ON THE
TREATMENT OF CONGENITAL RUPTURE
AT THE GROIN;

WITH THE DESCRIPTION OF A SIMPLE BANDAGE OR
SUPPORT.

By CHARLES VINES, Esq., M.R.C.S.

ONE of the principal difficulties we have to contend against in the treatment of the ruptures of young children, is the want of tact and perseverance, on the part of the mother or nurse, in returning the bowel whenever it has become displaced, and in keeping the bandage or truss properly adjusted.

With regard to the kind of appliance, I have seldom found steel, wire, or any kind of metallic truss suitable to young children. Trusses of this description are apt to become soiled and stiffened by the discharges, and the young infant can seldom bear the pressure and friction of the instrument. For some years I was in the habit of recommending a skein of wool, one end of which was looped round the thigh, and the other passed round the body, and fastened in the groin of the affected side. I cannot now call to mind the name of the gentleman who suggested this plan, which, in some cases, proved serviceable; but in the majority of the patients who came under my care, some more substantial support than that afforded by the wool was found necessary.

A lady, whose infant suffered from congenital rupture at the groin, and to whom I recommended the skein of wool, contrived a very simple yet efficient bandage to be worn in such cases. It consists of a long narrow loop of the finest flannel, rolled upon itself, with a pad of the same material at one end; attached to the pad are two little tape strings. The whole is represented by the following sketch:—

When worn, the circular end of the loop is passed over the thigh of the affected side, and the opposite, or padded end, is carried round the child's loins and opposite hip, so as to encircle the body. The pad is then fitted upon the seat of rupture, and secured underneath the loop around the thigh by the little tape strings. The mother should be provided with three or four of these little supports, so that every day, if necessary, a clean one can be used. The softness of the material, as well as a moderate degree of elasticity, constitute the advantages of this bandage. At least four cases of congenital rupture, principally occurring in my own practice, have been cured by the use of this ingenious, though simple, contrivance.

Reading, Dec. 1862.

A Mirror
OF THE PRACTICE OF
MEDICINE AND SURGERY
IN THE
HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proœmium.

MIDDLESEX HOSPITAL.

MULTILOCLAR OVARIAN TUMOUR OF TWO YEARS'
DURATION; OVARIOTOMY; RECOVERY.

(Under the care of Dr. PRIESTLEY and Mr. DE MORGAN.)

THE following two cases were reported by Mr. Langford, obstetric assistant:—

C. C.—, aged forty-six, admitted September 23rd, 1862. She is tall and well developed; complexion sallow. Has been a washerwoman for the last eighteen years. Was married at eighteen, and had one child, which died three weeks after

birth. She thinks she was injured during the birth of this child, as she did not get about for six months afterwards. Since then the catamenia have always been regular. About two years ago she felt a pain in the left iliac region, and discovered there a small movable tumour, which gradually enlarged. She avers that the suffering and discomfort constantly increase, and that now she is seldom if ever entirely free from pain. Her nights are frequently restless, and her capacity for exertion gradually diminishes.

On admission, a large ovarian tumour, believed to be of the multilocular form, was found occupying the abdomen, and reaching almost to the epigastrium. Its outline was somewhat irregular; and although mobility was rendered difficult by its size and the distension of the abdomen, it gravitated readily towards either side when the patient was placed in one or other lateral position. There was no evidence of pelvic adhesions.

The circumference on the 18th of October was forty inches and a half, and it steadily but slowly increased.

The operation was performed on the 28th of October by Mr. De Morgan, in a small ward in which she was to remain, and from which the other patients had been removed. The ward was warmed up to 70°, and the atmosphere kept moist with steam. Chloroform was used. She inhaled it quietly; but as soon as the first incision was made, violent straining, like efforts to vomit, came on, and recurred frequently during the operation so as to retard it in some degree. The straining usually ceased when she was brought more completely under the influence of the chloroform. An incision of four inches in length, and commencing about an inch below the umbilicus, was made through the skin, tendon, and fascia, when the peritoneum was protruded under the straining efforts by fluid contained in its sac. There was no bleeding. The peritoneum was then opened, and a large quantity of dark-coloured ascitic fluid allowed to escape. On introducing the hand no adhesions could be found. The tumour was now tapped with Mr. Spencer Wells's double canula trocar; but only about an ounce of thick curdly stuff escaped. The trocar was then pushed through a deeper cyst-wall; but with no result. As the tumour was not diminished in size by these punctures, and was too large to pass, the incision was enlarged to about an inch above the umbilicus, and the tumour was partly drawn, partly forced by the straining, through the opening, a portion of the bowels being at the same time protruded. This was at once covered with hot flannels. There was no adhesion. The pedicle was short, but not very thick. As the bulk of the tumour and the shortness of the pedicle did not allow their point of connexion to be seen, and some loops of intestine were protruded in the neighbourhood, an attempt was made to lessen the size of the cyst by making a free incision through it; but it was found to be made up of clusters of small cysts, from which very little fluid escaped, and no diminution of size ensued. The clamp was, therefore, very carefully applied to ensure the absence of any part of the gut, and the tumour was cut away. There was not any hæmorrhage into the peritoneal cavity, nor any escape of the contents of the cysts into it. Some of the peritoneal fluid was removed by means of sponges; but some remained behind. The opposite ovary (the left) was found to be quite healthy, as was also the uterus. The edges of the wound were brought together by silver sutures placed about half an inch from one another, and included half an inch of peritoneum on each side, the pedicle held by the clamp being left outside the wound. When the patient was cleaned and dried, a large casing of doe-skin, spread with soap plaster, which extended from the middle of the chest to the hips, was placed beneath her. This case came up on either side so far as to leave about six inches of the front of the abdomen exposed. Bands of broad elastic were fastened to one edge, and buckles to the opposite edge, so that an elastic support could be maintained and regulated over any part of the abdomen. A large linseed-meal poultice, covered with cotton-wool, was applied over the whole abdomen, and the straps buckled over it. She was then placed in bed, and wrapped in blankets. The temperature of the room was maintained to about 65°. The pulse, after the operation, was 100 to 104, irregular, small, and weak; but it soon gained more power, and became fuller. Three hours afterwards she complained of great pain throughout the abdomen; the pulse 96, small and irregular. She was ordered ten grains of compound soap pill.

She passed a good night, and was free from pain next day. She took arrowroot and milk-and-water during the night, and was free from sickness, though complaining sometimes of nausea. In the evening she again had pain, which was relieved by opium. On the whole, she had a quiet night, though not without occasional pain, as she thought from flatulence.