Two cases of hernia, both treated by laparotomy : I. A properitoneal hernia. II. A femoral Littré's hernia / by W.W. Keen.

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TWO CASES OF HERNIA,

BOTH TREATED BY LAPAROTOMY:

I. A PROPERITONEAL HERNIA; II. A FEMORAL DITTRÉ'S HERNIA.

BY W. W. KEEN, M.D.,

Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, etc.

THE following cases are of more than ordinary interest,—the first by reason of its rarity, and the second as a contribution to the present discussion on the proper treatment of hernia by laparotomy.

PROPERITONEAL HERNIA; OPERATION; DEATH.

CASE I.—A. B., a young man aged twenty-three, was admitted to St. Agnes's Hospital on June 15, 1889, just as I was about to leave the ward. He was suffering severe pain and was evidently exhausted. He stated that for many years he had had a hernia on the right side, and that two days ago, in consequence of vomiting, it suddenly began to give him great pain. He is quite sure that the vomiting produced the pain and tenderness in the right groin. He had been under intelligent medical care, with attempts at taxis, which, however, had effected nothing. He had vomited at frequent intervals, but the matter had no fæcal odor, so far as he can describe it.

Present Condition.—He walked into the ward bending over in a stooping posture. His face expressed great pain, and he was in a condition of marked shock. His color was bad,—congested and bluish. He was etherized at once, and the following conditions were found. A tumor existed on the right side, extending from a point a little internal to the middle of Poupart's ligament to the bottom of the scrotum. Its shape was cylindrical and sausage-like. It was very firm, elastic, and dull on percussion, except at the upper and outer end, where it was tympanitic. At the bottom of the scrotum the testicle could be distinctly made out. There was a noticeable fulness extending to the internal ring. Attempts at taxis were persisted in for a few minutes. There seemed to be slight reduction in its size, but the hernia was immediately reproduced when pressure was removed.

An incision was made from a point corresponding to the internal ring to the upper part of the scrotum. As soon as the sac was reached, it was opened, and a mass of omentum nearly the size of a fist, but sausage-like in shape, was found. It was much congested, but not gangrenous. It was divided into four portions, tied, and removed. There were many adhesions to the sac. A small knuckle of bowel was also discovered in the upper and outer part of the sac. Its color was dark, purplish black, but, as the consistence was firm, I did not think it beyond recovery. On trying to reduce the stump of the omentum and the bowel, considerable resistance was felt,

but on pushing them up in a direction parallel to Poupart's ligament, they entered what was supposed to be the abdominal cavity. I noticed, however, that the moment the finger was removed the bowel especially came down into the canal again. It would not stay reduced, and it had lost nothing of its dark color. I now continued the incision in the sac completely up to the internal ring, and passed my finger into the supposed abdominal cavity for the purpose of investigating the reason for this persistent reproduction of the hernia. I found a large smooth cavity lying in the iliac fossa and extending outward to about the anterior superior spine of the ilium. Omentum was readily felt lying in its interior. Exploring its wall systematically, I found a number of adhesions between the omentum and its wall, but the bowel was free from adhesions. As the finger passed around the wall and approached the position of the internal ring, I suddenly became aware of an opening corresponding to the position of the ring. It admitted only the point of my finger, but on gently forcing in the whole finger I found that it was then really in the abdominal cavity. The pouch which I first supposed to be the peritoneal cavity was really extra-peritoneal. Evidently, then, I had to deal with an inguinal properitoneal hernia. I found that the bowel and omentum protruded through the ring, and that this was the seat of the constriction. I now drew out all the collapsed bowel which lay in the properitoneal sac, and with two fingers stretched the internal ring with ease. I was then able to draw down the gut until I could see the seat of the constriction of the bowel. There were fifteen inches of bowel in the sac, and the narrow constriction was very marked. The gut dilated to about half its calibre so soon as the constriction was removed. I had now no difficulty in reducing both omentum and bowel into the true peritoneal cavity. The condition of the patient was very poor: his respiration was hurried and shallow, and the lividity of his lips made me anxious to terminate the operation as soon as possible; so I did McBurney's operation for radical cure. During the operation, which lasted about three-quarters of an hour, he had been surrounded by bottles of hot water, and brandy had been administered hypodermatically a number of times. He recovered consciousness quickly, but gradually sank from exhaustion, and died at 2 A.M., eight hours after the operation. No autopsy could by any possibility be obtained.

Remarks.—This case presents another illustration of the fact that a properitoneal hernia is almost never diagnosticated before operation. Had it not been that the bowel persistently returned after its apparent reduction, I should almost certainly have overlooked the properitoneal sac, and the condition would have been entirely unrelieved. His death was evidently the result of the marked shock from which he was suffering by reason of the obstruction.

FEMORAL LITTRÉ'S HERNIA TREATED BY LAPAROTOMY; RECOVERY.

CASE II.—Mrs. Y., aged sixty, of Newark, Delaware, was seen by me, at the request of Dr. Henry, June 7, 1891. Three days previously she had been seized with severe colicky pains, which Dr. Henry relieved by morphine followed by purgatives and later by enemata. The lower bowel was emptied of scybalous masses, after which no movement took place. She vomited almost constantly from the beginning of the attack, and by the morning of the 7th this had assumed a fæcal character. There had been no pain of any moment after the initial colic.

I found a spare but well-nourished woman, who before the present sickness had never been ill in her life. There was evident fæcal vomiting, slight pain referred to the region of the umbilicus, and obstinate constipation. Examination by the vagina and

rectum was negative; the rectum was empty. Naturally, I first carefully examined the hernial regions, but discovered no hernia. Dr. Henry and a prior consultant had done the same, with a similar negative result. The abdomen was not markedly distended, but in the right iliac fossa were some distinctly rigid coils of intestine, which suggested the possibility of intussusception. Very little pain was complained of, and there was no tenderness over any of the hernial regions.

As it was evident that there was acute obstruction from some obscure intra-abdominal cause, a median abdominal section was immediately done antiseptically. The belly wall was extremely thin. The moment I passed my fingers into the right iliac fossa, I discovered that she was suffering from a right femoral hernia. By slight traction from within and pressure from without, I was able to liberate the bowel, and found that it was a true Littré's hernia, a little more than half the calibre of the bowel being caught. The constricted portion just passed through the femoral ring, and, with my fingers in the abdomen, by bimanual examination I was able to recognize the hernia, although, when both Dr. Henry and myself carefully examined the part externally alone, no hernia was detectable. The condition of the bowel wall was very fair, and, after flushing the abdomen with boiled water to wash out the slightly-bloody serum which had accumulated, the wound was closed by suturing the peritoneum and the abdominal wall separately.

On June 30, Dr. Henry informed me that after the first day the temperature did not exceed 100° F.; but, while the peritoneum united promptly, the rest of the belly wall failed to unite by first intention and healed slowly by the granulating process. The value of separate suture of the peritoneum and the belly wall is well shown by this case.

Remarks.—At the meeting of the British Medical Association last August, Mr. Tait proposed laparotomy as the usual treatment for hernia. Exception was taken to this view by some of the most prominent men present. My own opinion is that herniotomy is the better operation for routine practice, but yet there can be no question that in a few exceptional cases laparotomy should be done. The present case is a good illustration of conditions requiring this method of treatment. Two competent physicians had examined the patient with great care in consultation before I saw her. I repeated the examination, and with the more care because of their prior examination and because there was nothing perceptible that could account for her condition. There was no swelling in any of the ordinary hernial regions—umbilical, inguinal, or femoral—on either side. The pain was referred to the umbilicus, and the physical signs led me to suspect intussusception at the ileo-cæcal valve. The absence of the usual signs of hernia is accounted for, of course, by the character of the hernia,—a small Littré's hernia, involving only half the circumference of the gut, yet producing complete obstruction. The ease with which the hernia was reduced and the good recovery which followed were very gratifying. The abdominal wall was so thin that the muscular and cutaneous layers failed to unite by first intention.