

HERNIOTOMY PLUS LAPAROTOMY SUCCESSFULLY PERFORMED UNDER VERY UNUSUAL AND DIFFICULT CIRCUMSTANCES.

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It is to be sincerely hoped that it will but seldom occur to a surgeon to be placed in the position in which I was on Sept. 8th, 1898, when on board the s.s. *Nineveh*, belonging to the Aberdeen White Star Line, while off the Cape.

The patient, a steerage passenger, thirty-eight years of age, when lifting a box in a strong gale of wind at 4 P.M. strangulated an old inguinal and scrotal hernia. I tried gentle taxis, ice, opium, and other usual remedies, but all to no purpose. I felt assured that an operation would be required and therefore I was very careful about taxis, not using more pressure than was absolutely necessary. At 8 P.M. I decided to operate, knowing full well that every hour would lessen the chance of success and the man was rapidly losing strength, vomiting being incessant and the pain excruciating. The rôle of anæsthetist I had to entrust to the purser (Mr. Freeman). In reply to my inquiries he said that he had seen chloroform given once and that he was "not afraid"; so I rejoined, "You will do." There was on board the usual amputation case which was of no use in this operation and there was also a pocket dressing-case. The latter had to supply all the instruments; it contained, luckily, a finger amputation knife. In the amputation case was a Wells's forceps of primitive pattern. The silk used was of the usual braided kind wound on a card and not too clean. I raked up six needles such as are to be found in pocket-cases and are used for sewing up superficial cuts. There were no sponges, but about $\frac{1}{4}$ lb. of alembroth wool as well as plenty of lint. Fortunately there was a bottle of iodoform gauze. For antiseptics I had to depend upon a bottle of solution of perchloride of mercury (B.P.) and boric acid, the latter being not too plentiful. Empty beer-cases and a mattress were made to serve as a couch, and the operating theatre was the surgeon's cabin, the available space of which was 6 ft. by 5 ft. 6 in. The patient's feet were against the door and his head was against the bunk. I thought of the theatre of St. Mary's Hospital where I had spent so many happy and profitable hours during the previous twelve months watching my old friends Owen, Page, and Pepper doing such brilliant things. If they could only have seen *my* theatre and instruments and assistants! For assistants I had to have two deck hands, whose sole duty was to keep the patient from rolling off his by no means safe couch, and in spite of every care we were hurled from side to side by the rolling, and more than once assistants, patient, anæsthetist, and operator were generally mixed up when an extra big sea hit the ship. The patient having been brought under the influence of the chloroform I again tried taxis with no benefit. After shaving the pubes and disinfecting the skin as well as I could I cut down over the sac which I rapidly opened and I divided the stricture (in the pocket-case there was a hernia knife). A "mixing up" such as I have referred to above then took place and when we had got back into our respective places I found that from 12 in. to 15 in. of intestines had come out of the scrotum (it was a big hernia). Then another interruption, a mere matter of detail, occurred—viz., artificial respiration had to be performed, the anæsthetist having been too liberal with his chloroform. That being successful I was again at liberty to resume my operation, but having no sponges and no assistants to look after the exposed bowel it had to take its chance whilst I was at the other work. That "chance" was not very bright, I thought, for the bowel was not too warm. I now tried to return the gut into the abdominal cavity, but do what I would I could not coax it back. There were no adhesions at the stricture, but the cause of my not being able to get it back was the presence of so much flatus. I was at my wit's end with not a soul to consult and with no friendly colleague to offer a suggestion. I decided to perform laparotomy and to draw the bowel from the inside. I made my incision 4 in. in length in the middle line. There was a large amount of venous bleeding from the engorged abdominal

vessels which I could only control with hot water. When this had been stopped I opened the peritoneum and passed my hand within the abdomen and by gentle manipulation from without and within I was able to pass the flatus on and thus get the bowel back into the abdominal cavity. The sewing up of the abdominal wound presented some difficulty, the needles being so short and the abdominal walls thick, and as there was no needle-holder the handle of the shut-up finger-knife had to be used to push the needle on, Wells's forceps doing the rest.

I thought that if the poor fellow lived I should like his hernia to be radically cured, but how on earth was I to get the pillars of the ring together? For I most certainly did not care to bury sutures with such silk as I was using, so I determined to gather the edges of the pillars like a purse, using one piece of thick silk armed with two of my little needles. After gathering it up I brought both needles out through the skin half an inch apart and an inch or so from the wound and tied the suture tightly. The result was most satisfactory for the parts became thoroughly consolidated.

The after-treatment consisted chiefly of the patient being rolled from side to side by the motion of the vessel for four days for it blew hard all that time, but in spite of everything against him his temperature never reached 99° F. and on Sept. 28th he walked off the steamer at Melbourne quite well. I heard from him from Tasmania on Oct. 24th that "he never was in better health, that the wounds were only faint red lines, and that he felt nothing whatever of his rupture."

Now, there is no use in publishing cases unless there is some lesson to be learnt, and what does this case teach? Firstly, to remember that in the majority of cases of strangulated hernia taxis will not be successful; therefore taxis should be used as little as possible and as gently as possible, for if operation is dispensed with for the time being it will have to be resorted to at some future time and the operator then will not be inclined to bless the practitioner who has made the patient run greater risk for the useless and perhaps rough manipulation which the bowel has received at his hands. Secondly, operation should be performed early. This man owed his life to the fact that I used but gentle taxis and that I operated within four hours of the strangulation, so that he was not allowed to get exhausted by vomiting and pain, when knowing full well that I should have to relieve him sooner or later by operative measures. Thirdly, never despair of, or "funk," an operation however black things look against its chances of success.

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A CASE OF CONGENITAL ABSENCE OF BOTH CLAVICLES.

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A GIRL, aged thirteen years, was brought to see me at the London Hospital with a history of losing weight and of sickness in the morning. Her picture appears at Fig. 1 of the accompanying plate. She was rather small and dark-skinned. The father and mother are both healthy and there are three brothers who are also healthy. There is no evidence of tuberculosis or of syphilis in the family. The child has always been weakly. She was "rickety" as an infant and could not walk till she was four years old. She has had measles and had at the age of nine years a long illness with fever and diarrhoea which may have been enteric fever. The patient is small in height and size, the height being 4 ft. 2 in. She is very dark in colour. The head is out of proportion to the body but not overlarge for her years. The frontal and parietal eminences are prominent and the depression between the frontal eminences is well marked. The fontanelles have closed. There is a large depression corresponding to the anterior fontanelle and a smaller one corresponding to the posterior fontanelle. The mother stated that the anterior fontanelle did not quite close till the child was nine years old and for that reason she was anxious when sending her to school. The conjunctivæ are very pale and there is slight general anæmia. There is some enlargement of the glands in front of the left sterno-mastoid.

On examining the front of the chest there is no very obvious