A CASE OF
STRANGULATED OBTURATOR
OR
THYROIDAL HERNIA,
SUCCESSFULLY RELIEVED BY OPERATION.

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PROTRUSION of a portion of intestine through the opening which transmits the vessels in the Obturator Ligament, is a displacement of very rare occurrence. The authors of our own country, who have devoted their attention to the subject of Hernia, and collected a vast amount of scattered information, have been unable to find a single case of this accident, which had been detected during life; instances are not so rare of the patient suffering from all the usual symptoms of strangulated intestine, and after death, a portion of intestine having been found protruding below the obturator ligament. Continental writers have described the disease more frequently, recorded a number of cases, and have preserved the parts, showing death to have been caused by undetected strangulation through this opening. I have been equally unsuccessful in finding in their writings instances in which this hernia has been relieved by operation. Sir A.

Cooper gives the account of a case by M. Malaval, published in the Memoirs of the Royal Academy of Surgery of Paris, in which he attempted to reduce a hernia of this description, and succeeded in returning the intestine, but not the omentum. M. Arnaud made an incision down to the swelling, and found a piece of omentum protruding, which he cut away, as well as a portion of the sac, and the patient recovered. The simplicity of the operation as described, must throw some doubt on the correctness of the description, of omentum having passed through the obturator opening. We cannot reconcile so deep a part being exposed by a simple incision. When we reflect on the depth of the obturator foramen, and its protection by muscular structures, which both cover and surround the opening, we can readily conceive not only with what difficulty the intestine can be displaced in this direction, but also when it occurs, how numerous are the impediments to its presenting the usual form and character of a hernial protrusion in other parts. The faithful narration of the symptoms and appearances which presented themselves in a case of this description, which lately came under my observation, will best enable others to recognise this accident, and prepare them for the difficulties which must present themselves, in an operation for the release of a portion of strangulated intestine so deeply situated.

Mrs. W—, a tall person, moderately stout, æt. 55, the mother of a large family, applied to Mr. Gardener, of Lisson Grove, on the evening of Tuesday, February 18th, 1851. She was suffering from abdominal pain and nausea: aperient medicines were prescribed. On the following morning, Mr. Gardener, finding her symptoms not relieved, inquired if she were the subject of rupture, and was answered in the negative. At the next visit, on the 20th, his patient had not received the slightest relief; on the contrary, the abdominal pain had increased, and was accompanied by vomiting. Mr. Gardener, feeling confident that these symptoms were the

result of some mechanical obstruction, examined the regions in which hernia is usually found, and satisfied himself that there was no hernial tumour, but a *little below* the femoral region on the right side, he detected a degree of hardness resembling a small gland, of the size of a bean, and deeply seated. During the day, Mr. Robinson accompanied him, to make a more careful examination of the thigh, but was unable to discover more than a general fulness of its upper and anterior part, in addition to the deeply-seated hardness before mentioned. These gentlemen were inclined to think a portion of intestine had become strangulated. Early on Friday the 21st inst., I visited the patient with Mr. Gardener. She was in bed, suffering extreme abdominal pain in the umbilical region, and during the previous 12 hours, her vomiting had become stercoraceous and incessant. The countenance was pale and contracted, the voice faltering, the pulse weak, small, and intermitting at every third or fourth pulsation; in short, all the symptoms of impending dissolution from strangulated intestine were present. Whilst sitting by her side, and examining her under the bed-clothes, I was unable to detect any tumour or swelling, and was inclined to consider the impediment as existing within the abdominal cavity, when Mr. Gardener directed my attention to the previously described hardness. On uncovering the upper part of both thighs at the same time, the eye detected a *slight degree* of fulness in Scarpa's triangle on the right side; this triangle of the opposite limb was well marked with a hollow or depression passing down its centre, but this was lost on the affected side, and the whole contour of this part of the limb was visibly fuller than that of the corresponding; there was no tumour or circumscribed swelling, but on standing over the patient, and using firm pressure with the ends of the fingers over the neighbourhood of the femoral artery, and a little below the saphenous opening, a distinct hardness could be felt (slight in its extent), giving an impression as if the sheath of the vessels were being pressed on. The patient still persisted in her statement,

that she never had been the subject of rupture. On further inquiry, however, Mrs. W— stated that she had felt some slight inconvenience and pain in the right limb, for the previous fortnight, which she attributed to the enlargement of two little glands, about the junction of the upper and middle thirds of the thigh, accompanied with pain in the part, so as to oblige her to rest the extremity. The action of the bowels had been irregular during the same period.

Her dangerous state having been duly considered, it was thought prudent to make an incision down to the hard structure, in the hope that it might be caused by constriction of the intestine deeply situated in the femoral canal. The uncertainty of the result having been named to the sufferer and her husband, they consented to the operation as a probable means of saving her life. I made a straight incision into Scarpa's triangle, as in the customary operation for tying the femoral artery, beginning about three inches below Poupart's ligament; the dissection was continued in the direction of the enlarged and hardened structure, until the cribriform fascia was opened, and the saphenous opening exposed, when some little disappointment was felt in not finding a portion of intestine confined there. The extremity of the index finger could now distinctly feel the hardened structure, deeply situated at the inner border of this opening; the dissection was resumed and continued with difficulty in so deep a part, and some embarrassment was caused by the saphenic vein, which passed through part of the wound, as did also branches of the anterior crural nerve. The fascia lata was divided, and the pectineus muscle exposed at the inner side of the wound, which it was found necessary to elongate, as it was impossible to continue the dissection at such a depth, unless the original incision were extended. The external fibres of this flat muscle were cleared from the surrounding structure, and divided transversely for about an inch and a half or two inches. I had only to separate with my finger some cellular tissue, when a portion of intestine, covered with its sac, and firmly held down by the other mus-

cular structures that surrounded it, came into view. On being liberated, it suddenly ascended into the wound, being distended by flatus to the size of a pigeon's egg. Its true character was now discovered, and the finger with some difficulty, from the depth at which it was situated, passed along the protruding intestine to the obturator opening, through which it had escaped. The narrow circumference of the foramen and the surrounding bones were examined both by Mr. Gardener and myself. The symptoms of strangulation having existed three days, it was considered prudent to open the sac, which contained a portion of the small intestine, blue and congested; and though the opening through which it had passed did *not tightly* inclose its neck, it was deemed prudent to divide its edge slightly, as some difficulty would have been found in returning the intestine without using pressure to empty it of its flatus. The extreme depth of the wound, added to the upward turn which the index finger was obliged to take in being used as a director to a blunt-pointed bistoury for the division of the stricture, was found the most difficult part of the operation, as well as to avoid various important vessels and nerves that surrounded the knife. Unfortunately the saphenic vein not having been sufficiently held out of the way, was divided at the same time as the stricture; and from the extreme depth of the wound it was a matter of congratulation that no other serious mischief had taken place. The intestine having been returned as well as the sac, some little difficulty was found in securing the *upper* division of the vein, which was the only bleeding part. This being the only ligature requisite, the wound was closed by the necessary bandages, and the patient placed in bed. No medicines were administered. As the bowels had acted three times in the course of the day, after the operation, an opiate was prescribed at bedtime.

22d. Has passed a good night. No abdominal pain; pulse intermitting; a rough sound to be heard accompanying the second sound of the heart.

23d. The patient is going on favorably.

March 1st. The ligature came away to day. From this time she made a rapid improvement; the pulse lost its intermission; the sounds of the heart became regular and natural; and when she was examined a month after the operation, no hernial protrusion was to be felt, and she had no inconvenience whatever in walking.