

up and the method of treatment placed upon a clearly defined basis. I believe that the matter contained in this paper, and the conclusions deduced therefrom, may contribute to this end.

DR. JOHN B. JOHNSON, of St. Louis, in discussing the paper, said that he had in mind a number of cases where the tubercular process was hastened or aggravated by the cure of the fistula in ano, and that the tuberculosis was not a local disease, but affected the follicles of the mucous surface of the digestive tract. He considered operation not justifiable in advanced phthisis.

DR. J. McF. GASTON, of Atlanta, thought there was no doubt about the salutary effect of operative treatment.

SOME OF THE COMPLICATIONS OF STRANGULATED HERNIA.¹

BY R. HARVEY REED, M.D.,

OF MANSFIELD, OHIO.

I will not presume on the intelligence of the members of this Association by unnecessarily occupying time in giving the history, anatomy, or even a description of this comparatively common operation, which is doubtless familiar to us all. There are few cities in America at this time, that have not one or more surgeons who can show a record of successful operations for strangulated hernia, and who are perfectly familiar with every step in this important operation. Hence I shall confine myself to a report of some of those complications which may arise in the path of any surgeon who seeks to relieve his patients of this dreaded malady by operative interference, as illustrated by a few cases that have come under my notice.

C. S., æt. 30, a vigorous, strong, muscular stone-mason. I was called in consultation with a physician of one of our neighboring towns on April 16, 1885, and found that about nine years previous to this attack, a hydrocele had made its appearance on the right side, which had subsequently been tapped and temporarily relieved. About the time the hydrocele made its appearance the right testicle was observed to be enlarging; this continued for some time, until it became more than twice its natural size, and remained so from that time on. On examination, it was found to be hard and of a fibrous character, was not painful, was adherent to the surrounding structures, and was to a great extent immovable, either voluntarily or otherwise. On further examination, he was found to have a large hydrocele on the right side, and a strangulated complete inguinal hernia.

Neither the patient or the attending physician had any knowledge of the existence of a hernia prior to his present illness, nor, in fact, then, until he commenced stercoraceous vomiting some ten or twelve hours before. After a fruitless attempt at reducing the hernia, I tapped the hydrocele and drew off over a pint of water, after which the hernia was reduced

by taxis, dressed with a spica of the groin, and the patient was given an anodyne, and rest in the recumbent position enjoined.

Very much to our surprise, we were informed the next day that the patient was no better, but, on the contrary, was still vomiting fecal matter, and gradually getting worse, owing to which they desired me to come and see him. Being so engaged as to make such a visit impossible at the time, I requested my friend, Dr. J. Harvey Craig, to go in my place. He found the hernia down, returned it without much trouble, and dressed it as before.

On the third day the same message was repeated, and we were again requested to visit him. By this time the case had become unusually interesting, and, in company with Drs. J. W. and J. Harvey Craig, I again visited the patient and held a consultation with his attending physician, only to find the same apparent condition as had previously been existing. We again reduced the hernia, and advised the attending physician to be vigilant in keeping it reduced, by carefully watching the compress and bandages, in the belief that that would give him the desired relief. Such was not the case; for the vomiting did not abate in the least, and on the fourth day the same message was repeated as before. Accompanied by Drs. Craig, Sr. and Jr., I again visited the patient and found the hernia protruding as before, which, owing to his incessant vomiting and straining, made it almost impossible to keep reduced. After a careful examination, it was agreed that some concealed difficulty of the bowel existed, and that an operation to discover and relieve it was in order.

Dr. J. W. Craig being the senior surgeon, performed the operation. The incision was made along the line of the inguinal canal, from Poupart's ligament to the internal ring, and the parts carefully dissected up until the inguinal canal was exposed, but no strangulation was found. The finger could be easily passed into the abdominal cavity through the internal ring, but no constriction could be found; the opening was enlarged sufficiently to admit of a careful examination of the condition of the small intestines, which were found normal. On further examination, however, it was discovered that the ascending colon had been dragged down further than usual, until the lower end of the vermiform appendix had escaped through the opening of the femoral ring and become strangulated at a point where it passed Gimbernot's ligament. When released it was found to be swollen to the size of a man's thumb, and very much discolored; so much so as to raise the question as to the propriety of removing it. But the gradual return of its natural color soon settled that question, and it was replaced in the abdominal cavity, and the wound carefully cleansed and closed. The operation was conducted and the wound dressed under antiseptic principles. The wound healed rapidly, and the patient made a perfect recovery without a single bad symptom, and returned to his usual occupation feeling as well as ever, excepting as to the hydrocele and the enlarged testicle, the former having been tapped twice since the operation, the last time being since the preparation of this report had been begun.

¹ Read in the Section on Surgery at the Thirtieth Annual Meeting of the American Medical Association.

It will be observed, the complications in this case were: 1, a hydrocele; 2, an enlarged and adherent testicle; 3, an obscure femoral hernia, consisting in the escape of the vermiform appendix with strangulation of the same, accompanied with all the symptoms of complete obstruction of the bowel, which, not being observable externally, was rendered doubly obscure by the existence of a complete inguinal hernia, which was supposed to be the source of all the trouble. Having had the continued symptoms of strangulation for four days, notwithstanding the inguinal hernia was reducible, and no other tumor was visible, we were confident of the existence of an obstruction of some character existing in the bowel, and felt that we were justified in laying open the inguinal canal and searching for the obstruction and removing it if possible.

In vol. i, page 490, Professor Agnew says in his "Surgery": "Should symptoms of strangulation be present without any visible tumor, and there be grounds to suspect the existence of a concealed, or an incomplete inguinal hernia, the surgeon should have no hesitation in laying open the canal in order to verify or to disprove its existence."

It was my fortune to witness an operation, by our honorable chairman, for strangulated hernia, on March 30, 1885, in the Milwaukee Hospital, a full report of which Dr. Senn has kindly furnished me for this paper:

Mr. W., æt. 35, a business man, had an old inguinal hernia which had been repeatedly strangulated, and reduced by various surgeons. For twelve years the omentum has been adherent to the entire surface of the sac. The patient was etherized, and the parts cleansed with a 5 per cent. solution of carbolic acid. A vertical incision was made, extending the length of the tumor and down to the sac, which was opened, exposing the omentum. The omentum being torn from the adherent surfaces, which included the right spermatic cord, necessitated the removal of the right testicle. After the cord was tied and cut, the omentum was ligated with a catgut ligature, which was passed through the tissue, then cut, making a double ligature transfixing the stump. The omentum was then cut off, the stump sutured with catgut to the edges of the internal ring, and the hernial sac dissected out. The parts were trimmed off, leaving enough to cover the stump, and sewed together with fine catgut. The external wound was then closed by sutures, a drainage-tube introduced into the scrotum, a full Lister dressing applied, and the patient kept at rest in bed. With the exception of a slight pain in the cord, a small rise of temperature for the two following days, the patient experienced no discomfort, and was discharged from the hospital on the 20th of April, just three weeks after the operation, perfectly well.

In this interesting case, it will be observed, there was both escape of the omentum and intestine, with marked adhesions of the former, involving the cord and necessitating the removal of the testicle, and protruding parts of the omentum, producing complications of a complex character.

In 1878 I was called, in company with a colleague,

to operate a young man who had a congenital scrotal hernia, which had become strangulated. The young man was about 21 years of age. Previous to this had enjoyed good health, and, with the exception of a congenital hernia for which he had never worn a truss, was a strong, muscular fellow, and used to "roughing it." The ordinary operation for strangulated hernia was performed, the patient making the usual progress in his recovery, with but slight trouble. But, notwithstanding our repeated instructions as to care and diet, he had several relapses after convalescence had set in, by eating bologna sausages, pretzels and cheese, drinking beer, and finally attempting to wheel brick on a wheelbarrow, before the external wound had closed entirely, and without any other support than that afforded by the compress and bandages, which resulted in tearing open the external wound for an inch or more, and in producing a small perforation of the protruding small intestine, with a discharge of the contents of the bowel externally. I dressed the wound, by thoroughly cleansing it with iodized water, closed the wound of the intestine with a fine silk suture, and after carefully replacing the bowel in the abdominal cavity, closed the external wound with interrupted sutures, and allowed it to heal by granulations; meanwhile keeping it cleansed with iodized water, well drained, enforcing quiet and a rigid diet on the part of the patient. He made a rapid and complete recovery without any further bad symptoms. In this case, the only complication arising in the case came on during convalescence, and was the result of carelessness on the part of the patient and friends.

Similar complications may occur in a country practice, where the surgeon has not the advantage of hospital nurses, and often the inconvenience of poverty to contend with, combined with ignorant and careless nurses, who either fail to realize or neglect to heed the surgeon's advice. While the operation for ordinary strangulated hernia is comparatively a common one, and when performed under ordinary circumstances, before it is too late, the prognosis may be considered quite favorable, yet the chances of complication are always possible, and when they do occur, the urgencies of the moment are generally great and more or less perplexing.

PEMPHIGUS CONJUNCTIVÆ.¹

BY WILLIAM DICKINSON, M.D.,

OF ST. LOUIS, MO.

Mr. White Cooper recorded the first case in England in Vol. I of the "Royal London Ophthalmic Hospital Reports." At that time about twenty cases only had been recorded by Continental writers. Mr. Lang, of London, has recently reported two cases, which are briefly recorded in the *Ophthalmic Review*, December, 1885. Stelwag, in 1870, von Graefe, in 1878, and Steffan, recognized this affection, and have written on the subject. Dr. James A. Campbell, of

¹ Read in the Section on Ophthalmology, Otology and Laryngology at the Thirty-Seventh Annual Meeting of the American Medical Association.