authors above quoted, and to hear explanations of apparent inconsistencies in the writings of Dr. Yellowly, Mr. Martineau, and others, connected with the justly celebrated notoriety of this district, on the subject of lithotomy.

About three or four cases of calculus in the female happened in the same period, in which we have generally been successful with Weiss's dilator. I shall now relate the case of a female, in which a singular malformation existed prior to the calculus.

CASE.

CALCULUS, WITH DISEASED KIDNEYS AND MALFORMATION OF PELVIS.

March 12, 1845. S. E—, aged 29, was admitted into the Hospital under the care of the physician, for what was supposed to be gravel, accompanied with offensive discharge from the vagina; she was in a state of great debility, and appeared to be much worn with pain and protracted irritation.

15th. I was desired to sound her on suspicion of stone, which was very readily discovered by the instrument striking against what appeared to be a very large one, within a line or two of the orifice of the urethra. A small quantity of foetid urine escaped by the side of the sound, and it appeared that the magnitude of the stone caused an incontinence, which produced the offensive smell, and made her fellow-servants complain.

There seemed to be something so unnatural about the formation of the parts concerned, on my examination under the clothes, that I was induced to turn them back, when I discovered that the symphysis pubis was separated to the extent of seven inches, forming two prominent points, like additional spines of the ilia, having a ligamentous band of half an inch broad, stretched between them. An oblong pouch presented itself just above this band, in the centre of the hypogastrium, looking like a shrivelled scrofulous abscess, with a scab on its surface, where it had apparently been fretted with the clothes; but this protrusion, upon further investigation, appeared to be the result of the divergence of the recti muscles, whose tendons were inserted into the separated angles of the symphysis, and thus left the anterior part of the abdomen without any other protection than the skin, fascia, and the peritoneum, which lined the pouch.

16th. The labia pudendi were separated and spread out to a corresponding extent, the intervening space being closed by the consolidation of the nymphæ and hymen, so as to leave an opening at the upper part only large enough to pass the little finger, and the orifice of the urethra was just within it; there was no vestige of the clitoris. I ordered her mild opiates, hip baths, poppy fomentations, &c., with wine, arrow-root, and strong broths, but all in vain; the pulse sank, the stomach retained nothing, and she died at night. A consultation had been ordered for next day, which was converted into a *post-mortem* examination.

This revealed extensive disease in both kidneys, which were covered and studded with large vesicles; a small calculus was in the right kidney, and I took from the fundus of the thickened bladder a rough stone, weighing four ounces and two drachms.

We took a cast of the malformation of the symphysis pubis and soft parts above and below, from the anterior superior spines of the ilia to six inches down the thighs, showing their unusual separation, &c. I

learnt from her mother that the deformity was congenital, that she walked at two years old, went out to service at sixteen, and had been cook in her last place for five years.

I afterwards removed the pelvis, which, with the cast and drawings of both, I purpose to exhibit to the meeting.

I have made enquiries for similar examples of malformation, and searched the Hunterian Museum in vain, but Mr. McWhinnie, demonstrator at St. Bartholomew's, has informed me that he saw an example in a male pelvis, in the Museum, at Berlin, a sketch of which I enclose. There is some analogy also in the lusus to the condition of the hedgehog and the female guinea pig, towards the end of pregnancy.

[The drawings and casts, together with the pelvis, were severally exhibited at the meeting.]

Winchester, Aug. 13, 1846.

TWO CASES OF INGUINAL HERNIA.

By OWEN ROBERTS, M.D., Edin., M.R.C.S.E.,
St. Asaph.

CASE I.

STRANGULATED INGUINAL HERNIA: REDUCTION.

Robert Jones, aged 40, residing three miles from St. Asaph, seaman, of athletic appearance, had laboured under an oblique inguinal hernia for many years, and had been wearing a truss for some years. The truss having failed to keep the bowel up, it became irreducible. On the 23rd of May, 1843, I was requested to visit him, when I was informed that he had been suffering under symptoms of strangulation, viz., vomiting of everything swallowed, hiccup, and constipation, for *sixty hours*, and that two other medical men had been attending him, and had failed in reducing the hernia, though they had thrown up some infusion of tobacco.

At this time, which was between three and four in the afternoon, I found the abdomen very painful; the hernial tumour, which was about the size of a man's fist, was exquisitely so, and extremely tender to the touch. Pulse about 100, wiry, and rather strong; the bowels had not been moved for several days. Twenty ounces of blood were taken from the arm, which brought on a slight faintness, but so fearful was he of my giving him pain, that he would not allow me to touch the tumour. I then gave him two grains of opium and a scruple of calomel, and returned home for my assistant, and the long tube with the enema syringe, some tobacco, and the instruments for operating, if necessary. I also took my friend Mr. Moses, surgeon, of St. Asaph, with me.

It was now late in the evening. We first threw up some turpentine injections, alternately with soap and water and aloe, through the tube into the colon, with the effect of relieving the bowel of a good deal of flatus; we then infused a drachm of tobacco in a pint of water, for ten minutes, and injected half of it up into the rectum, and the other half in about twenty minutes. Great prostration of strength followed, the patient begging us not to do anything more to him, for he was sure that he was dying. At this time we tried the taxis, and in about fifteen or twenty minutes had the satisfaction of seeing our efforts crowned with success, by the reduction of the hernia and relief to our patient.

He returned to his work in a few days, but in about a year afterwards, died from a strangulated hernia, while in the Chester river, where he was on board his ship.

The impression on our minds was, that the reduction in this case would have been quite out of the question, but for the aid of the long tube and the tobacco enemata. I should add, that "all hands" were *gently*, but *uninterruptedly* applied to the tumour, during the application of the taxis.

CASE II.

OBSCURE INGUINAL HERNIA, PROVING FATAL.

Ellen Davies, aged 51, living three miles from St. Asaph, of a weak constitution, of late suffered much from indigestion; whilst in a corn field gleaning, on the 8th of August, was suddenly seized with pains across the abdomen, and walked home, a distance of a mile and a half. About two p.m., she sent for a neighbouring practitioner, who administered some medicines.

On Sunday, the 9th, at nine p.m., I saw her. From the description of symptoms given by the messenger, I learnt that she had had some abdominal prolapse, which induced me to go fully prepared for operating in case of necessity, accompanied by my assistant. On questioning the patient, I learnt that the only prolapse which she had ever suffered from was that of the uterus, which I felt to be within an inch of the os externum. Not feeling satisfied that the symptoms could have arisen from that, I carefully examined the crural rings on both sides, where I could find no fulness nor pain at all. She had eaten a very hearty supper on Friday night, the 7th inst., of beef and potatoes. The symptoms present were constant vomiting; colic pains at intervals of ten minutes or a quarter of an hour; pulse 104, full; abdomen rather full, not very painful on pressure; no twisting pain nor dragging sensation in the abdomen; the patient slept during the intervals of pain. A person experienced in midwifery sitting in an adjoining room, would have imagined from her cries, and the intervals of ease, that it was a case of labour. The matter vomited was much greater in quantity than what had been swallowed, and had no stercoraceous smell. I was told that her bowels had been moved slightly, and that she had parted with flatus.

A sinapism was applied to the epigastrium. Ten grains of calomel and one grain of opium, with half a drop of croton oil, were administered immediately. An enema, consisting of sulphate of magnesia and decoction of aloes, was thrown into the colon by means of the long tube.

This was repeated again and again, with the addition of some spirits of turpentine, alternating with strong solutions of soap, between the hours of nine and half-past eleven p.m., with the effect of bringing down flatus, small portions of hardened fæces, and also patches of the skin of the potatoes, together with pieces of the same not digested. During all this time, viz., from nine to half-past eleven, the vomiting had ceased, the pain had subsided, and the patient expressed relief.

From this time until two a.m., she slept. On awaking, the vomiting returned with increased violence. The bowels were again moved slightly.

Between eleven and twelve a.m., on Monday, I saw her again. Since my last visit she had taken a second

dose of calomel and opium, also small doses of sulphate of magnesia, with infusion of senna, along with half-drop doses of croton oil in pills. The injections through the long tube were repeated twice, with the effect of allowing the escape of some flatus. Pulse at the same rate, but softer and weaker; countenance very anxious; abdomen much in the same state, not as painful as on the previous evening; no tympanites existed.

About twelve o'clock I left her, to return at two p.m., when I was informed by those present, that soon after my last visit her bowels had been thoroughly moved twice, the smell being very feculent. On examining the cloths on which the evacuations had been received, I found pieces of potatoe and patches of potatoe skin. Finding the sickness to continue, I again examined the crural rings on both sides. At this time I felt on the right side a lump, about the size of an unshelled almond, on the inside of the femoral vein, which I considered from its *solid* feel, to be an enlarged gland. This lump I could not return by the taxis, nor did it impart any impulse when the patient coughed. Not having been able to feel anything of the kind on the previous night, I was a little astonished, though Mr. Syme, in his "Principles," p. 434, says, "that the glands may become suddenly enlarged, and painfully so, in which case sickness, vomiting, and constipation, may be induced, not unfrequently by the irritation," in consequence of the straining from a violent effort. Knowing that enlarged glands sometimes disguise small hernial tumours, I made up my mind to cut down and satisfy myself on this point, if the vomiting did not soon cease. The absence of hiccup, the entire freedom from pain in the inguinal region, from the beginning as well as at this time, also the manner in which the bowels had been relieved, threw a doubt upon the existence of such a complication; still I considered that an operation would be justifiable in case the vomiting did not soon stop.

About eight p.m. I again visited my patient, accompanied with Mr. Moses and my assistant, when we found her much worse. Countenance more anxious; pulse very weak, intermitting, and scarcely perceptible; no hiccup nor pain in the abdomen or groin; abdomen flatter. One feculent evacuation was passed during our stay. We exhibited ammonia, opium, and brandy. The question now to be decided was, whether, under the existing collapse, we should be justified in cutting down upon the small and indistinct tumour situated in the usual locality of femoral hernia. After the most mature deliberation we resolved not to use the knife, fearing she would sink under the operation. She expired in five hours from this time.

Post-mortem twelve hours after death. We obtained permission to make a partial examination of the body, accordingly we cut down upon the supposed enlarged gland, extending our incision above Poupart's ligament. We found the tumour to consist of a small knuckle of the ilium, of a deep chocolate colour. The stricture was formed by the neck of the sac, considerably thickened, and not by Gimbernat's ligament.

Observations.—On reflecting on the above case, the following are points that appear to me worthy of the observation of the practical surgeon:—

1st. The non-existence of any tumour or pain in

the inguinal region, by the most careful examination at nine p.m., of the 9th.

2nd. The *total cessation* of the vomiting, and relief as expressed by the patient for five hours, following the use of the remedies first made use of.

3rd. The thorough manner in which the bowels had been relieved.

4th. The character of the tumour felt between two and three p.m., on the 10th, being so like that of an inguinal gland, not receiving the slightest impulse from the coughing of the patient, that if we had not seen it at the *post-mortem*, we could not have believed it to have been part of the bowel, though we were partly prepared to find some omentum in the ring.

5th. The absence of hiccup to the last; also of any pain in the inguinal region, as well as of twisting or dragging sensation in the abdomen.

The question is, how far the abdominal pains, vomiting, &c., were due to the presence of the intestine in the ring, from the beginning. Had it not been for the thickened state of the neck of the sac, forming the stricture, I should be inclined to suppose that the bowel had not even entered the ring, previous to the commencement of the sickness; the latter might have been caused by the quantity of indigested food in the bowels. Not being allowed to examine the abdominal cavity generally, it is impossible to say what was the state of things there. Supposing there was nothing but the extension of the inflammation from the strangulated bowel, I cannot help thinking, that had the hernial tumour been discovered on the morning of the 10th, the life of the patient might have been saved by an operation.

CASE OF COMPOUND DISLOCATION OF THE ANKLE: REDUCTION AND RAPID RECOVERY.

By EDWARD COPEMAN, Esq., Surgeon, Coltishall.

When we are enabled to adduce instances, not of triumphs of art effected by mutilation, but of recoveries from severe injuries accomplished by the wonderfully restorative powers of nature, the task is an agreeable one; and also instructive, for the purpose of shewing us how duly to appreciate the value of the art we practise as surgeons, and how not to abuse it, to the loss of limb or life of the unfortunate objects of our care. The following case exemplifies, better than any that has come under my own observation, the repair of a severe injury, without other assistance from art than that of placing the injured parts in a favourable position, and afterwards of guarding against counter-acting or disturbing causes.

A young man, aged 21 years, not of remarkably steady habits, a shoemaker by trade, was assisting in the hay-field, on Saturday, June 20th, 1846, and met with the following accident:—On driving a load of hay through a gateway, his foot became entangled against the post, and the waggon wheel coming in contact with the outside of the foot, forced it inwards, so as to dislocate the joint, the gate-post being the point of resistance. I found the foot very much turned inwards, the inner malleolus fractured off, and, with the astragalus, resting against the inner side of the tibia, some way above its extremity. The external malleolus was crushed by the wheel, and the lower

ends of the tibia and fibula, minus the two malleoli, projected through a wound in the integuments, to the extent of more than an inch, at the outer side. There was a free oozing of blood, but no large vessel opened. The cartilage covering the lower end of the tibia was visible, being exposed outside the wound, and the wound in the integuments was more than two inches long. With the assistance of my partner, I made several attempts to reduce the dislocation, but failed. In order to give the man every chance, I requested a consultation with Mr. Crosse before proceeding to any other means of relief.

Several hours elapsed before Mr. Crosse could reach the house; on his arrival, he advised another trial at reduction, and then, if not successful, the removal of the projecting portion of the bones. However, in our next attempt, we fortunately succeeded in restoring the bones to their natural position; the wound was then closed with two sutures, and covered simply with a piece of lint. A splint was applied along the inside of the leg and foot, secured by a few separate pieces of bandage, and the limb placed on a box in the same position as when reduced—viz., the thigh almost at right angles with the body, and the leg at right angles with the thigh, resting on the calf and heel. Cold water to the leg, and an opiate.

24th. Up to this time scarcely any local or general disturbance; bowels acting; no fever; no medicine; limb in very good position, and not painful; kept cool with water, and occasionally fanned; wound favourably situated, being, after reduction, somewhat above the level of the joint.

27th. Removed the sutures; health quite good; limb easy and not inflamed.

July 2nd. No illness, pain, nor swelling; no suppuration. All going on marvellously well.

24th. Just in the same quiet state; wound healed.

In six weeks from the accident, the splint was removed, and he got down stairs; and to-day, August 17th, I found him walking in his garden, able to bear considerable weight upon the limb, and possessing a good deal of power to move the joint, so much that I believe in a short time he will suffer no inconvenience whatever from the accident. There is neither swelling nor deformity of the ankle, and the man has really not suffered an hour's illness since his dislocation was reduced.

Sir Astley Cooper has drawn particular attention to the probability of recovery from compound dislocations of the ankle, without amputation; but he remarks that, "under the most favourable circumstances, three months elapse before the patient can walk with crutches; in many instances a greater length of time is required." The same surgeon states that, "the dislocation of the tibia, at the outer ankle, produces much more injury and danger than that at the inner, and amputation will be more frequently required for it, because both the bones and soft parts suffer more than in the dislocation inwards."

The case I have quoted is an example of a very rapid, uninterrupted, and perfect cure of the kind of dislocation which is thus said to produce the greater amount of injury and danger, and is well calculated to corroborate the now prevailing opinion, that amputation is not necessary in a majority of compound dislocations of the ankle-joint.