HAMILTON (C. S.)

REPORT OF OPERATIONS UPON HERNIAS.

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STRANGULATED HERNIA.

THE operative treatment of strangulated hernia affords one of the best illustrations of the diminished mortality attending surgical procedures since the introduction of antisepsis. If necessary, the sac may be opened with comparatively slight risk of peritoneal infection; and in the majority of instances this step is advantageous, if it is not absolutely necessary. The era of cleanliness in surgery has produced another striking change. The operation is not feared as it was formerly, and on this account is advised at a much earlier period, instead of being regarded as a *dernier ressort*. It is no longer justifiable to resort to prolonged taxis, which may result in additional traumatism to the already inflamed and softened intestine. The unrecorded history of strangulated hernia would doubtless furnish many examples of reduction *en masse*, rupture of gut, and similar catastrophes from long-continued efforts to reduce. The present attitude of the profession might be expressed thus:

So soon as the diagnosis is made, resort to anesthesia with intelligent and gentle taxis for ten minutes, unless it be contra-indicated by stercoraceous vomiting or gangrene. If taxis fail, the anesthetic should be continued and the operation performed at once.

The following group of cases is reported, not with a view to the maintenance of any special method of operating, but in order to record experience in a very interesting and practical branch of surgery:

CASE I.—Mrs. R. J. F., of Columbus, aged seventy-four, had had a small irreducible femoral hernia for five years. On June 23, 1890, while the patient was straining at stool, the protrusion suddenly enlarged. Severe pain was immediately felt in the lower abdomen, and vomiting occurred. During the next few days attempts were made to return the viscus. At midnight on the 25th she was referred to me for operation. At that time she was vomiting occasionally, and there had been no movement of the bowels for three days. Her pulse was 114 and irregular. Her arteries were evidently in a state of calcareous degeneration. Ether was given by Dr. Dennison, and the operation rapidly completed. On opening the sac some blood-stained serum escaped, and a mass of adherent omentum was removed after ligation with strong silk. Partly surrounded by the omentum was a knuckle of small intestine, dark red in color, and with swollen walls; incision of Gimbernat's ligament was necessary in order to return it to the abdominal cavity. The sac was ligated and removed. The patient's convalescence was uneventful in spite of her advanced years and feeble condition. She was discharged

from the hospital in four weeks. Hernia eventually returned, but is controlled by a truss, and now causes her no annoyance.

CASE II.—J. McW., of Marion, twenty-three years old, had had an irreducible femoral hernia for two years. On the morning of January 31, 1891, a violent muscular effort was followed by pain at the site of the protrusion and increase in its size. Vomiting commenced at once, and was continued until the evening of February 1st, when I first saw the patient. Dr. L. D. Hamilton, of Marion, had unsuccessfully attempted to reduce under chloroform. The patient's pulse was 115; he was vomiting frequently, and was tympanitic. Under ether, reduction was again attempted, but without success. The usual incision was then made over the length of the tumor, and the sac freely opened. Adherent omentum was ligated and removed, after which a slight incision in Poupart's ligament permitted the return of the discolored small intestine. The peritoneal sac was cut off as near the ring as possible, and the wound closed. The recovery was rapid. The hernia has recurred, but a water-pad truss prevents its descent.

CASE III.—A. D., of Lily Chapel, fifteen years of age, had an undescended testicle in the right inguinal canal. Early in the morning of January 29, 1891, while lifting a heavy basket of corn, he suddenly felt a sharp pain in the groin. During the day he walked five miles. At night the pain became more severe, with vomiting and abdominal distention. Dr. Jewett and Dr. Beach, of West Jefferson, were summoned, and found an obscurely fluctuating lump in close relation with the retained testicle. Taxis, with the aid of morphine and chloroform, was attempted without success. At daylight on the 31st I found the boy with an

irregular pulse of 124, vomiting matter of a slightly fecal odor, tympanitic, and suffering the usual paroxysmal pain between the umbilicus and pubes. There had been no action of the bowels since the 27th. I at once operated. The sac occupied the inguinal canal, and was distended with an ounce and a half of blood-stained serum. In order to expose it, the aponeurosis of the external oblique was freely incised. The testicle was apparently normal. A swollen loop of intestine, nearly five inches in length, and of a red-brown color, was the strangulated viscus, being constricted by the sharp margin of the internal ring. After incision of the ring, and consequent relief to its circulation, the intestine began to recover a more normal appearance, and was returned to the abdominal cavity. At this stage of the operation the patient's circulation became depressed. Free stimulation was resorted to, and the wound was closed after accurate stitching of the divided aponeurosis, no attempt be ing made to bring the testicle down to its propelocation.

After the reduction of the intestine, about six ounces of clear fluid escaped from the abdominal cavity. Notwithstanding the hasty termination of the operation, the patient recovered promptly, passing flatus on the following day, and having a normal evacuation on the second day. At the present time the testicle cannot be felt, having retracted into the abdominal cavity; nor has the hernia at any time returned.

Case IV.—Mrs. H., of Mt. Gilead, aged sixty-six, had had an irreducible femoral hernia for many years. When I was first called by Dr. Buxton, February 6, 1892, strangulation had existed for twelve hours, taxis having been ineffectual. The protrusion was oval in shape, occupying the right groin; its

dimensions, three by six inches. The part was exceedingly tender and the constant use of morphine had been necessary to control pain. The usual symptoms of strangulated hernia were found, though there had been no stercoraceous vomiting. Ether having been given by Dr. Buxton, operation followed. The sac contained some bloody serum, with a large amount of adherent omentum (the greater part of which was removed), and four inches of the dark-red colored intestine. It was necessary to nick both Gimbernat's and Poupart's ligaments in order to return the gut. After removing a portion of the sac, the remainder was tied close to the ring. Two stitches were then taken to approximate the edge of the enlarged opening, and the wound was closed. The patient recovered with a sinus leading probably to the silk ligature at the neck of the sac. There has been no return of the hernia.

Case V.—Mrs. C., of Plain City, thirty-six years old, had had a right femoral hernia for a year and a half. It had been strangulated for thirty-eight hours, when Dr. Gardner and Dr. Howland advised operation, after failure to reduce by taxis. She had a high pulse-rate, slight tympanites, umbilical pain, but no vomiting had occurred—possibly it had been prevented by the free use of morphine which her suffering demanded. The sac contained only a knuckle of small intestine of dark-brown color, and much swollen. In this case the constriction was so tight that division without injury of the gut was a matter of some difficulty. The sac was readily excised, and the patient recovered. She is now perfectly well, and wears a truss, although the hernia has not descended since the operation, March, 1892.

Case VI.—H. M., of Columbus, forty-two years

old, had for some years worn a truss because of a right inguinal hernia. On December 17, 1891, while working without his truss, he lifted a heavy weight, and felt something give way in the groin. Intense abdominal pain soon followed, with the symptoms of strangulated hernia. During the day his physician, Dr. Dumm, made efforts at reduction under an anesthetic, but without success. At 10 P.M., the patient was brought to Mt. Carmel Hospital for operation. An incision was made from the region of the internal ring well down to the bottom of the scrotum, as the tumor was very large. A considerable amount of turbid serum escaped from the sac, which contained omentum with fourteen inches of small intestine. The constriction was located at the internal ring. A portion of the omentum was removed, and the intestine carefully examined. Its walls were greatly swollen, and it was almost black in color. The constriction was divided, and the intestine wrapped in warm cloths. Before many minutes there were signs of resumption of circulation, as shown by change of color, and it was then decided to return the gut to the abdomen. It was a question in the mind of the operator at this time whether it would recover its integrity. As usual, the sac was removed and the wound closed.

The following evening the patient's bowels moved freely, and his condition was good until the 23d, when it became necessary to give him morphine occasionally on account of abdominal pain. On the 27th a small fistula formed in the upper part of the incision. From this date until his discharge, on January 15th, he was subject to attacks of pain in the right inguinal region, and after returning to his home he acquired the morphine-habit. Before leaving the hospital, abdominal section, with correction

of any faulty condition that might be found, was advised, but his consent could not be obtained.

This man died eight months after operation. The fistula had nearly closed, but the combined effects of fistula and opium, with a constitution impaired by excesses, carried him off.

It is possible that after its return to the abdomen, the strangulated and inflamed intestine became adherent to surrounding structures in such a manner as to narrow its caliber, and that thus it continued to act as a partial obstruction to the passage of intestinal contents. A secondary operation, if permitted at an early date, might have permanently relieved him.

CASE VII.—Mrs. J. D. E., of Columbus, aged sixty-five, was seized with severe abdominal pain and vomiting on the morning of April 13, 1892, while making some unusual muscular effort. Dr. Coleman saw her on the following day, and found the symptoms of strangulated hernia, with a small, painful tumor in the left groin. The patient had had no rupture until the time of this attack. The taxis having failed, at 6 P. M., on the 15th, operation was performed without difficulty, the hernia being femoral, and containing small intestine with omentum. The recovery of the patient was retarded by intercurrent disease. There has been no return of the protrusion.

RADICAL CURE.

CASE I.—W. E. of Moxahala, twenty-five years of age, had an undescended testicle, with incomplete hernia in the right inguinal canal. The testicle was so sensitive that no truss could be worn; the hernia was growing larger and causing much annoyance. Operation was carried out at Mt. Carmel Hospital, June 15, 1889. The testis was atrophied,

and hence removed. The sac was then dissected free from its connections, and McBurney's operation for radical cure completed. The wound healed rapidly, and the patient was discharged a month later. He writes that he has had no recurrence, and does not wear a truss, although he has been advised to do so.

CASE II.—Mrs. K. S , Columbus, aged fifty-two, had had a right inguinal hernia for thirteen years. For a somewhat shorter period irreducible umbilical hernia had also existed. She was a large, fleshy woman, the mother of six children. The protrusion in the groin was fourteen inches in length, and four in diameter, and could not be restrained by a truss. It frequently became incarcerated, and required taxis, with prolonged rest in bed, to effect reduction. McBurney's operation was advised by Dr. Lippit, and performed by the writer in June, 1890, followed for the time being by cure. The patient was advised to wear a truss in order to prevent a relapse, but failed to do so. Within the last two months there has been some sign of recurrence.

It is interesting to note that the umbilical hernia became larger after the operation, and has remained so up to the present time.

CASE III.—Mrs. H. L., of Lancaster, aged fifty-four, underwent operation in February, 1890, for the cure of umbilical hernia of twenty years' standing. The rupture was reducible, the aperture being half an inch in diameter. Operation was advised for relief of distressing gastro-intestinal symptoms incident to the hernia. After removing adherent omentum, and a return of the large intestine to the abdominal cavity, the sac was ligated and cut off short as possible. The edges of the ring were then approximated by a purse-string suture of strong catgut. Additional wire sutures were inserted to relieve ten-

sion on the catgut during the healing process. The patient was discharged in five weeks, and the rupture has not returned.

In all of these operations the usual antiseptic precautions were observed. Whenever the condition of the patient permitted, radical cure of the hernia as well as relief of strangulation was sought. The favorable results may be attributed largely to the promptness with which, in the several cases, the general practitioners recognized the condition and urged surgical interference to prevent an otherwise fatal issue.

Operations for the radical cure of hernia are only indicated in special cases, because, as a rule, the cure is not permanent from any of the generally recognized methods.

The following conditions would seem to justify its performance:

1. When the hernia is irreducible and painful.
2. When the hernia is very large, and cannot be controlled by a truss.
3. When the neck is so small that there is constant danger of strangulation.

In all cases a truss should be worn after operation in order to prevent relapse.