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SURGICAL CASES.

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Inguinal Hernia—Reduction—Intense Inflammation of Bowel—Death.

In the October Number of this Journal, amongst other cases, I related one of small femoral hernia of the left side, illustrating the fact that strangulation of the bowel for a very short period is sometimes sufficient in such cases to induce changes leading to ulceration or gangrene of the intestine, and to a fatal termination. The following case proves that even in large inguinal hernia, strangulation for an equally short period may lead to the same results.

I was requested by my friend Dr R. to visit a patient who was labouring under strangulated oblique inguinal hernia of the right side. The patient stated that he had been affected with the rupture for a number of years, but that it had always ascended when he assumed the horizontal position.

He had retired to rest at the usual hour on the evening of the day preceding that on which I saw him, and the bowel had returned as usual. He had risen to evacuate the bladder at five o'clock in the morning, and the bowel at the time descended; but he considered it as a matter of no moment, and again retired to bed, feeling no inconvenience from it, and expecting that it would return as usual. On rising late in the morning he found that the tumour was very tense, and that it had likewise become the seat of considerable pain. He tried to reduce it, but could not; and vomiting supervening, he applied to a medical gentleman who resided in the neighbourhood. Slight attempts were made by him to reduce it; and these failing, cold was ordered to be applied to the tumour, and a large enema to be administered, with the hope that when the bowels, which had previously been somewhat constipated, were moved, the reduction would be much facilitated. No evacuation followed, and the symptoms continuing, I was requested to visit the patient, which I did about half an hour after noon of the same day.

The patient was then suffering much, there was frequent vomiting, the skin was rather hot, the pulse about 90, and of moderate strength; but there was an expression of much collapse with occasional hiccough. The tumour was of considerable size, fully equal to that of a large fist. It was exceedingly tense, and somewhat painful to the touch. I immediately attempted the reduction, and this was, as I expected, accomplished without any great difficulty. The patient immediately expressed himself relieved, and after a short time the bowels were moved, and the vomiting ceased. I saw him again in the afternoon; he still appeared to be going on well, and there had been no return of the vomiting. Matters continued in this state until about midnight, when he was seized with violent pain at the lower part of the abdomen, followed by rapid sinking. He continued to get gradually weaker and weaker, and died in the course of the afternoon of the day following that on which the tumour had been reduced.

Post-mortem Inspection.—On laying open the cavity of the abdomen, two large folds of small intestine, about ten inches in length each, were found lying at the lower part of the abdomen, in a state of intense inflammation. They were of a bright scarlet colour, and contrasted beautifully with the subjacent and surrounding folds of intestine, which retained their natural hue. The affected folds were dilated, as well as the canal above them, and their parietes were somewhat softened, but in no part had gangrene supervened. The redness terminated by a defined edge, the continuous portion retaining its natural colour. There was no effusion either of lymph or serum into the cavity of the abdomen.

As no unusual degree of force had been employed in reducing the protrusion in this case, and as its reduction had been effected within seven hours after its descent, I had every reason to anticipate a successful result, and was consequently much disappointed next day on finding the change which had occurred. It appeared to me at the time that matters could only be explained in one of two ways,—either that the hernia had been strangulated longer than we had been led to believe, or that the bowel had given way at the time of the reduction. I did not think it probable that in so large a hernia as this was, and which had, as we had been informed, been strangulated only for a few hours, inflammatory action so intense as to prove so rapidly fatal could have been established in such a short space of time.

As to the first of these, we found on re-examination that the patient's wife adhered strictly to the account which both she and her husband had previously given us; and they were so distinct in their statements that we had no doubt as to their accuracy. As to the second explanation of the progress of the case, I was somewhat more in doubt. I could scarcely conceive, from the

little force which was used, that rupture of the intestine had taken place; but as it was a possible event, I was somewhat relieved on finding the explanation afforded by the post-mortem inspection.

In all the works on hernia we are told, and it is a well known fact, and one easily explained, that "large and old ruptures, which seem most formidable on the first view, are in reality attended with much less danger than small and recent ones." That "old rupture is not readily strangulated, and when it falls into this state, the danger is not imminent; the distention of the opening, previous to incarceration, has so dilated and weakened the parts that they can no longer produce a close constriction." As a general law, there is no doubt as to the correctness of the above statement, but results such as occurred in this case—and similar ones are every now and then met with—place in a strong light the impropriety and danger of delay in such cases. No great length of time is required to satisfy the surgeon whether the taxis and its subsidiary aids are or are not to be successful; and after these have been fairly tried, every minute allowed to elapse before the performance of the operation must be regarded as productive of danger.

Femoral Hernia—Gangrene of Gall-bladder—Extravasation of Bile—Peritonitis—Death.

Cases of reducible and irreducible hernia are sometimes complicated with other affections, which resemble them more or less closely, in such a manner as to render the diagnosis exceedingly difficult if not impossible. "The intestine," according to Mr Lawrence, "in a large hernia, may be affected with colic, and thus give rise to constipation and vomiting. Such an attack," he says, "may render a reducible hernia incapable of being replaced, particularly if the bowels are much inflated. An attack of ileus," as he says, "from some other source independent of the original cause, may likewise complicate the case." In either of these the performance of the operation would not only be useless but decidedly injurious.

In the first class of cases purgatives and emetics will procure evacuation of the bowels. In the second, if the hernia is reducible, little room for doubt will be left; but should it be irreducible, the diagnosis is rendered more difficult. The true nature of the case, however, may be frequently made out by careful examination.

The following case, in which the diagnosis was attended with much difficulty, appears worthy of being recorded, although the complication is one which can seldom occur, inasmuch as it exhibits a rare form of disease.

I was called to see a poor woman in Jamaica Street, who

was supposed to be labouring under strangulated femoral hernia of the right side. The general symptoms were those of strangulation of the bowel. There was a small tumour of the right side, which was tense and slightly tender, and at the same time the woman was affected with vomiting and constipation, distention of the abdomen, with general tenderness. The pulse was about 120, small but wiry. The countenance was expressive of much anxiety. Skin moderately warm. The symptoms had existed for upwards of twenty-four hours when I first saw her, and were believed by her to depend upon the state of the rupture.

The hernia was reduced without much difficulty, but the symptoms were not at the time much alleviated. After an hour or two, however, subsequently to venesection and the exhibition of aperients, the bowels were moved, but the pain of abdomen still continued. This likewise, after the exhibition of calomel and opium, and the application of leeches, abated considerably. Matters now appeared to be progressing more favourably, when an injudicious well-meaning lady who visited her, finding that she complained of great weakness, administered a glass of wine. This was followed by a return of the symptoms of peritonitis, with increased intensity. Matters passed rapidly from bad to worse, and the patient died in about forty-eight hours afterwards.

At the post-mortem examination, marks of extensive peritonitic inflammation were found, as indicated by sero-lymphatic effusion to a considerable amount. These were most intense in the right hypochondriac and lumbar regions, where the intestines were much matted together by lymph, with serum apparently mixed with biliary matter effused into the interstices. The gall-bladder was found collapsed and emptied of its contents, and its parietes on the inferior surface for about two-thirds of its length in extent, and half an inch in breadth, were in a state of gangrene. The slough had partially separated at one point, thus allowing the contents to escape into the cavity of the abdomen.

This is just one of the cases the diagnosis of which is attended with much difficulty. A surgeon, had the hernia been irreducible, would, under the circumstances, have been fully warranted in operating, a step which of course would not only have been useless, but possibly very injurious. Even as it was, I naturally ascribed the peritonitic inflammation to the strangulation of the bowel, the tumour, it is to be borne in mind, being the seat of some considerable uneasiness previously to its being returned. Subsequently to the reduction of the hernia, the symptoms were those of simple peritonitis, and consequently there was no ground for suspecting that internal strangulation existed, and therefore there was no call for any of the proceedings recommended in such cases. We are told

that, even in those instances in which the rupture is irreducible, we are sometimes, by careful attention to the symptoms as well as the history of the case, enabled to ascertain whether or not the strangulation of the bowel is to be regarded as their cause. We are told that the surgeon, by attention to the following circumstances, may be enabled to decide this point:—"The pain in ileus is felt in the abdomen and not in the swelling, which continues soft, while the belly is inflated, hard, and tense. The attack is sudden, and not preceded by any of the occasional causes which could affect the rupture; and the ring is free. The affection extends in the sequel to the swelling, which then becomes painful and tense; but it appears later here than in the belly, and does not proceed to so great a degree. All these circumstances will of course aid materially in enabling us to form an opinion as to the nature of the case; and two are related by Mr Pott, in which by attention to them he was led in both to form a correct diagnosis, and in one of them to refuse to perform the operation, which he was urged to have recourse to by the other surgeons in attendance. The operation in one, and the dissection in both, verified the accuracy of his opinion. It would, however, we believe, in many cases be dangerous to act upon an opinion thus formed, and we are the more convinced of this, inasmuch as we have seen more than one case in which all the indications thus laid down existed, and nevertheless the symptoms were clearly to be referred to the hernia, from the complete success which attended the performance of the operation.

What the cause of the gangrene of the gall-bladder was it is difficult to say. There was no obstruction in the ducts; but it is possible that some biliary calculus might have been temporarily impacted in them, but for a sufficient length of time to induce the inflammatory action which terminated in the formation of the slough.

Femoral Hernia—Difficulty in Diagnosis—Operation—Cure.

The following case illustrates the danger which might accrue were we to act upon the diagnostic marks as quoted above, as well as the propriety of the practice now generally recommended in doubtful cases. I was asked by Dr Simpson to see a poor woman in the Old Town who had been labouring for nearly two days under symptoms of obstruction of the bowels. In this patient the general symptoms had been urgent from the day before that on which I saw her. A small tumour existed in the region of femoral hernia of the left side, but was so perfectly free from pain that not only were the symptoms not believed to depend upon it, but by several the very existence of a hernia was doubted. When I first saw her the general symptoms continued urgent, and the patient had an expression of considerable anxiety. The

bowels were constipated, the vomiting was feculent, and there was considerable distention with tenderness of abdomen. In the left groin there was a small tumour of about the size of a large filbert. It was firm to the touch, and free from pain, and bore handling without giving more annoyance than would have been produced by treating a gland in the same manner. On careful examination a narrow pedicle could be made out, stretching in the direction of the ring. Not the slightest impression could be made on it by pressure, and some difference of opinion existed as to its nature, several of those who saw it believing it to be a gland, and that the symptoms of obstruction were independent of it altogether. No difference of opinion existed as to the practice which, under the circumstances, ought to be followed, *viz.*, to cut down upon the tumour and ascertain its nature. This I accordingly immediately did in the usual manner, and a very small knuckle of intestines was found much injected, but otherwise in a healthy condition. The stricture at the neck of the sac was exceedingly tight, and some little caution was required in dividing it. The intestine was then returned without difficulty, and the usual treatment pursued. The patient after this made a rapid recovery without the slightest bad symptom occurring.

Had we in this case acted upon the diagnostic marks laid down as quoted above, and treated the case as one of ileus, altogether independent of the tumour, there can be no doubt what the result would have been.

Oblique Inguinal Hernia—Indurated Omentum—Operation—Cure.

Some difference of opinion exists as to the proceeding which ought to be adopted in cases of large entero-epiptocele, where the omentum has become so much enlarged and indurated that it is impossible to reduce it after incision of the stricture to a moderate extent. Surgeons were formerly in the habit of surrounding the neck of the omentum with a ligature, and cutting away the portion below it. The fatal consequences which so frequently followed this practice have very properly led to its abandonment. The practice now most generally followed is either to leave the omentum in the sac after returning the intestine, or to cut it away, and ligature the vessels which bleed. Objections to both of these proceedings will at once suggest themselves. The best practice I believe to be to incise the parts to the necessary extent, and return the protruded omentum. This practice I adopted in the following case, in which the omentum was indurated and enlarged to a very great extent, with perfect success.

In the beginning of May 1842 I was called by my friend Dr Thomson to visit an old woman upwards of sixty years of age,

who had been labouring from the morning of the day preceding under symptoms of strangulation of an oblique inguinal hernia of the left side. The hernia was a large one, and exceedingly tense, but not very painful on pressure. There was likewise a large inguinal rupture of the right side, but it could be returned with facility. The taxis had been fairly tried on that of the left side, but no impression could be made upon it. Under these circumstances, and as the symptoms were urgent, I immediately operated, with the concurrence of my friends Dr T. and Dr Robertson.

A large fold of small intestine was found, in tolerably good condition, in the sac, and lying over it a large mass of indurated omentum in a highly injected state. The intestine was reduced with facility after incision of the structure to about the usual extent, but it was found impossible to return the omentum. The question now was, what was to be done with the omentum? From the bad consequences which have in so many cases followed the leaving the omentum in the sac after reducing the intestine, I felt very averse to do so; on the other hand, the vessels which must have been divided, and would have required ligature in this case, were so large and so numerous as to oppose a very formidable objection to excision of the part. Under these circumstances the best step appeared to be the more extensive division of the stricture, and the return by that means of the omentum. This was accordingly done, and the bandage applied in the usual manner. Every thing went on perfectly well until about eight days after the operation, when inflammation of the sac took place. This, however, was productive of no further annoyance than the local pain, and gave rise to little or no constitutional disturbance. There was no formation of pus, but simply effusion of lymph and serum, which after their absorption led to the complete obliteration of the sac. The patient made a perfect recovery.

The inflammation of the sac, after the operation, in cases of large hernia, is by no means a rare occurrence, and has followed in one or two cases on which I have operated. In some of them it has proceeded to suppuration; but in none has it extended to the cavity of the abdomen, or been productive of any alarming consequences.