

In advising a patient with advanced renal disease to submit to a serious operation the responsibility undertaken is very great. The treatment adopted in this case has, however, been fully justified by the event, not only because the patient's health has been improved for the time, but also because an increasing source of aggravation of the renal disease was removed, and the patient's chances of prolonged life have undoubtedly been increased thereby. These results could not have been counted upon if imperfect antiseptic precautions had been used.

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A CASE OF BLADDER IN AN INGUINAL HERNIAL SAC.

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IN the review in THE LANCET some time ago of "De la Cystocèle Inguinale rencontrée au Cours de la Kélotomie," by Dr. Henri Bourbon,¹ the author is stated to have collected eighteen cases where the bladder had been found in the sac of an inguinal hernia, and which he details in his memoir, taken from the practice of continental surgeons, no reference being made to any British or American writer. I am therefore induced to record a case in my practice where, in operating for a strangulated inguinal hernia of the right side, in which the bladder was found in the sac and down in the scrotum, the bladder was cut into, and at a subsequent operation the protruding portion was sliced off, and the edges of the bladder were sutured, the patient eventually making a good recovery, thus giving one more lesson of what contents may be found in a perineal sac, and the serious results that may follow from want of appreciating or diagnosing the condition. Much as I regret the misadventure of wounding the viscus, I trust I shall not be censured for reporting the case.²

On the evening of Nov. 15th, 1892, I was summoned to see a fleshy, stout-built man of short stature, aged fifty-six, who had for years been troubled with a scrotal hernia, which he was able to return, and who wore a truss. I found him on the present occasion suffering from symptoms of strangulation, no passage from the bowels, straining, vomiting, and excessive pain; no trouble in passing urine was complained of; his usual method of returning the bowel was by standing up and bending well over, doubling up his body and using his two hands, in which position he had never before failed. He tried it again on this occasion, but without success, and remarked there was something more than the rupture. I made every attempt to reduce the bowel and at one time thought I had made some impression, but did not realise that I was pressing urine back out of the bladder, which must have been the case. I failed in the reduction by taxis. I gave him a dose of morphia and sent him into hospital. The following morning I had a consultation with my colleague, Mr. Elam, who assisted me in the operation. We decided to operate. The report of the operation and notes of the case were taken by my late house surgeon, Mr. Sylvester Willard, to whose unremitting attention I wholly attribute the patient's recovery. The patient was anaesthetised, and another attempt was made to reduce the hernia, which failed. The hernia was on the right side, the tumour was resonant on percussion, and a large mass was drawn down into the scrotum. The ordinary incision was made over the swelling and the hernial sac exposed; with a little pressure on the enlarged scrotum the mass was brought outside. The sac was then opened and the gut isolated, the ring divided, and the gut was got back into the abdomen. The mass—as we thought, of omentum—now engaged our attention. No amount of manipulation seemed to produce any effect in its reduction. The surface of the mass appeared to be covered with exuded blood and lymph—so much so that it was deemed not advisable that it should be returned, but that it should be taken away. It was deemed to be omentum, with no bowel engaged. Before going further I made an exploratory incision into the mass from below upwards, on which urine flowed, when it was evident that I had cut into the bladder. A gum-elastic catheter was passed per urethram, whereupon the end showed in the

wound and was drawn forwards. Nothing was now left but to secure the open bladder in the position presented, which was attained by suturing each side of the wound of the bladder to the corresponding sides of the abdominal wound by means of silkworm gut; the skin was fitted round, and the remainder of the wound was brought together in the usual manner. A drainage-tube was placed into the wound of the bladder and a winged catheter passed per urethram. Ordinary gauze and wool dressings were applied and secured by bandage.

Nov. 16th.—The patient has had a very good night; he slept well; the dressings are saturated with urine; the catheter had slipped out; he passes a small quantity of urine by the urethra.—17th: Patient in much the same condition; the dressings are saturated; one of the abdominal sutures was removed, which gave exit to pus. A large oil and turpentine anæmia was administered, which opened the bowels well.—18th: The other gut sutures were removed; the purulent discharge from the surface was abundant; the patient feels well.—Dec. 14th: All purulent discharge has ceased; the tumour has shrunk. He passes a small quantity of urine by the urethra; the parts look healthy, and the surface is granulating. The abdominal wound is entirely healed and sound.

On Jan. 7th, 1893, the parts were considered sufficiently healthy to make an attempt to close the wound of the bladder. The patient was placed on the table and anaesthetised. I was now assisted by my colleagues, Messrs. Jessett and Elam. The protruding mass of the bladder, about the size of half one's fist, was sliced clean off, the bleeding vessels being tied; the edges of the skin were dissected all round the wound in order to free the flaps, so as to allow of their being brought together, undermining the skin flaps, and their edges being pared; the mucous coat was sutured with chromicised catgut; the integument and muscular coats of the bladder were then transfixed with quill (Halstead's) sutures; when all were passed the parts were pressed together and the sutures tied *seriatim*; the bladder was now filled with tepid water to test the opening; no leakage presented, and it appeared perfectly stanch; the wound was dressed and the parts were supported by a pad and bandage; a winged catheter was passed into the bladder.

Feb. 3rd.—I pass over the intervening daily reports. The wound several times looked as if it would not hold together. When the sutures were removed some trickling of urine occurred; this gradually improved, and now the parts are sound. The wall of the abdomen shows a bulging outwards when the bladder is full, but the prominence subsides on voiding urine. This condition necessitates the supporting pad and bandage, from which he obtains great comfort. During the month the bladder was irritable, as also the urethra, and the catheter was kept in, much against the patient's wish. The bladder was douched out with boracic acid water, and afterwards with quinine solution. He is allowed up, but he is kept under observation to prevent his straining either when at stool or in passing urine. He was discharged well on March 27th, 1893. I have seen him several times since, and he reports himself comfortable.

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ON EMPYEMA IN CHILDHOOD.

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EMPYEMA always has been, and always will be, a disease of very great interest and importance: of interest in that discussions on the treatment always give rise to differences of opinion; and of importance in that, so frequently, the presence of pus in the pleural cavity of cases brought to a children's hospital is there found to have been overlooked. The records tabulated below help to show that empyema in childhood is not a very fatal complaint; and, given that an early diagnosis is made and that the correct treatment is adopted, the number of deaths would be very materially diminished. The diagnosis in nearly every case is not a difficult one, the presence of dulness to percussion remaining permanent and perhaps increasing in area, weak respiratory murmur or bronchial breathing heard faintly over this area, occurring in a child, as a rule, after an acute pulmonary inflammation

¹ THE LANCET, Aug. 26th, 1893.

² THE LANCET, April 28th, 1894.