AN ACCOUNT OF A CASE
OF
OBLIQUE INGUINAL HERNIA ON
EACH SIDE,
IN WHICH,
THE TESTIS REMAINING IN THE BELLY,
THE HERNIAL SACS DESCENDED INTO THE SCROTUM AND ALSO
ASCENDED UPON THE APONEUROSIS OF THE EXTERNAL
OBLIQUE MUSCLE.
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THE extreme rarity of the complications met with in the following case is my apology for bringing a short account of it before the Fellows of the Royal Medical and Chirurgical Society.

A man, æt. 27, was admitted into the Middlesex Hospital, January 20th, with strangulated hernia.

The right side of his scrotum was distended by a large globular swelling, which stretched upwards along the groin to the anterior superior iliac spine. The inguinal and scrotal portions were separated by an intermediate narrow part, but an examination under chloroform—for there was too great tenderness to allow handling without anæsthesia—proved

that they were portions of a common *cavity*. Except at its pubic end, the inguinal portion of the swelling was accurately definable—the finger-tips could be dipped under its edge—which made it evident that it was not beneath the aponeurosis of the external oblique muscle, but superficial to it.

In the left groin there was a similarly superficial oblong swelling, also reaching from the external ring nearly to the anterior superior iliac spine. It was flaccid and painless, and felt coarsely granular. The penis was thrust towards the left, and nearly buried by the right hernia. Pus oozed from the urethra. Neither testis could be felt in the scrotum or groin.

He lay on his back with drawn-up knees, tossing restlessly, and crying out from the severity of the pain in the rupture and belly. Pulse small, quick, and compressible; face pale; beads of sweat rolling off his brow; features anxious.

His extreme suffering made him so impatient of being questioned that I could only elicit the bare facts that he had been ruptured since childhood, and that each rupture had been reducible until that morning.

The left was plainly an omental hernia, and not strangulated. Its deviation from the usual course of an oblique inguinal hernia was attributed to the non-development of the scrotum connected with arrested transit of the testis. But the nature of the right, the strangulated, hernia was not so evident. Supposing that the testis was in the scrotum, its concealment was consistent with congenital hernia, and, if inflamed and swollen (he had gonorrhœa), the testis, by preoccupying the scrotum, might have hindered the descent of the protruding gut, and in this way have led to the formation of the superficial diverticulum in the groin.

The taxis in a hot bath having been already tried by the house-surgeon, chloroform was given, and, reduction being still impossible, I operated at once, three hours from the beginning of the strangulation, making a cut one and a half inch long in the axis of the swelling, over the external ring. After dividing a little cellular tissue the sac, thin and trans-

parent as gauze, was exposed. I was obliged to open it in order to reach the ring, which lay deeply behind this part of it. After notching the external ring and cutting three deeper constricting bands, the finger slipped into the belly, and there was no other trouble in returning the gut than that occasioned by its great quantity.

When the sac was empty I swept my finger round the under inner surface of the internal ring in order to make quite sure that the extruded bowel was completely inside the belly, and in doing this I hooked something solid, which, being drawn gently down into view, proved to be the testis hanging from a mesorchion; it was replaced, and the wound closed.

The contents of the sac were several feet of dark red gut, blotched with extravasated blood, and some ounces of bloody serum.

Next morning he passed two copious, very offensive, loose, bloody stools, and he died in the afternoon, the symptoms of acute peritonitis having continued unabated from the hour of his admission.

His body was examined on the following day. The left hernia, that which had not been strangulated, was first dissected.

When the skin and superficial fascia were reflected off the groin a lobulated, oblong, hernial sac, reaching from the superior iliac spine to the bottom of the scrotum, came into view. The upper and outer part of this sac lay upon the aponeurosis of the external oblique muscle, in front of the inguinal canal and Poupart's ligament, its descent upon the thigh being restrained by adhesion of the superficial and deep fascia along the line of the groin. It contained a large mass of omentum and some turbid serum. The great distension of the scrotum by the right hernia had masked the scrotal portion of the left hernia during life. When the external ring, through which the sac extended, and the structures composing the front of the inguinal canal, had been slit, the testis was found behind the omentum in the canal, not fixed to the posterior wall of this latter, but hanging from a fold

of peritoneum drawn from the parietal layer near the abdominal surface of the internal ring.

The anatomical relations of the right hernial sac corresponded exactly to those of the left, the only difference being that the superficial diverticulum did not ascend quite so near to the iliac spine. The entire sac was inflamed, and it contained several ounces of turbid serum.

On opening the belly the omentum was seen tightly stretched and gathered in a fan-like form to the left internal ring. The transverse colon was also pulled down to this latter, but not engaged in it. The abdominal cavity contained many ounces of turbid serum similar to that found in the hernial sacs, and the serous surfaces were everywhere inflamed. Ten and a half feet of small intestine had been strangulated; they were intensely congested and blotched with small submucous extravasations of blood, but the most careful scrutiny with the naked eye failed to discover any breach of the mucous surface—a feature of interest in connection with the copious bloody stools. There were several large extravasations of blood in the mesentery of this portion of bowel.

The right testis hung freely entirely within the cavity of the belly, by a mesorchion drawn from the parietal peritoneum at the pelvic brim near the internal ring.

In ruptures associated with malpositions of the testis, where this has remained at some point above the scrotum, the bowel has occasionally been found to have slipped by it into the scrotum, being in these cases received in the vaginal process of peritoneum when the testis or epididymis has entered the internal ring, but acquiring a sac when the testis or epididymis continues in the belly. More rarely the sac, on leaving the external ring, has been found to have ascended upon the aponeurosis of the external oblique muscle instead of passing into the scrotum, the commonly accepted explanation being the resistance to the descent of the sac offered by the undeveloped scrotum.

The case which I have described combines both these

irregularities—the ascent of the sac superficially along the groin, and its descent into the scrotum. Their occurrence is explainable by supposing that the undeveloped scrotum was sufficiently inextensile to retard, but not altogether to prevent, the descent of the hernia. The hernial sac on each side was an acquired one, and not a derivative of the vaginal process, since the right testis and epididymis were within the belly, and the left testis, although found in the inguinal canal, was not attached to it, but hung freely from a long mesorchion attached inside the belly.