CASE OF
FEMORAL HERNIA,
WHICH HAD
DESCENDED BENEATH THE PECTINEAL PORTION
OF THE FASCIA LATA,
AND WAS
PARTIALLY COVERED BY THE PECTINEUS MUSCLE.
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DECEMBER 8th, 1859.—My attention was directed to the case of a female, æt. 45, who was admitted into the London Hospital, labouring under the usual symptoms of strangulation of the intestine, namely, constipation, vomiting, and pain in the abdomen. The history of the case was exceedingly obscure, but after the most careful inquiry of the patient herself, of the house-surgeon, and of a surgeon who had been called to see her, I came to the conclusion that, as no hernial tumour could be felt in the region of the crural ring, the case was one of femoral hernia, which had been reduced by the taxis, and in which the symptoms continued after the reduction of the hernia, probably from the effects of the stricture on the intestine. All that could be distinguished in the crural region were two moveable lymphatic glands, somewhat enlarged. The woman herself complained of some dull pain in this region.

Acting on the opinion I had thus been led to entertain, in which I was supported by my colleague, Mr. Ward,

I ordered her to take a grain of opium every four hours. Under this treatment the sickness subsided, the pain diminished, and she was able to retain small quantities of tea, &c., upon her stomach. The third day after the commencement of this treatment, the symptoms reappeared with increased intensity: this induced me to make a further examination, but I was unsuccessful in discovering any swelling resembling in the least a femoral hernia. I now ordered her an injection of warm water, night and morning, to take a grain of calomel, with opium, thrice daily, and to have some wine and brandy, if they could be retained.

The symptoms still continued, the matter vomited became more stercoraceous in character, and on my visit on the 13th everything seemed changed for the worse.

I had previously explained to Mr. Ward my intention to adopt an explorative operation in the femoral region if the exacerbation of her symptoms justified a measure of this doubtful character. I again directed my attention to the femoral region, and I now fancied I could feel a fulness considerably to the inner side of the usual site of femoral hernia, and, as it appeared to me, under the edge of the adductor longus; two moveable, lymphatic glands were readily distinguishable over this apparent swelling. I therefore ordered her to be brought to the operating theatre, and having turned the thigh outwards, I was able to bring more fully into view the fulness to which I have alluded, and I felt at once amply justified in proceeding with the explorative operation.

The operation.—I divided the skin and superficial fascia in a vertical direction over the swelling, and by cautious dissection came down to a dense, elastic fascia, raised slightly into the form of a *swelling* rather than a *tumour*. In clearing this of its cellular investment I divided a vein, which I took to be the saphena, about to terminate in the femoral vein. I was obliged to tie it. With my finger I could clearly distinguish the falciform boundary of the saphenic opening in the fascia lata on the outer side. The glistening and

tense fascia which was now exposed I regarded, from its position and depth, as the pubic portion of the fascia lata; I carefully scratched it, as it was exceedingly tense, and, passing a director beneath it, I divided it. I now distinguished, overlapping the swelling, some red fibres, which, from their direction, I thought to be a part of the pectineus muscle; I passed a director under the edge of this muscular band, and divided it transversely inwards. The hernial sac was at once apparent; I traced its neck upwards towards the femoral ring, and then opened it with the usual precautions; a small quantity of fetid pus at first escaped, and a portion of dark omentum, much congested, with about an inch and a half of small intestine, was exposed. The gut was obviously gangrenous, and a small quantity of fetid fluid oozed through some openings in it. Owing to the distance, I had some difficulty in reaching the seat of stricture, which was at the femoral ring; the stricture, unusually tight, was divided upwards and inwards, and immediately a considerable quantity of fecoid matter escaped from the bowel through the wound. I cut off the omentum, dressed the parts lightly with lint soaked in warm water, and ordered an increased quantity of brandy, and as much liquid nourishment as her stomach would bear. She died four days after the operation.

Post-mortem examination.—I raised the skin and superficial fascia from Scarpa's triangle; and I also exposed the lower part of the tendon of the external oblique and Poupart's ligament. It was apparent that the hernia had descended through the femoral ring, not in the sheath of the femoral vessels, but behind and somewhat internal to the femoral vein, in the direction of the pectineus muscle; indeed, it was placed between the vein and the pectineus muscle. The rupture had deeply excavated the muscle, apparently by pressure upon it; but a few of the inner fasciculi, namely, those arising near the spine of the pubis and on a level with the adductor longus, projected in the form of a fleshy column, and had overlapped the hernia. It was this which I had cut transversely with my bistoury during the operation. The remainder of the muscle on which

the hernia was situated was atrophied and somewhat sloughy. The strong column of muscle just mentioned was partly covered by the pectineal portion of fascia lata; but there was only a ragged vestige of this fascia covering the remainder of the atrophied pectineus. On sponging away the sloughs from the muscle, its surface was seen excavated into a deep cup-shaped depression, in which the hernia had been contained.

The hernia consisted of omentum and about an inch and a half of the middle of the small intestine. The omentum was firmly adherent to the neck of the sac, and appeared to be dragged down towards the femoral ring; the intestine contained in the sac was quite gangrenous, and the hernial sac itself was in a sloughy state. There was no great distension of the intestines above the hernia, but below this point the small intestines were empty. The peritoneal surface was inflamed, and covered by recently effused lymph.

There is some difficulty in coming to a very accurate conclusion as to the true nature of a case where the parts are in a state of gangrene, as in this instance, and where the coverings of the hernia are destroyed. But the observations made during the operation, and by dissection after death, lead to the following inferences: 1st, that the hernia was of the femoral species; 2dly, that the descent had not taken place in the sheath of the femoral vessels; 3dly, that it had passed behind this sheath, and had made its way behind and internal to the femoral vein, through some unusual opening in the pectineal portion of the fascia lata; 4thly, that that part of the pectineus muscle on which the hernia lay was deprived of its immediate fascial investment, and that the innermost fasciculus formed a strong fleshy column over the hernial sac, beneath the pectineal portion of fascia which covered it. In this respect the hernia differs from that variety of femoral hernia which descends in the sheath of the femoral vessels. Lastly, I believe that the hernia had existed for a long time as an *epiplocele*, and that the hernial symptoms arose from a sudden descent of small intestine behind the omentum.