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INTESTINAL PERFORATION IN STRANGULATED HERNIA.*

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While the title of this paper restricts our discussion to only one point of a very extensive subject, even this one point can be discussed only in a general way before a scientific body whose programme is crowded with papers, many of which may be of more interest to the general practitioner. Certainly few can be of more importance, as every medical man who has been confronted with a damaged intestine, always unexpectedly, will freely admit. Then is the moment when the patient's life hangs upon the merest thread, and then the moment when the thread shall be severed or judiciously husbanded by the medical attendant, and the correctness of his judgment will depend largely upon the thought he has previously given to the subject. There is no time to look up this authority or that, nor to judge between the flowery and convincing statements of the one, and the equally positive statements, directly contrary, of the other.

These then are the questions of vital importance for the consideration of a representative medical body, that a free comparison of views may be had, and that the members may go home with firmer convictions as to what should or should not be done when these grave emergencies arise. It is true that these conclusions may be in direct opposition to the reader of the paper, and still they are very liable to be approximately safe if they represent the judgment of a majority of those present who are qualified by experience or study to enter into the discussion. Another point that presents itself strongly to the mind of the speaker is, that it is far better to limit discussion, to a great extent at least, to the more simple methods of procedure that can be carried out by the average practitioner, rather than devote the time to those intricate operations that cannot be executed by any but the most experienced abdominal surgeon. If all cases of strangulated hernia received the prompt surgical attention that they are entitled to, then the discussion of the subject embraced in the title of this paper would be entirely unnecessary. Unfortunately, this much-desired state of affairs cannot be realized as long as there remain uncertainties in diagnosis, popular prejudices against operations, or—even worse—hesitation on the part of the medical attendant as to the proper course to pursue in order to protect his patient against so disastrous an accident.

The strangulation which leads to the destructive process under consideration may come about gradually, or be immediate, according to the circumstances attending the case. In the first instance, a loop of bowel lying through the canal is moderately constricted, commonly at the external ring. This constriction retards the return flow of venous blood. Progressive engorgement takes place until the blockade becomes so great as to shut off not only the return flow, but also the vessels of supply. Not only is the constricting band becoming tighter and tighter, but frequently, by the formation of gas in the interior of the bowel, the pressure is increased. This pressure from within the gut frequently has a far greater influence upon subsequent events than is generally recognized.

Immediate strangulation usually occurs as the result of forcing down suddenly a new loop of intestine or piece of omentum by the side of a protrusion already present, thereby blocking the canal to such an extent as to shut off at once all blood supply. In such cases the onset of the trouble is usually sudden and violent.

I feel that we should also give serious consideration to a third form of strangulation which is brought about in quite a different manner, and the true character of which is seldom recognized. It occurs in old irreducible hernias, and usually those of large size, where one or more long loops of bowel form the protruding mass. The bowel becomes adherent and otherwise crippled by bands

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