RADICAL CURE OF HERNIA AND OTHER CLINICAL CASES.¹

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I.—RADICAL CURE OF HERNIA.

THE patient I show you, aged 45, was operated on six weeks ago. The wound healed by first intention, and the man has been at the Lady Hozier Convalescent Home for a fortnight. At present you observe that the internal ring is completely plugged, the external quite closed except where the cord escapes, and the walls of the canal firmly fixed together. A vigorous cough betokens the strength of the abdominal buttress. The cure is perfect just now, with every prospect of a permanence.

In this case, and in another operated on eight days ago, which you will see in the adjoining ward, I performed the open operation which I described in the *BRITISH MEDICAL JOURNAL* for May 25th, 1879, an important feature of which is plugging the internal ring with a ball formed of the rolled-up sac. An incision was made from the external ring down over the front of the hernia, the bowel having been returned and retained by the finger of an assistant placed over the internal ring. Layer after layer was divided till the sac was exposed. With a forceps and end of a director the sac was separated from the cord, was lifted up till it was like the empty finger of a glove coming out from the external ring. It was now pulled upon till its neck was accessible from the external ring, when a thin catgut ligature was tied round it. When the tension was relieved, the tied neck recoiled back into the internal ring. I twisted the sac and rolled it up into a ball, which I pushed up the canal beyond the epigastric artery, so that it was now a plug blocking up the site of the internal ring. The stitches were introduced thus. A curved Wood's needle was passed through the external pillar of the canal from without inwards, opposite the site of the internal ring, was made to pass through the lower part of the rolled up plug, was pushed underneath the edge of the internal pillar for at least a third of an inch beyond its lower edge, so as to pick up and pierce what could be included of the internal oblique border, and then made to emerge through the aponeurotic pillar. A catgut ligature was then put through the hole in the needle's point, and withdrawn so that the ligature was passed through the external pillar, the ball plug, some part of the internal oblique, lastly, the internal pillar. Two other stitches were introduced lower down, of course, not including the plug. A last stitch, to which I attach much importance, was introduced as low down as to close the external ring just over the cord. This I passed through Poupart's ligament, near where Gimbernat's ligament is reflected from it, and on the upper side of the ring made it pass deep below the upper pillar, gripping up what is accessible of the conjoined tendon, and then made it emerge far inwards, even through the tendon of the rectus, to make it take a firm hold as a retaining suture. The catguts were now all drawn tight and tied, and so the inner ring was plugged, the walls of the whole canal were brought together, and the external ring closed.

In my own experience and that of others who have adopted the above method, the results have been so satisfactory that I have seen no reason to alter any of the details.

In 1879 some surgeons had already performed an operation for the radical cure, by stitching together the pillars of the external ring, after an operation for strangulated hernia. Others had adopted, now with antiseptic precautions, some modification of the old open operation by dissection in cases of reducible inguinal hernia, as a substitute for the subcutaneous operation with thick silver wire, introduced by Mr. Wood, of King's College, in 1862. In 1867 Sir Joseph Lister adduced two cases of radical cure of umbilical hernia, as illustrations of his new method of dealing with wounds on antiseptic principles (the application of which he had shown to me, in his first cases in Glasgow, in 1865). But, so far as I am aware, no one had practised or published the operation which I described, the distinguishing feature of which is the plugging of the internal ring with a ball formed of the rolled-up sac.

II.—LARGE PIECE OF BONE WHICH WAS IMPACTED IN THE LARYNX.

The man I show you, aged 55, was, eight days ago, taking

¹ Shown at the meeting of the British Medical Association, Glasgow Branch, held in the Western Infirmary on February 6th. The cases are from hospital records by George Burnside Buchanan, B.A. Cantab., M.B. and C.M., House-Surgeon, Western Infirmary.

his dinner of sheep's head broth. While his mouth was full his boy made a joke, which caused him to laugh; the back-draught of the laugh sucked a piece of bone into his wind-pipe, where it stuck; he tried to cough it out, but could not succeed. The bone was so placed that he could breathe, though with difficulty, so that he did not send for a doctor at first, but did so at night. The fauces were tickled to induce vomiting, but without success. Next morning he came to the infirmary. He could breathe, but not well, and had occasional spasms of the glottis.

My son, Dr. George Burnside Buchanan, who is acting as house-surgeon in my wards, examined with the laryngoscope, and saw a white piece of bone projecting up through the rima, but it was so firmly held that it could not be moved or extracted with the laryngeal forceps, so I was sent for. After the trial which had been made, it was hopeless to use more force, so I directed my son to perform tracheotomy. This he did, making a large crucial incision in the trachea, so as to admit the point of the little finger. This he passed up into the ring of the cricoid, and felt and moved the bone. A pair of dresser's forceps was passed up and grasped the bone, which was extracted by a little shaking and pulling.

The bone which I show you measures, length, 1 inch; greatest transverse, $\frac{1}{2}$ inch; vertical throughout, $\frac{1}{3}$ inch. It is evidently a piece of the cellulated ethmoid, and in shape resembles a truncated wedge, the smaller end of which measures $\frac{1}{4}$ inch across, and the two inclining sides are almost plane surfaces. Had it not been for the narrower end of the wedge presenting downwards, it could not have passed through the glottis.

The patient is now quite well, the wound closed; he will be dismissed to-morrow.

III.—SPINAL CURVATURE.

This patient, P. R., aged 33, was two years ago in perfect health. At that time he went to Egypt as a marine engineer. While there he had an attack of pleurisy, but it must have been of a very subacute kind, as he was never laid up. Three months after he came to this country and consulted Dr. Snodgrass, of Partick, and also Dr. Gemmell, who both told him he had still some pleurisy; but it must have passed off, as he was able to follow his trade—fitting engines in a dock-yard at Renfrew. Shortly after that he became aware of a prominence on his back between the shoulders. He found it out himself, not by any pain or uneasiness, but because he felt something preventing him sitting upright against the back of a chair or a pew in church; but he said nothing about it to his wife or his doctor. About six months ago he was conscious that the prominence had become much more projecting, and soon after he began to feel pains round the waist, shooting down to his legs, with occasional cramps. He now mentioned his state to Dr. Donald, of Paisley, who at once detected a pronounced angular curvature of the spine in the upper three dorsal vertebræ. Soon after other well-marked signs of some lesion of the cord became developed, and within a few weeks there was paraplegia below the umbilicus, complete loss of sensation in both limbs, loss of voluntary motion, cramps and twitching of the calf, loss of power over the bladder and partly of the rectum. When he came to the infirmary on September 6th all these conditions were well marked. The reflexes, patellar and ankle, were greatly exalted, so that the least touch below the patella caused the limb to be jerked up from the bed, while he could not make a voluntary movement. On gently pressing up the great toe the ankle clonus was exhibited to an extreme degree.

Dr. Beatson, who was acting for me at that time, ordered him to be laid on a water bed, and applied extension to the feet by weight and a pulley. Within a month he had so much improved that sensation was beginning to return, and slight power of movement. The improvement went rapidly on, so that by January 1st he could move his legs in bed and could feel quite well, and the function of urination was quite normal, while the bowels acted regularly. The reflexes were almost normal. But as he still felt the girdle pains when he moved his body, a plaster-of-paris jacket was applied. Since that date the pain has disappeared. Already he has been tried out of bed, and can stand, but he has been so long confined on his back that it will be some time before he is able to walk.

You now see that he can lift his legs and kick them freely about, and when I touch the ligamentum patellæ there is no response, and pushing the foot up firmly by the ball of the great toe does not produce any shaking of the foot or ankle.

The man was perfectly well two years ago, was completely paraplegic six months ago, and now you see him restored to a fairly healthy condition.

The pathology of this case is rather obscure. I believe it is an example of rapidly-occurring rarefying osteitis or dry caries of the bodies of the three upper dorsal vertebræ. There is no evidence of tuberculosis and no signs or symptoms of any abscess. I think it unlikely that the nerve symptoms arose from osseous pressure on the cord; I think it more likely that the subacute inflammatory condition which resulted in such softening of the vertebral bodies as allowed of their being crushed together extended to the membranes of the cord; that these became thickened and pressed on the cord as long as he was allowed to move himself; and then the perfect rest of the spine and some extension, with subsequently the plaster jacket, secured the subsidence of the inflammatory action and allowed of the absorption of the effused products which were pressing on or constricting the cord.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

LARGE FIBRO-LIPOMA.

THE accompanying photograph represents a case I operated on successfully about a month ago. The patient was a young

man, aged 26, and the tumour—which weighed when cut off slightly over 50 English pounds—had been growing for eleven years. The weight of the tumour was so great that

he, when walking, had to bend forward in order to support it hanging over his left hip. The neck of the tumour was about 17 inches in circumference, and it hung from underneath the left scapula. The tumour was composed of fatty tissue with bands of fibrous connective tissue running through it. On the skin covering the tumour were a great number of papillomatous growths, and on one or two places were patches of eczema due to the friction of the clothes. He was rather emaciated, as the photograph shows, but took his food well and was otherwise healthy. In operating the tumour had to be slung up to a beam in the roof as it was so unwieldy. The hæmorrhage during the operation was not very great, and the patient was able to be out in the street four or five days afterwards.

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Jinjaw, Manchuria, N. China.

ACUTE INFLAMMATION OF ANTRUM IN INFLUENZA.

CASES of acute inflammation of the antrum of Highmore being exceedingly rare, the following close parallel to Dr. Semon's own case¹ may be of interest:

Mrs. T. was seized with influenza on February 10th. Early on February 12th she complained of great pain in the left side of the face, attended with swelling, tenderness of the skin over the cheek bone, and abundant lachrymation from the left eye.

Excruciating pain continued without intermission till February 15th, when, during the act of drinking, a sudden rush of yellowish-green fluid from the left nostril was followed by immediate relief. Pain returned as before, and was again very severe till recurrence of discharge again gave relief. This happened three or four times in the course of the next four days, with gradual subsidence of symptoms.

In addition to the early stage of the influenza, at which the antrum became affected, the following points were noteworthy. The discharge of fluid on each occasion occurred, or was favoured by, the upright position. Lowering the head greatly increased the pain, and gave no vent to the discharge.

The pupils showed no abnormality at first, but after two days the left pupil was found to be decidedly smaller than the right, and to react slowly to light. This condition persisted for two or three days. There was no opportunity for transillumination.

Hadley, Barnet.

R. J. RYLE, M.B. Oxon.

PUERPERAL ERYTHEMA SIMULATING SCARLET FEVER.

ON July 18th 1893, I delivered Mrs. C. of her second child, a son; she did well; on the fourth morning they sent for me hurriedly, the temperature had gone up to 100° and a red rash had appeared on the thighs and lower portion of abdomen. This at first sight seemed like the true scarlet fever rash; there was, however, no sore throat and the discharges were perfectly normal; the rash spread rapidly, the patient the next day being covered from head to foot—a brilliant red—but the temperature had come down to normal; after this the rash rapidly faded, the patient recovering without a bad symptom and getting up on the tenth day; there was no peeling. On inquiry I found that when a girl she had suffered several times with erythema; this I believe to have been the case in this instance although she had no symptom of it in the first confinement.

Woodbury, Essex.

R. T. H. BODILLY.

THE FORCIBLE FEEDING OF THE INSANE.

PERUSAL of the interesting articles by Drs. Neil and Herbert, in the BRITISH MEDICAL JOURNAL of January 27th and March 3rd, would seem to me to give an exaggerated idea of the complexity and gravity of the operation of forcible feeding. The experience of some years leads me to believe that the operation, when conducted with care, is attended with little risk, even in extreme cases, and does not require any complicated apparatus to be carried out. I have the patient seated in a low armchair; one attendant standing behind the chair holds the head and gag; a second attendant, facing the first, grasps the patient's wrists, and holds them firmly down against the lower end of the thigh, at the same time pressing

¹ See BRITISH MEDICAL JOURNAL, February 3rd.