AMERICAN INTELLIGENCE.

ORIGINAL COMMUNICATIONS.

A Case of Strangulated Hernia of the Tunica Vaginalis of rare Variety; Operation; Gangrene; Death. Reported by GURDON BUCK, M. D., Surgeon to New York Hospital, St. Luke's Hospital, &c. &c.

Wm. McNulty, æt. 43, truckman, of robust constitution, residing No. 217 West 16th Street, while handling a heavy case of merchandise, aided by an assistant, had the entire support of it thrown upon him by his assistant giving out. He was conscious at the moment that his strength was taxed beyond its utmost capacity. This happened about three weeks previous to my visit; and two or three days after this occurred a swelling appeared on his right groin, that subsequently showed itself also in the scrotum and involved the right testis. He did not suffer sufficient inconvenience to interrupt his usual occupations. The swelling would partially disappear on lying down. On Sunday, Oct. 16th, at 3 P. M., I visited Mr. McN. at the request of, and in consultation with his attending physician, Dr. Henry McClain, and found that on the Friday preceding, while at his work, McNulty was suddenly seized with severe colic pains soon accompanied with vomiting which obliged him to give up, and which have both persisted to the present time. He has had no fecal evacuation since his seizure, though laxative enemata and other means have been resorted to. . . The vomited matter is represented as stercoraceous and stains his linen greenish yellow. The abdominal pain, which is very severe, is referred to the umbilical region. The belly is supple and but little distended. The countenance is calm, the pulse 82, and the respiration tranquil. The right testis hangs low in the scrotum, is more than double the size of its fellow; it retains its flattened, elongated form, and is of firm, solid consistence. The scrotum in contact with it is reddened and somewhat adherent to its anterior surface. From the upper part of the testis, the cord can be traced up to, and into the inguinal canal, and is of the size of the little finger, firm and cylindrical in form. The whole appearance was that of orchitis; the testis being also tender and painful under pressure. Besides the scrotal tumour, there was another distinct, well-defined, and rather prominent swelling over the inguinal canal and external abdominal ring. The skin covering it was unchanged in colour and supple. The subjacent parts constituting the swelling were supple and movable on each other, and nothing could be felt of a firm resisting character such as a strangulated hernial tumour would present.

The coincidence of what appeared to be orchitis with marked symptoms of strangulated intestine, and the equivocal condition of a second tumour in the groin occupying the ordinary situation of an inguinal hernia as it emerges from the abdominal ring, were conditions exceedingly perplexing in reference to diagnosis. The scrotal tumour itself isolated from the inguinal tumour by the intervening cord, appeared to have no connection with the hernia, and yet regarded as a coincident orchitis its origin lacked a

satisfactory explanation. It was, however, decided in view of the unequivocal symptoms of intestinal strangulation to perform an explorative operation notwithstanding the inguinal swelling itself presented nothing that could be regarded as incarcerated bowel. An incision was made over the inguinal swelling, commencing a short distance above it, and continuing downward and inward over the course of the inguinal canal a distance of about three inches. The subcutaneous tissues were successively divided, and the external ring exposed spanning and tightly constricting the parts emerging from it. Guided by the forefinger nail insinuated under the edge of the ring, Cooper's Hernia Bistoury was passed up into the inguinal canal, and divided the constriction. Other constricting bands situated higher up were also divided and the finger carried on beyond the internal ring, but without arriving in the open peritoneal cavity. The enlarged cord could be traced up to the abdominal cavity, but no strangulated intestine could be distinguished. Attention was now directed to the parts constituting the inguinal swelling. A sac appearing to cover and inclose these parts, an attempt was made to open and follow up its continuity into the peritoneal cavity above. Successive delicate layers were divided and fatty masses agglomerated together and resembling omentum were exposed, but no cavity could be distinguished. In this very perplexing state of things, Professor H. B. Sands was sent for and joined our consultation. After a critical examination of the parts Dr. Sands also shared our perplexity. Directing our attention again more particularly to the enlarged cord, a feeling of elasticity was observed which determined us to puncture its sheath. A director was then inserted through the puncture, and passed readily upward within the sheath, and arrived in the open wound high up. Dividing the sheath upon the director, to our great surprise, we found it inclosing a portion of intestine. Continuing the division of the sheath downward to the scrotal tumour, we exposed a noose of small intestine occupying the cavity of the tunica vaginalis, and lying in contact with the testis which was of normal size and condition. Withdrawing the incarcerated noose, a well-defined gangrenous spot of a grayish-brown colour, and of the size of a copper cent piece was found occupying the convex surface of the gut where it was doubled upon itself. The seat of strangulation had evidently been at the junction of the tubular sheath of the cord with the sac proper of the tunica vaginalis. Following the track of the open sheath upward, the finger arrived in the cavity of the peritoneum where it now moved freely in every direction. The hernia was now reduced with its gangrenous portion left out at the external ring, where it was secured by four opposite sutures inserted through the sound intestine above the line of demarcation bordering the slough and the corresponding edges of the wound. The gangrenous part was laid open to allow a free escape of the fecal contents of the bowel. Warm flaxseed poultices were directed to be applied to the abdomen, and special attention to cleanliness was enjoined. A pill of one grain of opium was ordered to be administered every two hours.

Oct. 17, nine o'clock A. M., patient comfortable; had vomited only once; pulse 76, soft.

18th. At 12 o'clock patient is progressing favourably; pulse 68, full and soft; complains of flatulency. A free discharge of fecal fluid is taking place from the groin. None from the anus. Suspend opium and give per anum an enema of infusion of catnip; apply cakes of oakum wrung out in hot water to the groin, and renew them every two hours.

19th. Patient continued comfortable as above reported till 4 o'clock this morning, when a change for the worse took place. He was seized with a chill, and acute abdominal pain and vomiting. His pulse rose to 120 and over, and became very small. The abdomen became tumid, and the fecal discharge from the groin ceased. Great restlessness also supervened.

At 11 o'clock in the evening, though quieted and somnolent from the effect of enemata of sol. sulph. morph., his condition is worse; all his bad symptoms persist. His pulse is very weak, his countenance anxious, his hands cold and clammy; in fact he is in a state of collapse—in which, however, he survived till the afternoon of the next day at 6 o'clock when he expired. No post-mortem examination was made.

The very remarkable and rare feature of this case consists in the fact that the knuckle of small intestine, in its descent along the cord into the scrotum, instead of distending the tunica vaginalis immediately after emerging from the external abdominal ring into a sac continuous with the pouch proper that lodges the testis, dilated it only into a tubular canal of uniform calibre throughout its entire length, which resembled very exactly an enlarged spermatic cord, such as is commonly met with in acute epididymitis. Hence the perplexity of the diagnosis. The works of the standard authors on hernia furnish no similar example.

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A Case of Asymmetry of the Two Halves of the Body. By J. C. HUBBARD, M. D., of Ashtabula, Ohio.

Master C. S., a native of this town, nine years of age; height 49½ inches; ordinarily active and intelligent. His father is of "Scotch-Irish" descent, rather under size, a family characteristic. The father inherits from maternal side some of the peculiar Celtic features. The boy's mother is rather above middle size, and has a brother and sister who are unusually tall and stout. Her blood relatives are large-sized people. She presents no marks of Celtic origin. About five months after the birth of this child, his parents noticed that his right hand, foot, and ear were larger than those of the opposite side. My attention was called to his peculiarities before he was a year old. We found the same disproportions existing then as are now presented; the deformity is undoubtedly congenital; there is but little if any difference in the size of the sides of the head, face, and jaws; none in the teeth, mouth, and fauces, excepting the tongue; the right half of this organ is notably longer and thicker, and constitutes rather more than two-thirds of the tip. When it is protruded it curves away to the left as though that half were paralyzed. The right eye, ear, and testicle are the larger. On examining the penis in its flaccid state it appeared symmetrical, but soon erection occurred, and the superiority in size of the right corpus cavernosum was found to be remarkable. The penis curves to the left, so as to present a striking deformity. The right half of the glans constitutes two-thirds of the whole. His gait is limping and very awkward. Active exercise produces undue weariness in the muscles about the right hip. The left hand and foot, aside from their disparity in size, are more delicate in shape than their fellows of the opposite side. The relative length of the forefinger to the stump and of the fingers to each other, the outlines of the wrist and palm, lead me to think that the