SOME CASES OF GENERAL SURGICAL INTEREST, INCLUDING REMARKS ON THE TREATMENT OF THE GANGRENOUS BOWEL IN STRANGLUTED HERNIA.

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List of Cases.—(1) Neprolithotomy by splitting of kidney; (2) Unusually large and dilated gall bladder; (3) A comparison of two cases of perforating gastric ulcer; (4) Compound dislocation of the astragalus; (5) Right inguinal hernia, containing ovary with blood cyst in it; (6) Gangrenous bowel, treated by glass tubes; (7) Gangrenous bowel, union by Murphy’s button; (8) Division in hand of the deep branch of ulnar nerve.

Neprolithotomy by Splitting of Kidney.—A delicate-looking girl of 21, who had been in both medical and special wards for a period extending over four years, and in whom the diagnosis between renal calculus and renal tuberculosis was very difficult, was about a year ago transferred to my care; scarlatinal nephritis was the commencement of her troubles. Two uncles on the mother’s side had died of phthisis. There was severe pain in both loins with night exacerbation. The urine was acid and contained much pus, but no blood. There was no increase of pain on active exertion. The usual loin incision was made over the right kidney, and, owing to a long pedicle being present, I was able, after some trouble, to bring the kidney outside the wound, so that it could be easily palpated; several stones were felt; I thought it advisable in her case to split the kidney, very much as one does in the post-mortem room. I was very glad that I had adopted this method, for although it would have been possible to get some of the calculi out by an incision into the renal pelvis, others were so fixed in the calyces that it would have been impossible to reach them. Five calculi in all were removed, the kidney was sutured by four catgut sutures which traversed capsule and kidney substance. The girl returned home in three weeks, the wound being completely healed, and I saw her lately, just a year after her operation, and she remains quite well.
Unusually Large and Dilated Gall Bladder.—A married woman, æt. 40, presented herself at the out-patient room with a most curious swelling which puzzled us all. It was placed in the right iliac fossa chiefly, and its lower margin was attached to Poupart's ligament. When she coughed there was a distinct impulse, and the swelling became about the size of a child's head. There seemed to be several loculated portions running in the abdominal wall, but the communication with the abdomen could not be distinctly felt. The diagnoses which were made, included hernia of the caecum, large hernia with extra-abdominal omental adhesions, cyst connected with some abdominal organ.

The history she gave us was, shortly, one of hepatalgia for fourteen years, but no jaundice. The present swelling was noticed two years ago while convalescing from typhoid fever. On making an incision over the tumour, I found that a number of loculations had to be dissected out before I could follow the swelling. One of these was firmly attached to Poupart's ligament. As one got all these loculations detached, there was found an hour-glass portion which disappeared through the abdominal wall, and on opening the abdomen a second dilated portion of the cyst was seen to pass up towards the liver. At the hour-glass constriction, the wall of the cyst was very thin, and a minute opening was made in it while detaching it. From this opening there flowed a large quantity of bile. The cyst, which now proved to be an enormously dilated gall bladder, was followed up, the incision having to be enlarged up to the costal margin. A small stone blocked the cystic duct, and, after many attempts to remove this had been made, it was found impossible, owing to its great depth, to do very much in that way. A pair of dressing-forceps, covered with sterilised gauze, were therefore used to crush the stone from without the duct, and, after cutting off the bulk of the cyst, the remainder was stitched to the abdominal wall.

Notwithstanding that the incision reached from Poupart's ligament to the costal margin, the patient was able to leave the hospital in three weeks, and reported herself later as being perfectly well.

A Comparison of Two Cases of Perforating Gastric Ulcer.—Both were females, æt. 22 and 23 respectively. One was a domestic servant; the other kept house for her father, a joiner. Both had a history of nearly five years' anaemia and dyspepsia with vomiting (in one case occasionally coffee-ground material). In A's case a pint of red blood had been vomited a week before admission.

Each had an anxious expression, but no collapse; skin warm, moist, and flushed; liver dulness well within the costal margin.

About fourteen hours before operation—

Perforation. — (A) Anterior surface; under left lobe of liver,
perforation, size of shilling; nearly a pint of contents of stomach in abdomen locked off by lymph.

About ten hours before operation—

(B) High up on anterior surface, near cesophageal opening, size of sixpence. In abdominal cavity and not much locked off, about a pint of contents of stomach, chiefly milk, of which her doctor had told her to drink as much as possible.

_Treatment._—(A) Ulcer cut out; two layers of silk sutures; small tongue of omentum, which lay handy, stitched over wound.

(B) Irregular edges of wound removed; two layers of sutures of silk.

In both, extensive mopping with sterilised gauze only resorted to; no washing out; a small gauze drain left in abdominal wound.

_Diet._—Nothing by the mouth for six days, except a little hot water; fed by rectal enules. After six days, Brand's jelly and fish soup by mouth.

Some sero-pus for a day or two. Both patients made excellent recoveries.

**Compound Dislocation of the Astragalus.**—A somewhat dissipated man, æt. 55, was admitted one evening, a little over a year ago, with a history that he was standing on the platform of an electric car, holding on to the upright hand-rail, when his left foot (which was at the time impacted between the hand-rail and the upper platform) was violently twisted by his falling off the car. He was dragged for some distance after the car, but ultimately got his foot disentangled. I found him at the hospital with a clean cut on the outer side of the foot, just sufficiently large to allow the astragalus to completely protrude. A pair of scissors was all that was required to free the astragalus, by dividing the stretched interosseous ligament. The foot was wrenched back into good position, and the whole operation took less than five minutes. He made a good recovery, and was sent out of hospital with quite a useful foot.

**Right Inguinal Hernia containing Ovary with Blood Cyst in it.**—A married lady, æt. 26, had suffered for twelve years with a right inguinal hernia, during the whole of which time she had worn a truss. For some weeks before I saw her she had had much sickening pain, especially when the hernia was manipulated by her doctors. So troublesome was it when she stood up for any length of time, that she was very desirous that something should be done for her. I did not try any taxis, but operated on her, to find an ovary nearly the size of the closed fist, with a blood cyst in its centre, no doubt due to the taxis and the fact that she had worn a truss for so long. The sac contained no bowel or omentum, and, due to the weight of the ovary, the broad ligament had become very much elongated. The pedicle was
transfixed, and the ovary and Fallopian tube were removed. The wound was well in a week, and she has been entirely relieved.

On the Treatment of Gangrenous Bowel in Strangulated Hernia.—Twenty years ago, one saw a great many more cases of strangulated hernia, where the patients were not sent into hospital till the bowel was gangrenous, than one does nowadays, when medical practitioners are so much better educated and the means of conveyance so much more rapid. What is one to do when the bowel, say in an inguinal hernia, is gangrenous or gangrenous and perforated? Almost all my teachers advised the slitting up of the bowel, and leaving things to right themselves. With this treatment I have not been at all satisfied. Then, many younger surgeons tried enterectomy with primary suture; but in my hands, and in the hands of many of my colleagues, the bowel has been found to be in such a condition that the sutures gave way.

The following two cases illustrate, I think, a way out of the difficulty:—

They were admitted in the same week; both were very feeble old women, and both were so collapsed that any operation was thought to be almost out of the question. The first was treated by means of Paul’s glass tubes, and the second by a small Murphy’s button.

Gangrenous Strangulated Femoral Hernia Treated by Glass Tubes.—A very feeble, thin woman, æt. 70, was sent into hospital in such a collapsed condition that the anaesthetist refused to give her even a little ether. As a dernier ressort I injected some eucaine in chloroform water under the skin, and very rapidly opened the sac of her femoral hernia, to find the bowel not only gangrenous but perforated. There was no omentum in the hernia, and as she was much too ill to think of suture or even the application of Murphy’s button, I enlarged the femoral ring in every direction, chiefly with the finger, so that the bowel moved quite freely above the pinched portion. The loop of dead bowel was then excised, and two small glass tubes tightly tied in, and the patient removed, as all of us thought, to die in a few hours. To our astonishment, however, she was pretty well next morning, and the tubes came away on the fourth day, the tissues cleaning up, so that at the end of ten days we were considering what form of intestinal fixation we should use, when our poor old lady contracted bronchitis and died. I shall certainly adopt this method should a similar case arise.

Strangulated Inguinal Hernia; Gangrenous Bowel; Union by Murphy’s Button.—This was a tailoress, æt. 58, a spare woman, who on admission to the infirmary was so collapsed that it was almost impossible to administer an anaesthetic, and the
greater part of the operation had to be accomplished with a 4 per cent. solution of eucaine in chloroform water. The smallest-sized Murphy's button was used to unite the bowel, after a gangrenous loop with a perforation in it had been removed. The abdominal ring was enlarged upwards, and that portion of the bowel which contained the button was placed immediately inside, so that if any leak did occur it was hoped that the discharge would find its way out. An uninterrupted recovery followed, and the button was passed on the tenth day.

Division in Hand, of Deep Branch of Ulnar Nerve.—A young engineer came to show me his hand six months after he had sustained what was at the time considered to be a trivial stab with a pointed piece of glass. He had practically a useless hand, all the interossei being paralysed and the fingers contracted, so that he had a typical claw-like hand. The scar, which was not an inch in length, was placed immediately below but a little to the palmar side of the pisiform bone. Sensation in his hand was found to be normal, the little finger and the adjacent side of the ring finger showing that the ulnar nerve had not been injured. The diagnosis forced upon us was that the deep branch of his ulnar nerve had been severed soon after it left the main trunk, and this proved to be the case when I cut down and was fortunate enough to find the two ends, and bring them together as well as I could with the finest silk suture. Within three months he was able to use his fingers for most kinds of small movements, his intermetacarpal spaces filled up, and, when last I saw him, he said he thought his hand was as good as it had ever been.

Clinical Records.

Two Cases of Tuberculosis of the Heart and Pericardium.

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Case 1.—W. R., aged 3, was admitted to the General Infirmary at Leeds, on July 1, 1899. His breathing was rapid—40 per minute; he did not seem to be suffering acute pain, but evidenced considerable uneasiness when moved. Effort on his part produced cyanosis. There was defective movement of the chest, especially on the left side. Breathing was chiefly abdominal. Breath sounds were absent below the nipple on the right side. The percussion note over this side was dull. The heart dulness extended to the left nipple, and could not be properly defined on the right side, as it merged into the lung dulness. The cardiac impulse was absent at the apex. A wavy impulse was seen in the epigastrium. The heart sounds were rapid; no difference in