

time, my attention has been principally devoted to the treatment of club feet and other analogous complaints.

It has always been my opinion, that the more the profession was divided and subdivided, and the more individuals devoted their attention to particular branches of it, the greater would be the progress, and the nearer approach to perfection would be made in our knowledge and practice of each branch.

I have above, although very imperfectly, given some of my views on the management of club feet. If they prove to be of use to those of less experience than myself, my object will have been accomplished. They may be thought by some too minute, but the treatment of club feet consists in minutiae. I may be thought egotistical, but it is difficult to relate one's own experience without having that appearance.

#### CASE OF HERNIA STRANGULATED BY THE NECK OF THE SAC.

BY THOMAS H. GAGE, M.D.

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MR. O. F., of Boylston, æt. 52 years; a farmer, and a healthy, vigorous man, had been troubled with an oblique inguinal hernia of the left side for more than thirty years, for which he had worn a truss. The external ring was large and open, and his truss poorly adjusted, so that upon unusual exertion the hernial tumor had often given inconvenience by escaping. He had, however, generally found no difficulty in replacing it himself, only on a few occasions having required the aid of a surgeon. At this time, June 17th, 1854, it was suddenly extruded by laughter at the dinner table. He attempted reduction, as usual, but failing, sent for Dr. Andrews, who had been in attendance some four or five hours when I first saw the case. The patient had then no febrile excitement; his pulse was somewhat accelerated, and the surface of the body was bathed in warm perspiration, attributable, mainly, to anxiety and apprehension. The hernial tumor, which was about the size of a turkey's egg, occupied the usual position of oblique inguinal, descending deeply into the scrotum. It was dull when percussed, and manipulation was unattended with intestinal sounds. The general feeling was that of an irregular, lobulated, non-elastic mass. There was no more local tenderness than might naturally result from the prolonged attempts at taxis; no tenderness of abdomen; and *no local pain*, or suffering, except a sensation of "heavy, dragging weight" at the loins.

Under full influence of sulphuric ether, taxis was renewed, and as the effect upon the tumor was somewhat peculiar, and important in its reference to diagnosis, I will describe it in full. It was

evident that a considerable portion, almost the whole, could be forced back through the external ring, and this was several times effected, yet as soon as pressure was removed, it re-appeared, suddenly, with something like a spring, so that it was plain that the impediment existed beyond that point, and I supposed it to be at the internal ring, concluding that when the hernia seemed to be returned it was really pushed into the inguinal canal. Yet there was a kind of resilience about the sudden appearance which I could not understand, and which was explained to me by the operation only. This was found necessary, and performed about eight hours after the accident, Drs. Kendall, Andrews and Sawyer assisting. The contents of the sac having been fully exposed by the usual operation, they proved, as had been anticipated, chiefly omental, only a knuckle of ileum as large, perhaps, as an English walnut, occupying the upper and posterior part. Except great venous congestion, the whole mass was healthy. I enlarged the external ring, to facilitate the introduction of the finger, by an incision vertically upward for two or three lines, and then felt for the internal, which proved to be large and free, not constricting the mass at all; but passing my finger still upward and backward, and towards the spine of the ilium, for a distance of at least two inches, a constriction was found at the neck of the peritoneal sac, and so firmly embracing the neck of the hernia that it was with great difficulty the knife, even, could be passed through it, before bringing its edge to bear upon the stricture. The division of this (which was made in a direction upward and outward, towards the crest of the ilium) was followed by a copious discharge of colorless serum, and the contents of the sac were easily returned into the abdominal cavity.

Violent vomiting was caused by the ether, but there was no recurrence of the tumor. I brought the edges of integument carefully together, securing them by sutures and adhesive straps, and overlaying these by lint and cold water compresses. The whole was made firm by a figure-of-eight bandage. Union of nearly the whole wound took place by first intention. There was no subsequent peritoneal irritation, and very little fever of any kind. At the end of three days the patient had Rochelle salts sufficient to gently move his bowels, and for a few days subsequently he had two or three loose stools every day, but no troublesome diarrhoea. At the end of a month he could do some light work, but was then, and has since remained very dependent upon his truss, the tumor escaping quite as easily as before the accident.

This form of strangulated hernia, being the only one in which that serious accident, reduction "*en masse*," is liable to occur, is possessed of great practical interest to the surgeon, and is worthy of very careful study. In the case now reported, had the tumor been smaller, or even had the attempts at reduction been longer

persisted in, I believe that dangerous symptoms might have taken place.

The immediate cause of strangulation in the mouth of the sac is sufficiently obvious. Subjected to frequent distension and stretching as it is, especially in old cases like this, where escape has been a common occurrence, and pressed upon constantly by an irritating truss, the serous and sub-serous arcolar tissues at the point of exit through the internal ring, where they have the least freedom for expansion, become thickened and indurated, entirely losing their elasticity; so that if the amount of escaping abdominal contents be unusually large, or the ordinary hernia become accidentally congested and swollen, strangulation is inevitable. Then of course, when taxis is attempted, if there be no impediment in either natural opening, and none in the canal, the whole force used must be exerted upon the peritoneal attachments around the neck of the sac, and tend directly to separate that membrane from the inner surface of the abdominal walls, thus forcing an artificial lodgment for the sac and its contents between the peritoneum and fascia transversalis. I suppose that in this case it was the elastic yielding of this thickened peritoneum around the orifice of the true sac which permitted a partial and deceptive reduction, and which also caused the *springing* re-appearance when pressure was removed.

A careful study and discrimination of the *nature of the resistance*, when the reduction of hernia is difficult by taxis, is a sufficiently obvious lesson to be derived from this and similar cases. I am inclined to call attention to a single other circumstance in connection with the case. There was *no local pain*, notwithstanding the severe constriction. In a fortnight after Mr. F.'s case came under my notice, I was called into a neighboring town to see a gentleman whom I found very near his death, as was, and had been supposed, from a severe attack of "bilious colic." A strangulated femoral hernia, as large as a walnut, was found in the right groin. *No local symptoms* of any description had called the attention of physician or friends to that vicinity, and the patient died before any surgical remedies could be attempted.

*Worcester, February, 1857.*

#### PERITONITIS FROM PERFORATING ULCER.

BY W. B. CASEY, M.D., MIDDLETOWN, CT.

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ON Friday, January 30th, at 4, P.M., I was requested to meet Dr. Charles Woodward, a highly respectable physician of this place, in consultation upon the following case.

E. A. R., æt. 33, tall and of rather spare habit, dark hair and eyes,