneous cellular structure. The operation was immediately decided upon, and was performed at eight, p.m., sixty hours after the strangulation took place. The sac contained a small knuckle of intestine of a dark color, and approaching to a state of gangrene. I hesitated as to the propriety of returning it into the abdomen, but, as I did not feel certain that it was past recovery, I decided upon doing so, leaving it as near as possible to the opening from which it had protruded, and leaving the wound open, in order to avoid the danger of extravasation into the cavity of the abdomen, in the event of its sloughing. After the operation an opiate was administered, followed by an effervescent

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