A CLINIC AT ST. BONIFACE HOSPITAL.

By Dr. J. O. Todd, Winnipeg.

No. 1.—This is a case for diagnosis—It has been referred to us as one of ventral, omental hernia—The patient is a farmer, aged 35, he has been absolutely healthy until one year ago, when he began to suffer from an obstinate pain at a point midway between the ensiform cartilage and the umbilicus. He treated for indigestion without benefit, until August 1898 there was no swelling apparent, then while stacking grain he suddenly noticed a lump about the size of a pea at the point above noted; this has never increased in size, but to the persistent pain has been added a troublesome vomiting. Looking at our patient as he lies before us we can see no lump whatever and it is only by palpation that a small nodule, no larger than a pea, is located. This is not tender and the examining finger can detect not the slightest separation of the aponenrotic layer. I candidly confess that this incision is an exploratory one which I deem justified by the persistence of pain and swelling at this fixed point. The integument being divided by a two inch incision the nodule is disclosed and resembles nothing more than a small lipoma—lifting it up by dissection we disclose an important factor, namely, a pedicle, the closer following of which leads to a fine opening about one quarter of an inch to the left of the median line—a light touch of the knife proves our nodule to be a sac containing, unquestionably, a tag of omentum which is firmly adherent at the edge of opening—this is enlarged by incisions upwards and downwards, the tag loosened and we can now by traction run out a couple of inches of omentum. I think we will all congratulate heartily Dr. Stevenson, of Moosomin for the accuracy of his diagnosis. A catgut ligature is thrown around the omental tag, the disbal part excised and the proximal returned to the abdominal cavity—fine silk sutures are now passed through layer after layer of peribonеuni aponeurosis and sheath of rectus; the skin being closed by silkworm gut.

No. 2.—This case is one of fibrous union of a fractured patella. Our patient on the 27th of August last violently wrenched her right leg while recovering herself from a mis-step taken amongst some uneven boards. There was no blow on the patella and the case is one fracture from powerful contraction of the quadriceps extensor. She felt a severe pain at the knee-cap and there was immediate loss of function of the right leg. The leg was treated by her medical attendant by adhesive strapping and splints the patient refusing operative interference, the result being, as you see, a wide separation of the two fragments. She is almost helpless in respect of extension and cannot without supports move herself about. We find the two fragments movable upon each other, but without crepitus, two fingers easily rest between the broken bone, the line of fracture is transverse and runs across the junction of the upper with middle third of the bone.

Our treatment of this case to-day will consist of the placing of three wire sutures, the incision is longitudinal directly down to the bone, dissection of flaps reveals a mass of fibrous tissue between the ends. This being removed, hæmostasis is carefully carried out and three holes bored in each fragment, a curved needle is pushed into each of these threaded with wire, which is thus easily drawn through, the two ends are approximated and the sutures tightened, the twisted ends being