would be absurd; and yet a clamour is continually being made about a patent for some extract, solution, or residuum, as though the very rights of property were involved in its preservation intact. We say that, in ordinary cases, professional privileges are the legitimate rewards of discovery, and in extraordinary cases, there should be special rewards from the state and public bodies, and these rewards should neither be as few nor as niggardly as heretofore.

The last point treated of in the letter to Lettsom is, medical history; and here everything remains to be accomplished. A history, not of books nor of men; of countries, or of schools of medicine; but a philosophical history of the ideas which have been age after age evolved and made definite by the medical mind, would be of incalculable benefit to medicine. We want the same philosophic light thrown upon our professional life as that which has been thrown in recent times upon general history, and which has made it scientific instead of didactic, a detail of the functions, instead of the facts, belonging to the human race. We want medicine treated as one great whole, from the votive tablets in the early temples of Esculapius to the latest pages of Science. Then we are convinced that medicine would prove to be a fabric of fair if not of perfect proportions; its outline presenting proofs of symmetry, and its organs performing appropriate functions; all being animated by scientific ideas as by a soul; and then we are persuaded it would appear plain also, that its various imperfect institutions, its fleeting theories, and its temporary systems, were but as excreta, mean and worthless in themselves, but necessary for the health of the body medical, and indications of progressive growth and nutrition from facts and conceptions becoming more and more perfect in every succeeding generation.

Medical Societies.

WESTMINSTER MEDICAL SOCIETY.

SATURDAY, DECEMBER 12, 1846.—MR. HANCOCK, PRESIDENT.

CASE OF STRANGULATION OF A PORTION OF THE ILEUM, FROM A CONGENITAL BAND OF FIBRES PASSING FROM THE APPENDIX CÆCI TO THE MESENTERY.

MR. MARSHALL stated, that cases of strangulation of the intestine were comparatively of rare occurrence, one or two only being related previous to the commencement of the last century. Cases of intus-susceptio, however, were much more frequent. This might be inferred from the numerous specimens in most museums of pathological anatomy in this and other countries. Dr. Copland was the first who had treated the subject systematically. Mr. Marshall proposed to divide cases of strangulation into two kinds—viz., those arising from a band or bands of lymph thrown out during inflammation of the peritonæum, and remaining quiescent, so to speak, until a fold of intestine becomes incarcerated by these bands. The second kind consisted of those arising from adventitious bands, produced by a prolongation of peritonæum, or mesentery, as in the following case, which occurred to himself:—

Mrs. O——, twenty-four years of age, a woman of good constitution and healthy aspect, in the eighth month of her first pregnancy, was seized on Saturday morning, March 21st, with severe pain, extending over the whole of the belly, of an intermitting character, becoming aggravated at intervals, varying from a quarter to half an hour. The pain was accompanied by sickness and vomiting; but there was little or no tenderness on pressure on the abdomen. Pulse 80; skin moderately cool; the bowels had been acted upon by a dose of castor oil taken some hours previously. This woman had had twice or thrice during the time of her pregnancy similar attacks of pain; but described them to be of a more severe nature now than on any former attack. A grain and a half of opium was administered, together with a carminative mixture. In the evening the pain had somewhat abated, and the vomiting nearly ceased.

22nd.—She had slept very little during the night; the pain was as severe as yesterday morning, with shorter intervals of intermission, and the sickness and vomiting returned. Opiates were continued at intervals, and a saline effervescing mixture, together with aperients, and fomentations to the abdomen. In the evening, the pulse was upwards of 100; slight distention of the bowels from flatus, and the breathing became rather quick. An enema was administered, and followed by a copious and healthy evacuation. The thirst was now considerable.

23rd.—She had passed another restless night, with general aggravation of the symptoms; the pulse had increased in frequency to 120, and full; the breathing became extremely hurried, the thirst intolerable, and the countenance anxious. Sixteen ounces of blood were abstracted from the arm, which greatly relieved the difficulty of breathing. The pulse became small and weak after the bloodletting, but was not diminished in frequency. A grain of calomel and half a grain of opium were now ordered to be given every four hours, and the saline effervescing mixture continued. The glyster was again repeated, but no fæcal evacuation followed.

24th.—Ten A. M.: Had vomited a considerable quantity of a dark-green fluid during the night, but not possessing any fæcal smell. The pain was somewhat abated, but was still general, and not local. A state of collapse soon followed, and the patient died in about four hours after, and about eighty-six hours after the time of her being first attacked.

Post-mortem examination, twenty-four hours after death.—The abdomen was found much distended by gaseous matter; a considerable quantity of fluid escaped on making the first incision into the abdomen. The gravid uterus was found occupying the lower part of the abdomen, extending upwards to the umbilicus. The transverse arch of the colon towards the right iliac fossa was considerably distended; a portion of the ileum, in an abnormal position and highly inflamed state, was found strangulated by means of an adventitious band formed by the peritonæum, and extending from the appendix cæci about its middle to a separate part of the ileum superiorly. A space was thus formed, large enough to admit the thumb, through which the strangulated portion of the ileum passed, about eighteen inches of which, doubled on itself, were thus enclosed. On examining the degree of tightness with which the band pressed upon the ileum, it gave way under the finger, but had been tied again by a thread, and could be examined in the preparation which was before the Society. On a minute examination of the strangulated ileum, the whole of the coats were found highly congested, and pervaded in their entire length by a dark colour, indicating a near approach to gangrene, although no solution of continuity and softening was observable in any part of the tissues. Immediately to the right of this ligamentous band, a portion of the peritonæum was observed, passing from the cæcum itself to the ileum, forming a pouch by its curved free border, into which the finger for about two inches could be insinuated. Mr. Marshall thought it difficult to assign any cause for this displacement of the ileum, but that it probably arose from the gravid uterus having displaced the small intestines, and that during an effort to expel the fæces the strangulation took place, or that some mechanical violence had been the cause; for it was stated to Mr. Marshall, that about a fortnight previous to this last attack of illness, her husband had thrown a large book at her, which struck her on the abdomen. As to remedial measures, Mr. Marshall said there were none, except such as are offered by an operation, which the profession seemed now to regard more favourably than formerly, more especially since the numerous successful operations for ovarian dropsy; but he thought the cases scarcely parallel, for in the one instance we have a disease in which a sure diagnosis can be formed, whilst in the other, a very doubtful one is all that can be arrived at. Dr. Copland, however, was inclined to believe that a tolerably accurate diagnosis could be made, in most cases of intestinal strangulation, by means of percussion, as the sound emitted by the strangulated portion of the bowel would be sufficiently indicated by dulness; and that the diagnosis would be strengthened, if there were pain, accompanied by tenderness on pressure. Mr. Curling, in his case read at the Medico-Chirurgical Society last week, was inclined to cut down on the stricture; as was likewise Mr. C. Hawkins. Mr. Marshall considered mercury, in its crude state, in cases of intus-susceptio, a very questionable remedy; but in cases of strangulation wholly inapplicable: that he once witnessed the exhibition of it to a patient labouring under intus-susceptio, and that the greater part of it was immediately vomited up again, with excruciating agony to the patient.

Dr. SNOW considered it a congenital malformation, as there were no signs of old inflammation, and but a very little recent lymph. The appendix was adherent by a mesentery of its own, leaving an aperture through which the thumb could pass. The strangulation, however, was caused by a separate band. In the "Mémoires de l'Académie de Chirurgie," he found a case exactly resembling this, where a band three fingers'

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breadth long, and one inch from the cæcum, was attached to the appendix and the mesentery. He thought that the pushing of the uterus may have caused the bowels to become strangulated; and this he considered borne out by M. de la Faye, (vol. iv.,) in whose case strangulation was brought on by change of posture. The man had had several attacks of pain previous, which were probably owing to the bowel becoming strangulated for a short time. Dr. Snow then showed the impropriety of active purging in cases where suspicious pains have existed before. At the *post-mortem* of Mr. Marshall's case, the uterus had to be opened before the seat of strangulation sould be seen; the colon was turned over; the ilium lay on the outside of it, requiring the parts to be reversed, after the band was broken, before they could be placed in their proper position; the tongue was red and dry; the mucous membrane of the stomach a little softened. He then mentioned a case where the appendix vermiformis was found with a mesentery attached to it, in an embryo; another, where the cæcum and appendix were both found in an umbilical hernia; and a third case where the appendix was in the pelvis.

In answer to a question by Mr. Brooke, Mr. Marshall said that the pain in his case was general, and not at all local.

Mr. Brooke mentioned, that in the case narrated by Mr. Curling elsewhere, the exact spot was pointed out by the patient himself. At this spot, there was great tenderness on slight pressure; but nowhere else could any tenderness be found. Hence it was argued that the seat of injury was near the surface, and that in consequence an operation might have been performed. He had attended a cabman, who, having fasted all day, ate a hearty supper of cold potatoes, with some bacon; in the night he felt pain in one part of the abdomen, to the left of the umbilicus. His symptoms were those of indigestion. About forty-eight hours subsequently, stercoraceous vomiting came on. The large intestines were completely washed out by enemata, yet the vomiting and thirst continued. He died on the fifth day: the pain had much subsided the day preceding; he got out of bed, was taken in a collapse, and died. An examination of the body proved the injury to be in the spot where he had felt the pain—two inches of intestine had slipped under the cæcal appendage, just enough to prevent the passage along the bowels, but to stop the circulation. In this case the operation might have been performed; but generally there is too much distention and unsatisfactory indication of the spot. Could he have known then what he now knows, he would have performed an exploratory operation, using the same precautions as to temperature &c. that Dr. F. Bird uses. Mr. Brooke then stated the question to be—Is not a surgeon called upon to operate, if the indications of the seat of injury are probable?

Mr. Clarke remembered a case of Mr. Bryant, of Kennington, where there was internal strangulation, and the pain was quite local, and therefore a case fit for operation. But the questions to be solved first are, is it strangulation or intus-susception? and, what symptoms justify an operation? He doubted if the remarkable dulness on very careful percussion could be found in one spot only, in many cases, as advocated by Dr. Copland: the operation would generally be a *dernier ressort*, and not performed soon enough to save life.

Mr. Norman would not trust too much to local pain, until there was a diagnosis of the various sources of obstruction to the intestines. In a case he had seen, the intestines were bound closely together by old inflammation, causing a gradual stricture.

Dr. Chowne doubted if the attachment to the appendix was congenital, as adhesions take place very often, as is exemplified by adhesions of the ovaries and Fallopian tubes. He then narrated the following cases, illustrative of the formation of bands across the abdomen:—A man died after eleven days of constipation, a film being thrown out over the intestines. One of them becoming swelled, bursts through this film, pushes it aside, and rends it so as to reduce it to a band. This man had no pain during eight days, referrible to any part. No effect was produced on his pulse, or on his countenance; only there was constipation. He then became seriously ill.—Another patient had had no other symptom than constipation for six or seven days, who died about the 10th. Dr. Chowne felt assured that pain would never show us the seat of injury. Percussion was fallacious, from the abdomen being everywhere inflated. There are cases, also, in which, at the point of death, the bowel becomes disentangled, and recovery takes place.

Mr. Hancock considered the condition of the patient, in strangulation of the bowel, to be worse than in disease of the ovary, therefore the operation would not be so successful. He then related the following case:—A gentleman ate profusely: he took some castor oil, and his bowels acted well, yet he got worse. Mr. Hancock then saw him, and recommended venesection, calomel, and opium. He heard nothing of the patient for eight or nine days, when he found him in collapse. For two or three days he had vomited stercoraceous matter. Suspecting the existence of hernia, he examined him carefully, and found a hardness in the left iliac region. He made an opening over the inguinal canal: from the peritonæal cavity came forth several ounces of pus. The gut was quite black, and nearly mortified. He made an incision, and several pints of fæces passed. The patient revived instantly, but died twenty-four hours after. No post-mortem was allowed. He would not open the abdomen at all, except to save life.

Dr. Coley asked what was the best time to operate. In collapse, a fatal result would probably follow. In a case which during a fortnight showed no urgent symptoms, the pulse not being more than 100, an artificial anus was made in the sigmoid flexure, and life prolonged six months. He thinks there is no risk in abdominal incisions, if the patient be in good health at the time.

PATHOLOGICAL SOCIETY OF LONDON.

December 21st, 1846.—Dr. Copland in the Chair.

Dr. Garrod, Dr. Hudson, Dr. M'Intyre, Dr. Protheroe Smith, R. Barnes, Esq., E. E. Baron, Esq., H. C. Curtis, Esq., John Dalrymple, Esq., H. C. Johnson, Esq., John Marshall, Esq., — Sharpe, Esq., C. Walsh, Esq., R. Wollaston, Esq., were elected members.

Dr. Clendinning exhibited a specimen of

HÆMORRHAGE CONFINED TO THE SPINAL CANAL, WITHOUT ANY WELL-MARKED DISEASE OF THE CEREBRUM OR CEREBELLUM.

This specimen was taken from a man of intemperate habits, aged thirty-three, who was admitted into the Marylebone Infirmary on Nov. 22nd. On admission, there was observed coldness of the surface, weak but regular pulse, dilated pupils, and general prostration. Shortly before admission, while in a public-house, he suddenly leaned back on his seat with a vacant stare, losing all consciousness. The usual treatment for apoplexy was adopted without effect, and he died on the third day after admission. The post-mortem was made thirty-seven hours after death.

The cerebral arachnoid and pia were firmly adherent in the median line to the anterior portion of each hemisphere; a small part of the cortical substance, opposite the cribriform plate, appeared softer than natural, accompanied with slight congestion of the corresponding medullary portion; about two ounces of clear fluid in the lateral ventricles. The spinal arachnoid cavity was posteriorly filled with fluid, dark coloured blood; there were, however, a thin coagula on parts of the cords and membranes, which were generally stained deeply red. One lung was congested inferiorly. The heart weighed eleven ounces and three quarters; the liver weighed sixty-five ounces; and the kidneys were double their normal weight. The spleen weighed five ounces and three quarters; the stomach was normal. Dr. Clendinning remarked that the following positions might be hazarded in reference to this case:—

1. That it was a case of comatose disease of the apoplectic class.
2. That the coma was produced immediately by the cerebral congestion.
3. That the existing cause of the coma was probably the liquor he had taken.
4. That the remote causes were hypertrophy of the heart, and intemperate habits.
5. That the spinal hæmorrhage should be regarded as a complication rather than a cause of the coma.

Dr. Copland remarked, that affections of the spinal cord had of late been very frequent, and that he had had in his own practice three cases within a very short time.

Mr. Nathaniel Ward then read a communication, accompanied with drawings, from Dr. Letheby, on two cases of poisoning. The following are the particulars of the cases:—

POISONING BY SULPHURIC ACID.

Case 1.—On Monday, Dec. 29th, 1845, a boy, aged nine, was admitted into the London Hospital, under Dr. Little, suffering from the effects of oil of vitriol. He was at play in the street, when a strange boy gave him a teaspoonful of it to drink; he swallowed about an ounce of the acid, and was instantly seized with excruciating pains in his throat and stomach. He