Mr. Jonathan Hutchinson has lately drawn attention to the unsatisfactory results following operations for strangulated hernia, and severely criticised surgeons who advise operations without a careful use of the taxis in cases where the contents are in a fair condition. He made the astounding statement that in the London Hospital, which had the largest hernia practice in London, or perhaps, anywhere, in 1861, 33 per cent. of operations on strangulated hernia were fatal. At St. George’s Hospital at the same time 30 per cent. were fatal. At the London Hospital now 50 per cent. of those operations were fatal. Mr. Hutchinson further states that modern operative treatment could nowhere show as low a mortality as 30 per cent., that the fatality after operations upon hernia should have remained the same, or actually increased during the past 30 years is not in keeping with the advance in other branches of our art, and is a standing reproach to our boasted modern surgery. To what then is this high mortality due? It requires little experience to teach the practical surgeon that in the early performance of kelotomy lies its great safety. The high mortality is to be ascribed to the length of time elapsing between the date of strangulation and the operation undertaken for its relief. It is not so much the operation but the delay that kills. In many cases the early management has been bad, the hernia possibly not made out for one or two days, taxis used unskilfully or persevered in too long. In spite of all that has been taught concerning the importance of early operations, kelotomy seems to be regarded even yet by some practitioners in the light of a last resource, and one that is unsafe to use until the symptoms have persisted for days. Of late years, however, the teaching in our colleges has been in the direction of advising not only early operating but avoidance of too prolonged use of taxis. Its dangers although increasing with the age of the strangulation, have, it is to be feared, been greatly exaggerated. Mr. Hutchinson is of the opinion that the present high mortality in London is due to the surgeons not using the taxis at all.

*Read before the Ont. Med. Association, June, 1894.*
days from exhaustion, apparently, who was 76 years of age, and suffering from hemiplegia at the time of the operation; the last in thirty hours, from exhaustion.

One of the herniotomies was for femoral rupture in the male; one for inguinal in the female. In all the other cases operated upon the inguinal hernias were in males and the femoral in females. In six of the cases the sac contained both bowel and omentum, in five, bowel only; in four, omentum; in one, bowel and descended testicle, which was removed. In most of the cases where omentum occupied the sac it was adherent, a ligature was applied above the adhesions, and after resection returned to the abdominal cavity. In No. 13 (report), the bowel was wounded accidentally in relieving the stricture, Lembert's cutures were applied and the wound enlarged to cleanse the peritoneal cavity. The operation was prolonged, owing to this unfavorable complication, to one hour and a-quarter. Death took place in eight hours, apparently from the shock. The sack was opened in every case but one. In No. 16 (report) alone was there a certainty of gangrene, and an artificial anus made. No. 10 (report), the omentum looked suspicious; it had been strangulated for five days, but the patient recovered. In No. 1 the bowels looked dark and doubtful, but was returned with a cessation of symptoms; the bowels moved during the night, pain and vomiting ceased, but she died on the third day of what the attending physician thought was peritonitis. In case No. 15 the hernia had been long irreducible with the bowel and mesentery firmly adherent; the stricture was relieved, but no attempt made to sever the adhesions. Death ensued; the age was 76. The operations extended over a period of 12 years from May, 1882 to May, 1894. An attempt at radical cure was made in 75 per cent. of the cases. In 1, 13, 15, the patients being much exhausted, and the necessity of a rapid completion of the operation plain, the sac was left alone and the wound closed. My experience of strangulated hernia leads me to the conclusion that adherent omentum is present very frequently, adherent bowel rarely. The former condition was found in ten cases, the latter in one only. The omentum generally in addition to being adherent, was found matted together, and so altered in structure that it was thought best to remove it.

Comments.—The table shows an analysis of 17 cases of hernia with 16 operations. Of these 12 recovered (6 males and 6 females), 4 died (2 males and 2 females), as well as No. 17 upon whom no operation had been performed. In the former 2 had been strangulated three days, one (an omental hernia) five days, and in 3 others, two days. Of the remaining 6 cases 2 had been in a condition of strangulation one day, and the remainder from five to twenty hours. Of the fatal cases, one had been strangulated six days, 1, twelve days; 1, two days, and another two and one-half days.

Of the operations, eight were performed on males and eight on females. Of these, eight were for femoral ruptures with two deaths, and six for inguinal, with two deaths. The youngest operated on was 19, and the oldest 76 years. Three were between 30 and 40; seven between 40 and 50; one between 50 and 60; two between 60 and 70. Of fatal cases, one died on the third day from supposed peritonitis, but there was no autopsy; another in eight hours from shock; one in three
by drawing down the now adherent portion, liga-
turing with silk, and after excision return to the
peritoneal cavity. In case 15, where the bowel
and mesentery were both firmly adherent to the
sac, the patient weak, suffering from hemiplegia,
and 76 years of age, the operation consisted in re-
lieving the stricture and closing the wound as
speedily as possible.

In none of the fatal cases was there an autopsy.
In the first, strangulated it was supposed about
six days, peritonitis was alleged to be the cause
of death. The 2nd, fatal result was due to shock
after prolonged operation with slight wound of the
bowel. The third died apparently of exhaustion
on the third day. The fourth in thirty hours from
the same cause. The real cause of death after
herniotomy is usually difficult to make out in each
case.

In the early part of the present century the in-
troduction of chloroform displaced all other
methods of treatment in strangulated hernia. We
are told that the question in connection with the
operation was whether or not the sac should be
opened if taxis failed. It was considered the best
practice to try the taxis patiently and for a con-
siderable time, providing that the hernial contents
were in a fair condition. If the surgeon suspected
gangrene from the symptoms present, the advice
was given to operate at once without any manipu-
lation, and always to open the sac. The vital im-
portance of early operations was insisted upon
then as now, but the taxis was very much more
prolonged and considerable force used. Either re-
duction by the taxis or Petit’s operation, in the
event of the former failing, was considered a great
improvement on any operation necessitating an
opening into the peritoneal cavity. Since the im-
proved method of treating wounds has come into
use, it is recommended in most cases to open the
sac, thoroughly examine the hernial contents, and,
after dealing with them as their condition requires,
complete the operation by performing the radical
cure. Later still, there has grown upon us a dis-
position to use the taxis only for a short time and
very gently, and a decided preference for early
operation. Some surgeons go the length of not
using the taxis at all. No doubt this practice is
fairly successful in experienced and skilled hands.
We must bear in mind, however, when approach-
ing this subject, that we are dealing with cases of
emergency. Probably one half the operations of
strangulated hernia are performed by general
practitioners, far removed from hospital accommo-
dation, without the necessary assistance; to this
may be added inexperience in operating, bad san-
itary surroundings, and possibly, imperfect light.
In cases suitable for taxis (that is of not too long
duration) where the patient is a long distance in
the country, and the aid of a fellow-practitioner
not at hand, I am disposed to think the physician
would be justified in giving chloroform alone, and
attempt reduction. As a general rule, however,
the patient’s consent should be obtained for a cut-
ting operation before an anaesthetic is given, so
that should the taxis fail, relief can be given by
knife. Whatever line of treatment is adopted,
there should be no excuse for delay, for every hour
that elapses carries the subject of a strangulated
hernia, nearer and nearer to his grave. I am one
of those who believe that a patient should not be
allowed to vomit a second time from strangulated
hernia without attempting something for his re-
lief. In all but two of the 17 cases reported, taxis
has been used, and in the majority, persevered in
for some time, but in none had any appreciable
harm been done to the hernial contents. The
bowel is capable of enduring a great deal of mani-
pulation, provided the strangulation has not long
been present and the taxis used in the right direc-
tion. All matters relating to the operation of
herniotomy and its usual complications are so well
understood and familiar to all that it would be
out of place to refer to them. I make exception
to the condition of gangrene and shall report the
histories of the two cases from the annexed table
where this was present.

Mrs. Geen, aged 70, admitted to hospital March
2nd., 1894, with fecal abscess resulting from gan-
grenous femoral hernia. It was ascertained from
her family physician that he had been called in
about February 12th. At that time the bowels
had not acted for two weeks, though she was mov-
ning about and doing her own work. From this
date to the 18th., she suffered from pain in the
abdomen, vomiting and constipation. An enema
caused an evacuation, after which diarrhea set in
and lasted for four or five days. On the 22nd of
February she complained of a painful swelling in
the groin, poultices were used and a discharge
took place on the 26th, four days before her ad-
mission to the hospital. Delirious at times with a rapid and feeble pulse. She took nourishment fairly well and most of the discharges took place per anum, and for a time it was hoped she would recover. An eczematous eruption spread around the opening in the groin, and the patient gradually sank and died from exhaustion on the 26th of March. The autopsy showed omentum adherent to the femoral ring, as well as a perforated ileum about six feet from its termination, no spur could be seen and the fistula was the size of a thumb nail. There was a rather free passage towards the cecum through which much of the discharges had passed.

Case 16.—Mrs. P., aged 48. Was called on May 28, about 6 o'clock in the evening. The abdomen was greatly swollen, very tense and nothing had passed her rectum for 12 days. There was a swelling in the right groin in the region of the femoral canal. The patient was weak, pulse small and rapid. Two hours later she was admitted to the hospital, and under an anaesthetic, an incision made down to the stricture. Both bowel and omentum were adherent, the former gangrenous, and pus was present among the adhesions. The bowel was incised and an artificial anus made. Death took place in 30 hours.

Treatment of Gangrene.—These are the only two cases of gangrene of the intestine that have come under my notice, and as they afford an illustration of treatment by artificial anus, I have thought it my duty to draw particular attention to them. In looking up the literature of this subject I found the following taken from a valuable contribution by Runsoff, of Cincinnati. Of 27 cases of hernia coming under his own observation, four were gangrenous, one being of the bowel and one of the omentum. Of 170 kelotomies for strangulation in Hagedorn's clinic, gangrene, real or suspected, was encountered but 25 times.

Of 486 cases collected from different sources, only 68, or about 14% were gangrenous. In the 170 cases of Hagedorn the omentum was dead in one only. This condition if so very rare that some surgeons doubt its existence altogether. In strangulated omental hernia the symptoms are said to be less severe, the pain, vomiting and constipation not so well marked. I have seen, however, as complete constipation in these cases as when the bowel occupied the sac. No doubt a number of omental hernias are irreducible and adhesions have formed long before the date of strangulation, the compressed portion of omentum receiving its blood supply from the wall of the sac beyond the point of constriction, and thus gangrene is averted. When this rare condition is met with the treatment consists in relieving the constriction, drawing down the mass, ligaturing, cutting off in sound tissue, and returning the stump to the abdomen. I am inclined strongly to the opinion that the cases in which gangrene is found are usually those that are reducible before strangulation, yet even here adhesions form around the seat of constriction, the septic products found in the sac are prevented from entering the abdominal cavity and the development of general peritonitis averted; but where this condition exists it is advisable in operating to use drainage and not close the wound. When gangrenous bowel exists, the question as to the proper course to pursue is a difficult one. Of late years, many recoveries have followed primary excision, with suture of the intestine. The old operation (formation of an artificial anus) is anything but attractive, and the per centage of deaths has been large. Much has been written upon the treatment of gangrenous hernia, and great difference of opinion manifested by surgeons. When the bowel is in what may be termed a doubtful condition it has been recommended by Paulsen to divide the stricture, and, after drawing down and covering the intestine with antiseptic dressings, await developments. I think, however, it is, as a rule, better to carry out the plan recommended by Treves, and replace it within the peritoneal cavity with a drainage tube under antiseptic precautions. When, after this treatment, the bowel gives way, experience has shown that the contents escape through the wound. Many experienced surgeons have met with cases in which the congestion of the bowel has been so extreme that they have doubted whether it was possible for repair to take place, yet its return led to complete reco very. As one meets with such a condition but rarely, it is difficult, or perhaps, impossible to say when the bowel is past the state of resolution. If the intestine, when exposed, be gangrenous, two courses are open to the surgeon, division of the stricture, followed by resection and suture, or formation of an artificial anus. Mr. Kendall Franks, of Dublin, has lately collected to-
gether a table of 222 cases of gangrenous hernia in which resection of the bowel had been performed, the mortality amounting to 48 per cent., while in a rather larger number, where the surgeon had made an artificial anus, the deaths amounted to 80 per cent. (Med. Rec., Nov. 11th, 1893, p. 621). Zudler, of St. Petersburg, gives a paper of 289 cases in which primary resection was performed, and 287 in which an artificial anus was made. The first group showed a mortality of 49.13 per cent., and the second, 74.22 per cent. As to which method is the better, resection and suture of the bowel or the formation of an artificial anus, the decision must depend upon the local condition of the hernia and the ability of the patient to withstand a prolonged operation under an anaesthetic. In some cases of gangrene, more particularly of the femoral variety only a very small knuckle of intestine is involved, and this, after the formation of an artificial anus, closes frequently without any operation whatever, the gut being simply incised and the wound treated as an abscess, when a small fecal fistula results and the contents of the bowel take their natural course with trifling danger of death from inattention. Banks strongly recommends that the stricture be not divided in these cases as the abdominal cavity is opened and exposed to infection from the putrid sac. In one of the cases presented, although no operation was ever attempted, nature performed all this for the patient, the small aperture discharging, and most of the intestinal contents passing her anus, and had the patient been admitted to the hospital earlier, or been younger in years, and had better care, I feel quite confident she would have recovered.

In other cases where there is a considerable section of the bowel in the sac where the strangulation has existed for several days, or been unusually acute, the portion at the line of constriction may be completely dead from direct pressure. The bowel beyond, may be gangrenous throughout or only in part; the centre of the coil, directly opposite the mesenteric attachment, is the portion that usually suffers. If the strangulation has been of long duration adhesions will be found inside the constriction, rendering the withdrawal of the bowel extremely difficult, after the stricture has been divided from inflammation and subsequent matting together of the hernial cover-
occupied in its performance. The anastomosis button of Murphy may be also used with decided advantage, it is more easily inserted than stitches, requires little technical skill for its application and very much shortens the operation. Dr. Murphy, in Med. Record, May 26th, 1894, reports six cases for strangulated hernia, in which the button was used with five recoveries and one death, and six cases for faecal fistula with no deaths. Dr. Walker, of Detroit, reports two cases with one death after it use. The union may likewise be effected by Senn's bone plates or Abebe's cat-gut rings. Probably the best method has not yet been devised, and as these appliances are not usually at hand when required, the suture will probably hold its place until surgeons are agreed upon one plan of treatment.

In carrying out the operation of resection some surgeons establish an artificial anus and close this after a day or two; this proceeding being applicable to cases where the collapse is severe or the primary operation contradicted, owing to the limits of the gangrene not being absolutely determined. The advantages of primary incision, as compared to the formation of an artificial anus are great. After resection of the bowel the patient is restored to health in a few weeks, whilst in the latter the condition is most pitiable, a worrying eczema, the constant dread of a secondary operation, and the existing offensive discharges, leave the patient in so sorry a plight that death is almost preferable to existence.

Although, during the past six years, many cases have been successful after primary resection, yet each operation has its proper place. I am disposed to think that most of the successful cases after resection were operated upon rather early, and in comparatively strong patients. In many gangrenous hernias the general condition of the patient is so bad that it would be impossible for such an operation as intestinal excision to be borne. The proper course to be pursued in each individual case must be left to the judgment of the surgeon. Certainly resection of the bowel is an ideal operation and where the necessary assistants are at hand, and speed can be used, I think it should be tried provided the patient is not in a state of collapse.—J. Wishart, M.D., M.R.C.S., Eng., F.R.C.S. Edin. London, Ont.

STOMATITIS NEUROTICA CHRONICA.1

BY A. JACOBI, M.D., OF NEW YORK.

Case 1.—C., fruit business, 42 years old, married; had one child which was stillborn. His father is alive, 78 years old; his mother 75. There are no other relatives except one sister, who is described as being perfectly normal, and one brother, whom 1 personally know. He appears fairly well developed physically, but has no whiskers, no hair on the pubes, none in the axilla, and the sexual organs are those of a child of 10 years. Both of these persons have had pemphigus in the mouth all their lives.

Patient appears to be pretty well developed, his complexion, though, is sallow; all his internal organs are in fair condition. His urine has a specific gravity of from 1.018 to 1.025; is always negative. He has always complained of a sensation of fatigue. He tires very easily, drags his limbs; cohabitation, which occurs but once a month, exhausts him; his hands were always weak, and moderate exertion results in tremor. He has trouble in keeping warm, and complains a good deal of precordial pain, both on pressure and before his meals. This pain, as he expresses himself, was never so bad as when, under the orders of a physician, his diet was restricted. He has a melancholy temperament, and expresses now and then a number of hypochondriacal notions.

Up to his 13th year he suffered severely from urticaria. Since his 13th year this urticaria has disappeared, and has been replaced by pemphigus in the mouth. A few blisters will form quite suddenly, sometimes on the tongue, mostly on the cheeks, frequently in their lower parts, near the alveolar processes. They will burst after a

1 While this paper was being put in print, Dr. O. Rosenbach published (Deutsche med. Wochenschr., June 28, 1894) a paper containing a "Contribution to the Vesiculating Affections of the Oral Mucous Membrane," Its conclusions are as follows: "The local pemphigus of the mucous membrane of the mouth is a variety of erythema exudativum multiforme, and ought to be called erythema bullosum. Whatever has been described as urticaria, herpes, etc., of the oral mucous membrane, is mostly this erythema bullosum. It is often complicated with the same eruption on the genital organs. It has a tendency to relapse." The very variety of the symptoms, and the etiological identity evidenced in the histories of the cases, makes me believe that the name selected by me is more significant and appropriate.