

enemata were given. On the eleventh day after operation the wound was re-packed gently; no fresh bleeding was taking place. That evening he had another severe arterial hæmorrhage from the wound which could be controlled by firm pressure over it. An anæsthetic was given; the wound was enlarged and the peritoneum was peeled up, but the hæmorrhage was so free that search for the bleeding point was impossible. It was controlled by pressure over gauze packing, whilst through a vertical incision, splitting the right rectus with the patient in the Trendelenburg position, the external iliac artery was ligatured transperitoneally just below its origin. There was no sign of a vermiform appendix on hasty examination. The vertical wound was closed with sutures and the old wound was explored. The severe hæmorrhage had ceased, but there was a little pumping from the distal part of a ragged sloughing portion of the external iliac artery which opened up the lumen of the vessel for about one and a quarter inches. A silk ligature around this distal part controlled the bleeding. The cavity was wiped with pure carbolic acid and packed with gauze. The pulse was 136, very small, and soft after the operation. The foot of the bed was elevated, the limbs were bandaged over wool, and normal saline enemata, six ounces, with liquid peptonoids and a little brandy, were given every two hours. A hypodermic injection of 5 minims of liquor strychniæ every three hours was ordered later, as his pulse appeared to be weaker. He gradually improved after this, though very anæmic. The vertical incision healed by first intention; the oblique one healed gradually and not completely till the silk ligature (placed distally to the ulcerated portion of the artery) came away on Nov. 14th. He was discharged convalescent about a month later.

Tasmania.

#### NOTES ON A CASE OF STRANGULATED LEFT DUODENAL (RETROPERITONEAL) HERNIA SUCCESSFULLY RELIEVED BY OPERATION.

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THE notes of this somewhat interesting case are as follows.

I first saw the case at 3 A.M. on July 15th, 1902, with Mr. J. A. Marsden of Lightcliffe. The patient was a finely built young fellow, aged 26 years, some six feet in height and very muscular. He had been playing in a cricket match on the 12th, and in the evening he had had a very hearty supper of beefsteak and peas. In the early morning of the 13th he was awakened by severe pain across the abdomen, vomiting following, and he could not get any action of his bowels. Mr. Marsden had attended him for a similar attack in the early part of April, 1902, and relief had been obtained by calomel; the patient had also had an attack in the beginning of the same year when the bowels had refused to act for two days. Neither of these attacks was so severe as the present one, the pain and vomiting being much more severe. The pain was very intense, became worse at intervals, and was only partially relieved by morphia. At 3 A.M., when I saw him, he was pretty deeply under the influence of morphia and complained even then of the pain coming on in spasms. He had passed neither flatus nor fæces since the 13th; the vomit had no fæcal smell, but was darkish brown in colour such as often precedes stercoraceous vomiting; the pulse was good and not quickened. The abdomen was moderately distended all over, but there seemed occasionally to be a more pronounced distension localised to an area in the middle of the abdomen and this localised distension and some peristalsis were more marked when the attacks of pain came on as if the distension and pain were due to local spasm of the intestine. The abdominal wall was somewhat rigid, but there was no marked abdominal tenderness. The temperature was normal; enemata had been given without effect. A diagnosis of probable intestinal obstruction was made and it was decided that if he were no better in a few hours operation should be strongly recommended. He was seen again about noon on the 15th. Turpentine and castor oil enemata had been given without avail and the last vomit was distinctly fæcal. Laparotomy was recommended and agreed to, no decision being come to as to the cause of the obstruction.

The abdomen was opened on the same afternoon and before opening it the localised distension before mentioned was more distinctly marked owing to relaxation of the abdominal muscles by the anæsthetic. This distension covered an oval area some seven or eight inches long by four or five broad; the long axis of the oval was placed somewhat obliquely from right to left across the middle line, the upper pole being to the right of the middle line below the liver. On opening the abdomen and pulling aside the omentum the small intestine was seen to be moving behind the mesentery and a diagnosis of retroperitoneal hernia was made. The opening of the hernial sac could not be felt, so the incision was enlarged upwards when it was found that a good portion of the small intestine was contained in a sac behind the mesentery; the mouth of the sac looked obliquely upwards and to the right with a slight forward inclination, the anterior and lower margin being thickened and arched. The finger was passed inside the sac and about a yard of intestine was withdrawn; the abdomen was then sewn up. The patient progressed without a single bad symptom and the stitches were removed on the twelfth day, but on the thirteenth day after a severe sneeze the patient felt something give way and on removing the dressing it was seen that the skin wound had been torn open except the upper two inches of the incision, the muscles being exposed. Chloroform was given and the wound was sewn together with a curved Hagedorn needle. Some suppuration took place and about a week later the patient complained of occasionally feeling what he described as a "puffer" going off under the dressings; two or three days later it was discovered that there was a small intestinal fistula which discharged wind and a small quantity of bile-stained fluid at intervals. Whether this was caused by the needle in the second sewing having perforated the small intestine or not I cannot say, but this seems the most likely explanation. The patient is now in good health and has had no further attacks of pain.

With regard to the diagnosis of the condition before operation I think a fairly accurate diagnosis might have been made had the condition of retroperitoneal hernia been borne in mind; to assist the diagnosis there were the history of two previous attacks of partial obstruction, the presence of a more or less central tumour, and the paroxysmal character of the pain; these would certainly suggest retroperitoneal hernia as the cause of the obstruction. Another point to which I should like to draw attention is the exact cause of the obstruction in these herniæ. Treves<sup>1</sup> says that when strangulation occurs it is always produced by the margins of the orifice of the sac. In this case it was not the orifice of the sac which was causing the strangulation, for the finger and thumb were introduced without much difficulty into the orifice and the intestine was fairly easily withdrawn, nor were there any marks of strangulation on the bowel. That the obstruction was due to volvulus or twisting of the bowel admits of no doubt. The sac in retroperitoneal hernia is a congenital condition and probably always contains more or less intestine; should the amount of intestine in the sac become increased and distended or should the intestine usually contained in the sac become more distended from some indiscretion in diet increased peristalsis occurs and twisting may easily take place leading to obstruction. Knaggs<sup>2</sup> has drawn attention to the occurrence of volvulus in hernia as a factor in causing obstruction and Moynihan<sup>3</sup> mentions that volvulus has been found in retroperitoneal herniæ. As the inferior mesenteric vein lies in the neck of the sac one would hesitate to cut the margin and for the same reason I did not make any attempt to close or to obliterate the mouth of the sac. Lastly, there is the question of nomenclature. Treves<sup>4</sup> gives some seven names for this hernia and too many names lead to confusion. It would be a gain if these herniæ clinically were called right and left duodenal hernia, leaving to the anatomists any discussion as to the exact fossa which forms the sac of the hernia. Moynihan<sup>5</sup> says the left duodenal hernia is in the fossa of Landzert and not in the fossa duodeno-jejunalis. However this may be, I think it would be a distinct advantage if the terms right and left duodenal hernia were applied to these cases. The left duodenal herniæ are much more common than the right duodenal herniæ.

Halifax.

<sup>1</sup> Intestinal Obstruction, p. 111.

<sup>2</sup> On Volvulus in Association with Hernia, *Annals of Surgery*, April, 1900.

<sup>3</sup> Retroperitoneal Hernia.

<sup>4</sup> Op. cit.

<sup>5</sup> Op. cit.

# A Mirror

OF

## HOSPITAL PRACTICE, BRITISH AND FOREIGN.

*Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.*—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

### HOSPITAL FOR SICK CHILDREN, GREAT ORMOND-STREET.

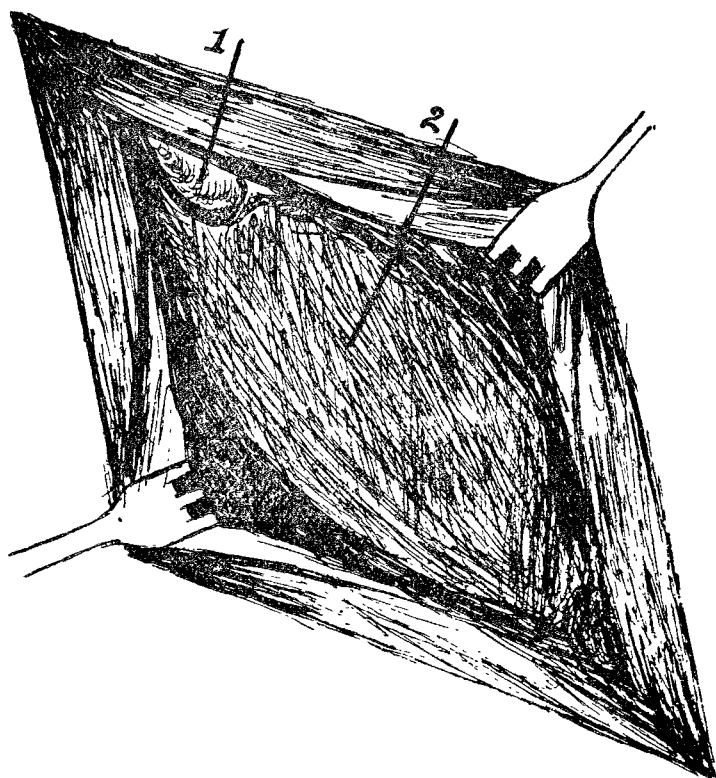
A CASE OF DOUBLE CONGENITAL HERNIA, WITH HERNIA OF THE BLADDER ON THE RIGHT SIDE AND HERNIA OF THE CÆCUM AND APPENDIX ON THE LEFT SIDE.

(Under the care of Mr. H. STANSFIELD COLLIER.)

FOR the notes of the case we are indebted to Dr. H. Y. Taylor, late house surgeon.

The patient, a boy, aged two years, fat and healthy-looking, was admitted to the Hospital for Sick Children, Great Ormond-street, for "double rupture." The following is a brief history of the case. There was no evidence of hernia at birth. A swelling in the left groin was first noticed when the child was six weeks old. The swelling was then of the size of a marble but gradually increased in size and at the end of a month it reached to the scrotum. At the age of five months a similar swelling appeared in the right groin and gradually increased in size until it reached to the scrotum. Various forms of trusses were applied by the medical attendant but were of little use. Between the age of six and eighteen months the child had occasional attacks of "colic" lasting for four or five hours. On these occasions the scrotum became more distended and tender to touch. The herniæ had never been irreducible and there had

FIG. 1.



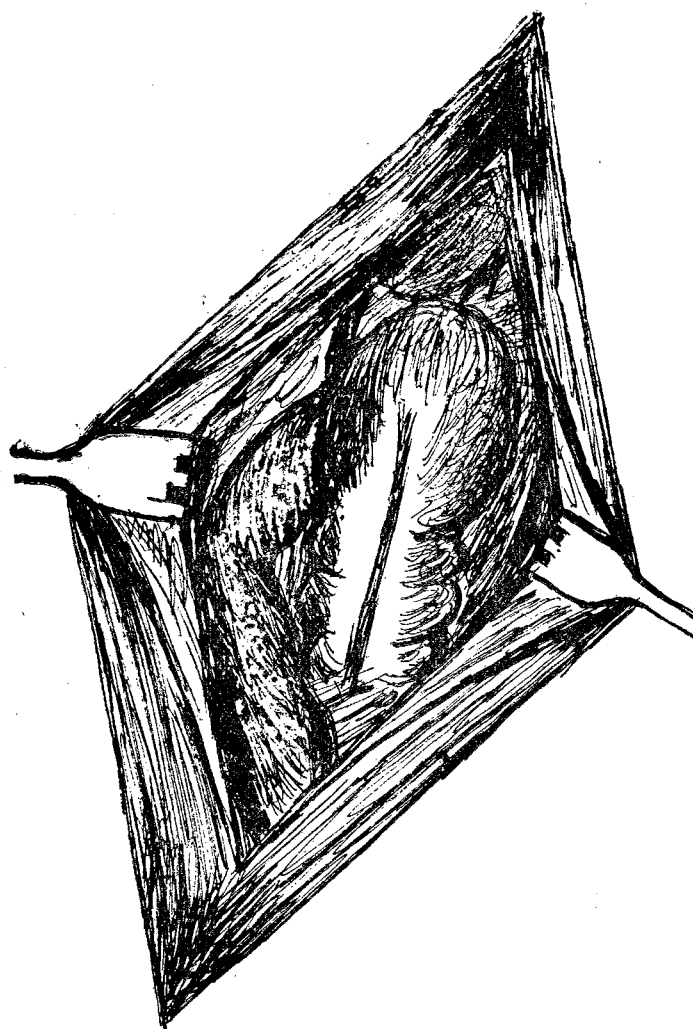
1, Bladder. 2, Sac and contents.

been little or no constipation. There had been no difficulty in passing urine nor had anything abnormal been noticed in regard to micturition. On admission the child was found to have a very large double hernia filling up the inguinal canal and scrotum on each side. Both herniæ were easily reducible. There was a slight phimosis but urine was passed readily enough. The bowels were regular and the general health was excellent.

At Mr. Collier's request Dr. Taylor operated on the right-sided hernia. It was found to be a congenital hernia, the sac containing small intestine. The sac was dissected out and the contained bowel pushed up into the abdomen. There was difficulty in separating the sac from the surrounding tissues, as the former was very thin and tore readily. There was then found to be an apparent thickening of the sac at its upper end extending from the neck of the sac for three-quarters of an inch along its inner aspect. On examination this proved to be due to a para-peritoneal hernia of a portion of the bladder (Fig. 1). This was not closely adherent to the sac and was easily loosened from the tissues in which it was lying and pushed gently back into the abdomen. The sac was then ligatured, the pillars of the ring were brought together by silkworm gut stitches, and the operation was completed in the ordinary way. The child made a straightforward recovery. It is important to note that there had been nothing in the history of the case or in the local condition to lead one to suspect before operating that there was a hernia of the bladder.

Three weeks after the first operation Mr. Collier operated on the left-sided hernia. The sac was exposed and opened and the contents were found to consist of cæcum, appendix, an inch of ascending colon, and two inches of ileum (Fig. 2). The appendix was

FIG. 2.



Sac laid open showing contents.

quite healthy and two inches long. The contents were pushed back into the abdomen, the sac was ligatured, and the operation was completed. Recovery was straightforward. Two weeks afterwards circumcision was performed and a week later the boy was discharged well.

### WATTON COTTAGE HOSPITAL.

A CASE OF CHRONIC ULCERATION OF THE STOMACH COMPLICATED BY HAIR-BALL.

(Under the care of Dr. H. MALLINS.)

A WOMAN, aged 22 years, was admitted into the Watton Cottage Hospital on April 12th, 1902, suffering from gastric symptoms. With regard to her previous history the patient,