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FLAP SPLITTING OPERATION FOR VENTRAL HERNIA.

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What I have to say on the subject of ventral hernia, will be principally with reference to that form of hernia occuring in cicatrix following abdominal section, and, as a forerunner, I shall report a case on which I operated some months ago.

In December, 1890, I removed uterine appendages from a patient suffering from chronic oöphoritis and prolapse of ovaries; abdominal walls were thick and fat, no drainage tube was used, recovery from operation was somewhat retarded by suppuration in track of a couple of sutures on left side. She was in hospital about three weeks after operation, and then went home, but did not move about much for some time. An abdominal belt was worn after wound healed, though not continuously; always wearing a bandage, however when not wearing a belt.

About following June, she noticed a bulging at lower end, and to left of cicatrix. The protrusion increased in size slowly. On my return from Europe in November last, she called on me, and on examination I found a ventral hernia in line of cicatrix, and to left of it about two and a half inches, in both linear and transverse diameters. The recti had separated along line of incision, for a distance of about two and a half inches. The left rectus appeared to be separated from median line a greater distance than right. The cicatrix had not widened out much. The mass could be pushed back into general peritoneal cavity, but could not be retained in place by any kind of support, owing to wide separation of recti muscles low down. After trying to keep protrusion back, by means of supporter for a time, and failing, I advised operation, to which the patient readily consented.

On January the 7th, 1892, after preparation as for laparotomy, I operated in the following way: I made linear incision in line of cicatricx down to sac; after carefully opening sac, adhesions were separated sufficiently to return contents, which were chiefly omental, into general cavity. I then clipped away superfluous sac, and with scissors split inner border of each rectus along whole length of separation to a depth of about half an inch, making an anterior, and posterior flap; then by means of a Tait perineum needle I passed a row of buried silk worm gut sutures in such a way as to separate the flaps, and bring together the broad raw surfaces of muscle thus made, taking care to have the wound perfectly dry and no clots between flaps thus brought together; then carefully drying superficial wound, I united skin and superficial fascia by a superficial row of silk worm gut sutures, thus closing the whole wound completely without drainage.

The operation was performed in as thoroughly an aseptic manner as possible. The dressings, and after-treatment were the same as after abdominal section for other purposes. Bowels were moved on the fourth day by salines and enema. Patient made a rapid recovery. Temperature never rising a half a degree above normal. I removed superficial sutures on eighth day, the wound having completely healed by first intention. The deep buried sutures were left to take care of themselves. Patient was up at the end of the third week with a thick solid wall in place of the hole which had marked the site of the hernial protrusion.

It is now nearly six months since the operation. I examined the patient but a short time since, and found the support as one would naturally expect a more firm and solid one than that which nature had originally given her.

Eddebohls in a paper published in the *American Journal of Obstetrics*, May, 1891, has pretty thoroughly ransacked the literature on the subject of ventral hernia. The literature on this subject up to that date was found to be rather scanty.

Very little is said on the subject in the ordinary text books on surgery, either general or special. Most of the literature being obtained from the published transactions of gynæcological societies. I suppose the scantiness of the literature on the subject may be accounted for by the fact that the vast