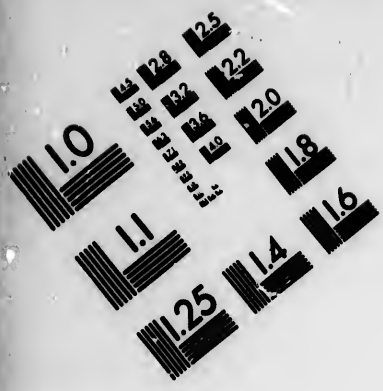

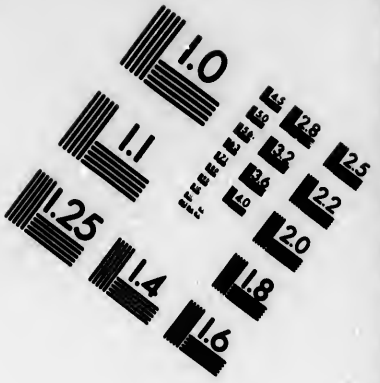

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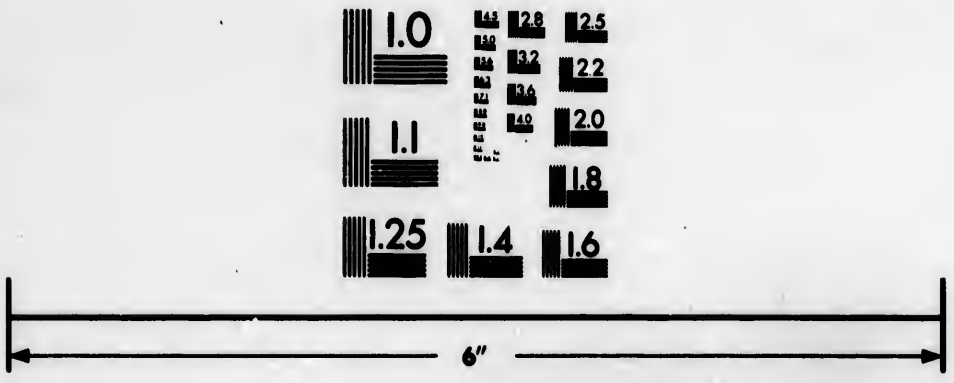

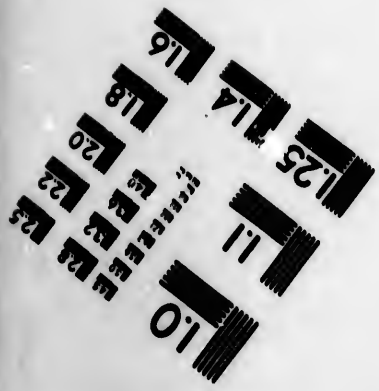

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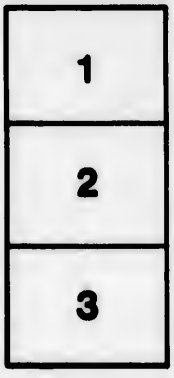

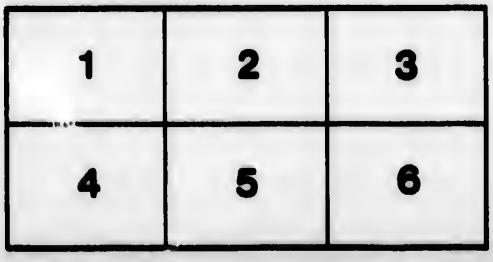

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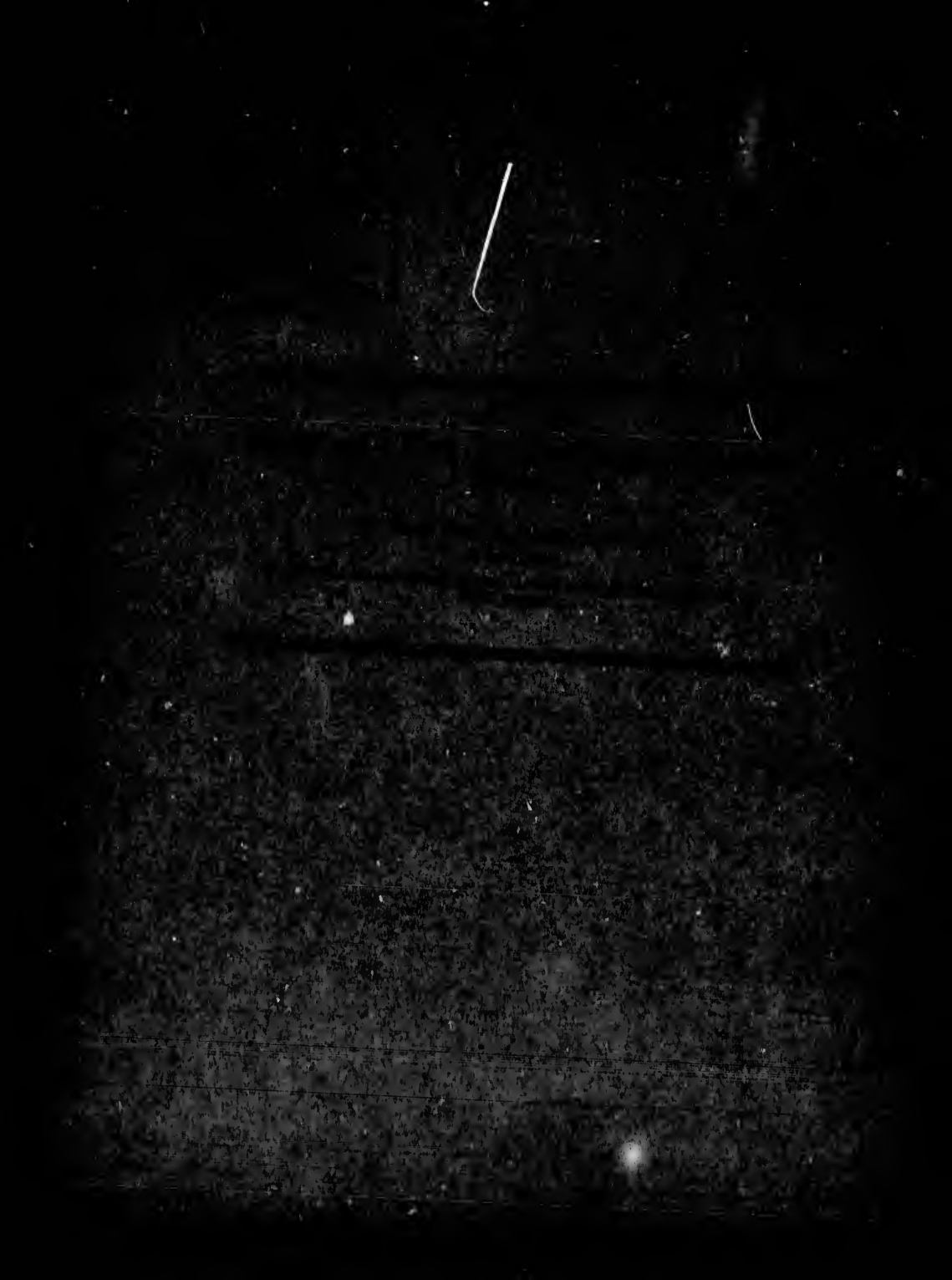

REPORT OF A CASE OF STRANGULATED OBTURATOR HERNIA.

By JOHN MUNRO ELDER, M.D., C.M.,

OF MONTREAL,

SURGEON TO THE MONTREAL GENERAL HOSPITAL; LECTURER ON SURGERY AND CLINICAL SURGERY AT M'GILL UNIVERSITY.

THERE are, comparatively speaking, not many cases of obturator hernia reported in surgical literature, and all the text-books agree in placing it among the rarer forms of hernia.

Sajou's "Cyclopædia of Practical Medicine" mentions it as a rare variety, placing it last on the list, after such forms as perineal, ischiatic, and hernia through the foramen of Winslow, and gives no literature on the subject. The "American Text-Book of Surgery" gives about the same information, while the "International Text-Book" (1900), though describing it as a rare variety of hernia, does give the symptoms and some rules for treatment.

In the London *Lancet* for May, 1895, Mr. W. H. Bennett, of St. George's Hospital, reports a case occurring in a woman, aged seventy-eight, whose symptoms and treatment were so identical with the present case that I shall not repeat them. She, too, was discharged cured in three weeks.

In the same journal for April, 1896 (quoted by "American Year-Book of Medicine and Surgery" for 1897), W. Anderson, of St. Thomas's Hospital, reports two cases, one of which was bilateral, the recurrence on the second side coming on while the patient was still in hospital under treatment for the original hernia of the opposite side. In reporting these cases, he remarks, "Obturator hernia is one of the rarities of surgical practice, only one case is mentioned in the surgical records of this hospital from 1870 down to date of these two

cases, and only thirty cases have been recorded as operated on in Europe down to the present day" (1896).

CASE I.—Woman, aged seventy-one, gave a history of repeated attacks of intestinal obstruction. A tumor could be felt at inner margin of Scarpa's triangle, and this proved to be a strangulated hernia through the upper part of obturator foramen. It was reduced from the outside with relief of symptoms, and patient did well. Twenty-six days later a similar hernia appeared on the opposite side, and, as the patient had not yet left the hospital, she was at once operated on by the same method as formerly, and was ultimately discharged well, though wearing a double truss.

CASE II.—An old woman; strangulation for some time, fæcal vomiting, with great prostration. Laparotomy was done, but patient died on the table. Mr. Anderson then gives the best description I have yet read of the surgical anatomy of the obturator foramen and its surroundings.

In the *Lancet* for June, 1897, Mr. R. Godlee, of University College Hospital, cites three operative cases, all women, varying in age from forty-seven to seventy-four, and all fatal. Laparotomy was done in two of these three, while the other was operated on from without, and the tumor reached by separating the fibres of the pectineus muscle and its underlying fascia. In all cases the strangulation had been present for some time, and there was gangrene of the bowel. Here, again, the chief symptom was (as it always is) that due to obstruction, and only in one could any tumor be made out, or was there any pain referred down the obturator nerve. Mr. Godlee advises a combined external and internal operation, so that through the laparotomy wound one could pull on the strangulated loop of bowel, while, at the same time, through an opening down to the obturator foramen, made at the inner side of Scarpa's triangle, one could more readily disengage the strangulated gut, which Mr. Godlee found he had torn in one of the laparotomy cases.

The case I now wish to report is that of a maiden lady, aged seventy-three, of very spare habit, whom I was called to see on December 13, 1899.

The following history was given: Three days previously she received a sudden jar by missing a step at the bottom of a stairs, and at once felt a severe pain across the lower zone of the abdomen and shooting down right thigh to the knee. She was, however, able to walk about half a mile to her home, where she soon began to be nauseated, and vomited shortly afterwards. Her condition was not regarded by herself or her friends as serious until I was called in on the third day. The vomiting had by this time become markedly fæcal in character and odor; there was marked distention of the abdomen, and she was very weak, but there was no evidence of peritonitis. The bowels had not moved since accident. Temperature, 101° F.; pulse, 112. She had, in fact, all the symptomsof intestinal obstruction, and I was unable to make any more definite diagnosis, having examined her, in vain, for any hernial tumor. I advised immediate opening of the abdomen, with a view, if possible, to find and relieve the cause of obstruction, but her condition was so bad that I could not hold out much hope of a successful result. Consent being readily given, I at once had her conveyed to the Montreal General Hospital, and made arrangements for immediate operation. Just before going on the table, she was given an enema of peptonized milk four ounces, somatose half an ounce, and brandy one ounce, which she retained. The patient was then etherized and prepared for laparotomy in the usual way. A median incision below the umbilicus was made, and distended small bowel at once presented. Although the gut was deeply injected, there was no peritonitis. On pushing aside the distended bowel, collapsed small bowel was seen. This was followed down into the pelvis, behind the right pubic ramus, until it was felt to be tightly grasped at the upper part of the obturator foramen. A coil of the distended bowel was traced up from the same spot, which was thus proved to be the point of obstruction. Pulling on these two lines of bowel with one hand, I managed, with some difficulty, to disengage the knuckle of bowel from the foramen, separating the adhesions with the index-finger of the other hand. This strangulated knuckle, when brought into view, was inky black, but the discoloration only extended around three-quarters of the circumference of the bowel, and did not involve the mesenteric vessels. It was a Richter's hernia, in other words, though sufficient to produce complete obstruction. The application of hot towels to

the black spot for a few minutes completely restored the circulation, and, as the mesenteric vessels had never been compressed, I had no fear of subsequent gangrene, and therefore dropped the bowel back into the abdomen. I made no attempt to close the obturator opening, and indeed, on subsequently feeling for it, could not definitely make one out; and as my patient's condition was not, by this time, very good, I filled the abdominal cavity with warm normal saline solution, and quickly closed the abdomen without drainage. I have before used saline solution in this way in laparotomies, especially if the patients were much exhausted or exsanguinated (as in a ruptured ectopic pregnancy), and always with the best effect, and moreover find it prevents, in a great measure, the excessive thirst which is so apt to torment these patients for the first twenty-four or thirty-six hours after such operations.

The patient only vomited four times after operation, and within four hours of her return to the ward could take milk and soda without nausea. With the exception of an annoying attack of cystitis, which I attributed to careless catheterization for the temporary retention of urine immediately following the operation, the patient made an uninterrupted recovery. The wound healed by "first intention," and the old lady left the hospital, cured, on the twenty-first day after the operation, and is to-day in excellent health.