ABSTRACTS FROM CURRENT MEDICAL LITERATURE.

SURGERY.

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Adhesions and Bands as Causes of Severe and Persistent Colics.—Lauenstein narrates 9 cases of this kind on which he has operated; in one of them the operation was repeated successfully after an interval of six months, making a series of ten operations, with one death. The fatal case was from collapse on the day following the operation. The operation was by no means a severe one, but the patient, a man of 52, was feeble.

In all the cases the symptoms had extended over a series of years, all had been treated by several and some by many physicians, and in all, before proceeding to exploratory incision, exhaustive examinations were made by the methods of the physicians and gynecologists.

In most of the cases the procedure was by median incision, followed by systematic exploration of the intestine. Beginning with the cecum, the vermiform appendix was examined, and then the great intestine. Next the small intestine was traced upwards, and then attention given to the stomach, gall-bladder, kidneys, and pelvic organs.

In 3 cases the site of the incision was determined by the existence of special sensitiveness to palpation or the localisation of pain.

In the development of adhesions and bands a part is played by all so-called inflammations in the abdomen. The importance of gall-stones in this connection has already been demonstrated by Riedel (Correspondenzbl. d. a. ArtzL. Verien, v. Thüringen, 1891). Besides this Lauenstein mentions gastric ulcer, the introduction of corrosives into the stomach, the free communication of the female genitals with the abdomen, and finally laparotomies.

Bands are commonly supposed to be derived from the omentum, but the omentum is often unaltered, and the theory is unnecessary. It is reasonable to suppose that they result from traction exerted on adhesions which form between surfaces which are for the time lying in contact.

Positive symptoms are almost wanting. The diagnosis is reached by a careful process of exclusion. The cases are non-febrile in the typical state, but this may of course be altered by the development of an attack of strangulation. Further, to put it shortly, however hopeless the case may seem, and however long the symptoms may have lasted, the subjective symptoms predominate, the whole clinical picture is one rather of severe suffering than that of marasmus.

Regions of special sensitiveness and of special localisation of pain, irregular distension of parts of the bowel may exist, and suggest an explanation of the kind under consideration.—(Langenbeck's Archiv., xlv, Hft. 1.)

The Radical Cure of Hernia. Kocher.—Professor Kocher reports on the results of his operations in the four and a half years up to June, 1891.

Of 94 cases on which late reports were obtainable, recurrence had taken place in 20. This is a higher percentage of failures than in the author's previous series. As explaining this fact, he points out that (1) since the date of his last report he has extended the application of the operation to a much larger number of cases—in fact, practically no case has been considered inoperable. (2) In nine of the cases which relapsed, the operation for radical cure was incompletely carried out (for various reasons). (3) The complete disuse of a pad (on the ground of views advocated by Socin) was, he thinks, made too universally the rule. (4) The period of quietude required of the
patients was entirely too short—viz., seven and a half days only of confinement to bed in the 89 per cent of cases which healed per primam; excluding, that is, the infected and suppurating cases, and those in which, on account of thrombosis, the healing process required a longer time.

Discussing this last condition, Kocher admits, with Macewen, that it is right and desirable that after a radical operation the patient lie six weeks in bed, and do not return to work until after eight weeks, after which his plea of want of room in the hospital, and want of time on the part of the patient, seems of questionable validity, even though he can say that even under these conditions a cure is effected in four-fifths of the cases. The short period is, on his own showing, not of universal applicability. The statement that within the period mentioned by Macewen there is time for a repetition of the operation, is open to two objections—first, that after an operation of the kind has failed it cannot, as a rule, be repeated under the same, or at least the typical conditions; and, secondly, that a second operation always means exposure for a second time to the risks of the operation per se.

Healing per primam, as may be supposed, is a sine qua non of success under Kocher's conditions. Accidents will occur, but the use of a drainage tube to obviate these is not permissible; it means the sacrifice of that early adhesion which is to initiate the process. Out of the author's 94 cases, suppuration occurred 8 times, and in the 5 cases in which suppuration was deep, recurrence took place.

Apart from the necessity for rigid asepsis, the first condition of success is complete removal (=obliteration?) of the hernial sac and its neck, so that not the slightest excavation of the peritoneum shall remain. The second essential is a thorough closing of the hernial canal. Here Kocher is at one with Risel, Czerny, and Lucas-Championniere, and is at variance with Socin. Kocher refers to the analogous case of hernias developing in the laparotomy scar after careful suture of the peritoneum.

As regards Macewen's procedure in the treatment of the sac, Kocher attributes its success, not to the formation of a tampon, but to the immobilising of the peritoneum. Of the second step in that operation, while recognising its value, he maintains that "the inguinal canal is by this means closed in its entire length, which is more important than the restoration of the oblique course of the canal which Macewen emphasised. In this endeavour to close the inguinal canal in its entire length, the spermatic cord is a very great obstacle—not so much in closing the external ring, but in closing the internal opening." The credit of having got over this difficulty belongs to Bassini.

Bassini lays open the inguinal canal in order to free the spermatic cord as high up as the place at which it passes into the abdominal wall. The spermatic cord is then lifted up with a hook, and the posterior wall of the inguinal canal from the internal ring to the pubic bone sewed in such a way that the fascia transversa is united with Poupart's ligament, and with the border of the rectus. The cord is then laid back on the suture line and the cut edges of the fascia of the external oblique again united over it. [No mention here of the conjoined tendon.—Ed.]

"The fascia transversa." (tranversalis), says Kocher, "appears simply as a thickening of the peritoneum. . . . An efficacious closing of the posterior inguinal ring by means of sutures is therefore out of the question. What must restore a true resistance is the firm union of the lower border of the internal oblique and transversalis muscles with Poupart's ligament, and on the other side especially, the tensely stretched fascia of the external oblique."

The most important thing in closing the opening of an inguinal hernia can be accomplished without employing the method of Bassini, in cutting open the canal. The spermatic cord is pushed back, and the sutures beginning deeply in the canal near the internal abdominal ring, are passed through the internal oblique and transversalis with their fasciae, and through the tense separated fibres of the external oblique muscles.

Kocher describes finally a procedure which he has lately adopted, he believes with good results. The skin and superficial fascia are divided over
Passing the forceps and the index columnar fascia and other envelopes are divided, and the sac carefully cleaned and isolated, until it can be strongly drawn down and its pedicle exposed. The index finger of the left hand is now introduced into the inguinal canal, and externally to the posterior inguinal ring a small opening is made through the aponeurosis of the external oblique. A slender pair of artery forceps is passed through this opening, and through the lower muscular fibres of the internal oblique and transversalis muscles, following the index finger as it is withdrawn through the canal and out at the external ring. With these forceps the isolated sac is grasped, and drawn through the canal, and out through the narrow opening in its anterior wall. It is drawn out as much as possible, then energetically twisted and laid down over the situation of the canal and the external ring.

Deep sutures are now applied above the twisted sac, through aponeurosis of the external oblique, fibres of internal oblique and transversalis, through the hernial sac itself, and including the ligament of Poupart beneath.

A modification of the operation has been applied in the case of femoral hernia.

From an incidental remark, we understand that the author considers it essential to success that the sutures be of silk, with a view, it is to be presumed, to their greater persistence; upon which point the remark would seem apposite that there is a fallacy in the use of persistent sutures where these are inserted under a high amount of strain, for just in proportion to the strain the tissues will cut.

The article is a most interesting one—historically, anatomically, and statistically—on the operations at present in use. The author would seem to be convinced of the anatomical reasonableness of the operations of Macewen and Bassini, the former more especially, and he cites with satisfaction the admirable results that they have obtained. That his operation is less complicated than that of Bassini may perhaps be granted; that it is less complicated than Macewen's is by no means obvious. This, however, seems plain, that it is by no means so precise.—(Annals of Surgery, December, 1892.)

Reflexes in Hip-joint Disease. Dr. E. G. Brackett gives, in the Boston Medical and Surgical Journal for 31st March, 1892, the results of an investigation into the state of the knee tendon reflex in cases of hip-joint disease, especially as compared with cases of spinal caries. He finds this test is often a valuable one, particularly in cases where the question is between morbus coxae and spinal caries at a low level—sometimes a difficult question to settle. The nature of the information gained may be gathered from the following table:—

HIP DISEASE (47 Cases).

| Quiet cases, without spasm, 16 | Reflex equal, 15; unequal, 1. |
| " " " with " " 19 | Normal, 11; increased, 5. |
| Irritable cases, with spasm, 12 | Equal, 3; unequal, 16. |
| " " " with " " 13 | Normal, 6; increased, 13. |

SPINAL CARIES (21 Cases).

| Quiet cases, without spasm, 6 | Equal, 6. |
| " " " with " " 14 | Normal, 5; increased, 1. |
| Irritable cases, with spasm, 1 | Equal, 14. |
| " " " with " " 12 | Normal, 12; increased, 2. |
| " " " with " " 9 | Equal, 1. |
| " " " with " " 2 | Normal, 1. |

—D. M.P.