A SECOND CASE OF DOUBLE LOOP HERNIA.

BY

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IN the BRITISH MEDICAL JOURNAL of April 2nd, 1910 (p. 799), I reported a very unusual form of double loop hernia, and discussed the theories in connexion with the formation of that uncommon condition.

On September 1st, 1913, a man aged 26, suffering from a large strangulated right inguinal hernia, was admitted to the Royal Infirmary under my care (while acting for Mr. Paterson).

He stated that the hernia had been present for at least four years, his work, to which he attributed the affection, having entailed heavy lifting; that it had been gradually increasing in size but had always been easily reducible, and had caused so little trouble that he had never worn a truss. On the morning in question the hernia came down, and was larger than at any previous time. He could not reduce it, and walking was rendered difficult. The strain of subsequent vomiting made matters still worse. The bowels had always been quite regular, and had moved shortly before strangulation occurred.

The hernia was moderately large and tense, and presented a marked prominence in the inguinal region, projecting abruptly almost opposite the position of the internal ring.

On incision the mass was found to consist of two loops of bowel, each some 4 or 5 in. in length, which were prevented from returning by a constriction at the internal ring. This constriction was neither very firm nor tight, and it was possible to pass the finger up between it and the bowel. Had a single loop of bowel been present reduction without cutting would probably have been easily accomplished, but under the circumstances it was necessary to cut the band to enable the middle connecting abdominal loop to be brought down for inspection.

The two herniated portions were bound together by numerous fine translucent bands, which were certainly not of recent origin, and when, after manipulation, the abdominal loop (which was some 8 or 9 in. in length) was brought into view, it was found that these fine bands ran up from the herniated loops to it. The arrangement of the herniated and abdominal loops resembled the Greek capital letter omega, and the fine adhesions running from the herniated to the abdominal loop involved the mesentery of the abdominal loop. All three loops of bowel were dark in colour, congested, and distended. The fine adhesions were broken down, camphorated oil was applied with a view to hindering recurrence, the bowel was replaced, and the radical cure performed. Save for an unusual complaint of pain over the region for a couple of days after operation, the patient made a normal recovery.

In addition to referring to some of the theories put forward to explain the formation of "W herniae," I mentioned in my previous article suggestions made and experiments done to elucidate the reason why the intermediate abdominal loop should suffer so markedly in strangulation of the herniated loops. It appears to me that the fine adhesions found in this case would at least partly explain the implication of the abdominal loop. Traction upon these bands (which, it must be remembered, are abnormal, and would, therefore, not be present in the experimental production of such hernias in animals) rendered them tense, and, attached as they were to the mesentery, must have caused them to drag upon and compress the mesenteric vessels, and thereby interfere with the blood supply of the abdominal loop.

THE Legislative Council of the Federated Malay States has voted £5,000 towards Mr. Chamberlain's appeal for the endowment of the London School of Tropical Medicine. The fund now amounts to £70,000.

A PHYSICIAN practising in Brest, Dr. Lenoble, has detected the presence of a very definite, yet always transitory type of paralysis of the lower extremities, in two families of Breton peasants. A father and two sons were attacked suddenly when working in the fields, and two brothers and a first cousin of the other family suffered in precisely the same manner. All recovered speedily. Lenoble is of opinion that these pareses, which are accompanied by trophic disturbances, are to be traced to a lesion in the anterior cornua of the grey matter of the cord, with implication of the roots of the nerve supplying the vasti, extensor communis digitorum, and extensor proprius hallucis, a very localized anterior myelitis of undetermined origin. The report of these cases was communicated to the Académie de Médecine, Paris, by M. Achard.

THE SCIENCE COMMITTEE
OF THE
British Medical Association.REPORT TO
THE THERAPEUTIC SUBCOMMITTEE.PART II.—ON CERTAIN NON-OFFICIAL FATS
AS OINTMENT BASES.

BY

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IN Part I of this report¹ the formulae of the official ointments were considered with especial reference to their bases, and certain suggestions made with a view to modification in those cases where experience had shown the present formula to be unsuitable.

In this part it is proposed to report upon a certain number of non-official fats which have been examined during the past two years in the laboratory and, when found suitable, made into ointments and tried in actual practice.

Various combinations were made, and also mixtures with paraffins and other bases, in order to modify their consistency or other properties. The ointments thus made were compared with the official formulae, and it may be shortly stated that none of those hitherto examined have shown sufficiently valuable properties to justify their inclusion in the *Pharmacopoeia* as general substitutes for the bases already official. Some of them, however, have been found to possess special properties which render them useful for particular purposes.

The soft bases in the *Pharmacopoeia* are wool fat, lard, soft paraffin, almond oil, and olive oil; the hardening substances are beeswax, suet, spermaceti, and hard paraffin. All the official ointments are made from these, either alone or in combination. Their properties as bases have been dealt with in Part I; the substances which have been tried as possible substitutes are butter fat, margarine, marrow fat, goose fat, turtle fat, cocoanut oil, nucoline, cocos white, palm oil, and, as hardening agents, carnauba or Brazil wax, and ceresin.

Butter Fat.

Butter fat has been used from a very early period as an extemporaneous base; the presence of a certain amount of water (12 to 15 per cent.) makes it a pleasant, cooling application, somewhat of the character of a cold cream, but this water also hastens its decomposition and impairs its keeping properties. The presence of about 7 per cent. of the glycerine esters of the more volatile fatty acids—butyric, caproic, capric, and caprylic—also lowers its stability. The melting-point is low—from 31° C. to 34° C.—but, in spite of this, ointments made from it are of good body and rub well.

Margarine.

Margarine in commercial samples resembles butter in its properties. It usually contains only a small amount—usually under 1 per cent.—of the butyric group of fats, and seems to be of somewhat firmer consistence than butter when made into ointments. Probably a very satisfactory ointment base could be obtained by selecting certain portions of the margarine, but the result would not have any advantage over lard, and it is doubtful if it would be any less expensive.

Marrow Fat.

Marrow fat is a cream-coloured solid fat of granular consistence. It rubs smoothly, however, on the skin, and is not sticky or oily; it has a slightly beefy smell. The melting-point was 45° C. to 48° C.; it was not easily