

PART III.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—SIR THORNLEY STOKER, M.D., F.R.C.S.I.
General Secretary—JAMES CRAIG, M.D., F.R.C.P.I.

SECTION OF SURGERY.

President—ARTHUR CHANCE, P.R.C.S.I.
Sectional Secretary—EDWARD H. TAYLOR, M.D., F.R.C.S.I.

Friday, December 2, 1904.

THE PRESIDENT in the Chair.

Exhibits.

MR. R. C. B. MAUNSELL exhibited a child after operation for spina bifida, also the meningocele which he had removed.

MR. KENNEDY exhibited (a) an infant operated on for intussusception; and (b) a child treated for hydrocephalus by repeated lumbar puncture.

MR. BLAYNEY exhibited a Gasserian ganglion removed for epileptiform neuralgia.

MR. W. TAYLOR exhibited (a) a gall-bladder removed for gangrenous cholecystitis; and (b) a hydronephrotic kidney.

A New Method of Procedure for the Radical Cure of Inguinal and Femoral Herniæ.

MR. EDWARD H. TAYLOR read a paper so entitled, and illustrated its various stages by means of lantern slides. Having introduced the subject by some general remarks concerning the anatomy of the inguinal canal and the aims of herniotomy, he proceeded to explain his method of operation. With the patient

in the Trendelenberg position, a vertical incision about four inches in length is made midway between the middle line and the outer border of the rectus muscle, in its lower part. The superficial tissues and the rectus sheath having been divided, the outer lip of the divided sheath is raised and the corresponding border of the muscle is defined and drawn inwards. The transversalis fascia is then divided and the extraperitoneal fat exposed. The next step consists in fully retracting the outer margin of the wound towards Poupart's ligament, and identifying the neck of the hernia. By seizing the parietal peritoneum close up to the internal abdominal ring with the finger and thumb, the sac is drawn up to some extent out of the inguinal canal and opened, after which a finger is introduced into its interior to act as a guide while it is being separated from the structures of the cord. A ligature or purse-string suture is then applied to the neck of the sac, and the fundus is cut away. The inguinal canal and the two rings are now explored by the finger, the structures of the cord are identified, and the deep epigastric vessels are held aside. By means of special needles in handles—modifications of the ordinary aneurysm needle with a slot at one side opening into the eye—a series of silk sutures (No. 6 size) are passed so as to connect the conjoined tendon and the transversalis muscle with Poupart's ligament, just enough space being left to allow the structures of the cord to pass without being unduly compressed. The rectus muscle now resumes its normal position, but for greater security its outer border is connected to the deep aspect of the transversalis muscle by a few interrupted sutures. Finally, the rectus sheath is closed in front by interrupted sutures also, and the skin margins are approximated by a continuous subcuticular suture of silkworm-gut. Should the external abdominal ring be unduly patulous it may be readily exposed before closing the wound by drawing aside or reflecting the overlying tissues, and its dimensions may be reduced by one or two sutures. In the case of femoral hernia the steps of the operation corresponded to the above up to the point at which the femoral ring is exposed. The sac is isolated as already described, ligatured at its neck, and its fundus is cut away. The closure of the femoral ring is then effected. Two sutures generally suffice for this purpose. Each passes through the conjoined tendon and Poupart's ligament in front, beneath Cooper's ligament behind. In some cases it is advisable to pass them through two holes previously drilled in the pubic bone. Mr. Taylor pointed out that a somewhat similar

method for occluding the femoral ring had been described by Mr. Mayo Robson in the "Year-Book of Treatment" (1904), but, nevertheless, it differed from his in certain important particulars.

MR. JAMESON-JOHNSTON expressed himself in favour of Bassini's operation, as he considered it the simplest, most scientific, and the easiest. He regarded the objection to dividing the aponeurosis of the external oblique in this operation as more or less theoretical. Mr. Taylor's operation would probably be a good one in old herniæ, in which the internal abdominal ring approached the middle line.

MR. T. E. GORDON considered there was no one method of operation for hernia. Mr. Taylor's method was not suitable in the case of a congenital hernia in a young child. He believed that many of the operations practised were hopeful as regarded ultimate success. The essential thing in these operations was asepsis.

SIR THOMAS MYLES referred to the valve-like nature of the inguinal canal. So long as its anterior and posterior walls remained in contact and the muscles are sufficiently tense a hernia was unable to push these walls apart. He thought there was a hereditary predisposition to hernia. The valve-like closure of the canal, due to muscular action, was essential, and that being so, no amount of suturing of the conjoined tendon to Poupart's ligament would provide an obstacle to recurrence, because sufficient space had to be left to permit the cord to pass.

MR. BLAYNEY was of opinion that the weakness of the abdominal wall in the inguinal region was for a special purpose—viz., to allow the thin fascia transversalis to be pushed against the external oblique when the intra-abdominal pressure was increased.

MR. TAYLOR, in reply, stated that he believed his method of operation was best suited for large, well-developed inguinal herniæ, in which the inguinal canal had undergone marked changes in size and direction. As bearing upon the success of the procedure he thought it of importance to mention that the sutures in the conjoined tendon should not be tied too tightly, and that the parts should be kept at rest for a sufficient time afterwards to permit of healing taking place. Patients were frequently allowed to get about too soon after herniotomy; absolute rest for at least a fortnight was desirable. As to the mode of development of an inguinal hernia, he thought it probable that there was in many instances a degree of congenital

weakness at the internal abdominal ring, in consequence of which the latter went on increasing in size. There was such a thing as a hernial type of abdomen, and it was in such cases that weakness or dilatation at the internal abdominal ring was most likely to be found. Upon the hernia commencing to develop, the conjoined tendon and the fascia transversalis yielded more and more, and the inguinal passage became progressively larger and less oblique in its direction.

Acute Intestinal Obstruction from a Gall-Stone.

MR. T. E. GORDON read an account of the following case :—The patient, aged seventy-three, had an attack of biliary colic in February, 1904, and she did not recover fully from this for two months. On August 6th she was seized with intense pain in the liver region, and this was followed by complete obstruction of the bowels. Three stages in the course of the illness were clearly defined : (1) A stage of onset lasting from August 6th to August 7th, marked by intense epigastric pain and vomiting, but without fever ; (2) a stage of quiescence lasting until August 9th ; (3) a stage with unequivocal signs of intestinal obstruction. The operation was performed by Mr. Gordon on August 11th. A gall-stone was found firmly impacted in the upper part of the jejunum. After the operation all vomiting ceased, and the patient was able to leave her bed in about a fortnight. Mr. Gordon, in attempting to interpret the clinical signs, said he thought it probable that impaction did not occur prior to the third stage. It was difficult to understand why a stone of such small size should cause intestinal obstruction. Spasm was obviously an important factor.

MR. W. TAYLOR stated that he had seen the patient a few days before Mr. Gordon performed the operation, and on the day before he left town for his holiday. She was then under the influence of opium. He thought that at that time the gall-stone made its exit from the bile passages. At the same time, however, he had not overlooked the possibility of intestinal obstruction. He would like to know if any reasonable explanation could be offered why a calculus of this size should become impacted.

SIR THOMAS MYLES alluded to a case in which he had removed a large impacted gall-stone fifteen years ago. He thought it likely that the impaction in the present case was due to the opium administered, the muscular tissue of the bowel being paralysed. He would advise in such cases that the incision into

the intestine be made not directly over the gall-stone, but on the proximal side, as otherwise one cut through infiltrated and devitalised tissues.

MR. JAMESON-JOHNSTON inquired as to the amount of distension present and the condition of the bowel at the site of impaction. Mr. Gordon alluded to spasm, but he did not think spasm could exist under the conditions present—viz., inflammatory infiltration and œdema of the bowel wall.

MR. BLAYNEY thought the impaction of the gall-stone in the present case might be due to its rough exterior, by which the mucous membrane of the intestine was irritated and abraded, thus permitting micro-organisms to act. This resulted in œdema of the sub-mucous tissue which extended inwards rather than outwards. He believed the impaction was due more to inflammatory œdema than to spasm.

MR. GORDON, in reply, said he thought some of the suggestions which had been made as to the cause of the impaction were correct, but he himself had none to offer. The abdominal distension was not very great. He made the parietal incision above the umbilicus, because the early pain complained of was referred to the upper part of the abdomen.

SECTION OF PATHOLOGY.

President—H. C. EARL, M.D., F.R.C.P.I.

Sectional Secretary—A. H. WHITE, F.R.C.S.I.

Friday, January 6, 1905.

THE PRESIDENT in the Chair.

Anæmic Infarction of Liver.

PROFESSOR O'SULLIVAN, for Dr. Roy Dobbin, showed specimens from a case of extensive anæmic infarction of the liver. The case was one of puerperal eclampsia, with jaundice. A large gall-stone was impacted in the upper end of the gall-bladder. The smaller branches of the hepatic artery showed an extensive degeneration of the walls, commencing in the muscle cells of the middle coat, and accompanied by a similar change in the walls of groups of capillaries in the neighbourhood of the branches of the artery. The degenerated material took on Weigert's fibrin stain deeply, and gave none of the amyloid reactions. Hyaline thrombi