STRANGULATED FEMORAL HERNIA CONTAINING APPENDIX.

REPORT OF TWO CASES.*

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Strangulated femoral hernia with the appendix alone as the contents is of sufficient rarity to report. In the literature I find reports of about 100 cases in which the appendix was found in femoral herniæ, but in only a few of these was the appendix the sole occupant of the hernial sac, and in only one or two has a primary strangulation of the appendix occurred. In most cases the appendix was found as a passive occupant of the sac, sometimes accompanying the cecum in its descent, and at other times projecting through the ring with a separate loop of bowel or piece of omentum. In order that the appendix may pass through the hernial ring it must be free in the abdominal cavity and possess a meso-appendix sufficiently long and lax to allow its descent. No case has been reported in which the appendix was found in a left femoral hernia.

CASE 1.—My first case was Mrs. D., aged 66 years, who had been in good health for many years with the exception of a lump in the right groin which had been noticed for nine years, but which had given no particular trouble. Though occasionally it was tender on pressure, there never was enough discomfort to necessitate the services of a physician until the present attack. The patient was first seen by Dr. William N. Sullivan, who found that she had been suffering for three days from pain and tenderness over the mass in the groin. There was no vomiting or hiccough; pulse 85, temperature 100 F. I saw the case the next day in consultation, and found an inflammatory mass about two inches in diameter exceedingly tender to the touch situated directly over the right saphenous opening.

I made a diagnosis of either infected inguinal glands or a strangulated omental femoral hernia. The patient was removed to the hospital and operated on immediately. When the sac was opened about half an ounce of bad-smelling serosanguineous pus ran out. The contents of the sac consisted of the appendix, which was large, inflamed, and had a large perforation near the tip; an appendolith, which was lying in a small circumscribed abscess, and the meso-appendix, which was much hypertrophied from its long stay outside of the abdominal cavity. The whole mass was separated from the sac wall to which it was firmly adherent up to the ring, where it was found that the adhesions were so firm that it was not safe to attempt to liberate them, so the appendix and its mesentery were ligated *en masse*, removed, and the stump touched with pure carbolic acid. The cavity was drained with gauze. It closed rapidly, and the patient went home in three weeks. In this case no attempt was made to close the hernial opening because the stump formed an impassable barrier to any future hernia, and any such attempt would have been followed by failure on account of the infection. The appendix must have descended at the beginning of the trouble and during its long incumbency became firmly adherent to the femoral canal. Whether the concretion had started previous to the hernia or not can not be stated, but from its size and consistency it had certainly increased materially during the past few years.

The strangulation in this, as in most similar cases, was secondary and due to the swelling which followed the inflammation of the appendix; and from the condition of the structures in the femoral canal it would take very little swelling of the appendix to cut off the circulation and produce necrosis.

* Read at the September meeting of the California Academy of Medicine.

CASE 2.—Mrs. C., aged 69 years, had had good health previously with the exception of backache, which was worse when she was sitting than when standing or walking. She had never noticed any disturbance in the groin at any time. She woke up one morning feeling perfectly well, and prepared the breakfast. During the meal she was seized with cramps and a bearing-down pain in the lower abdomen, more on the right side. She went to bed immediately and discovered a small lump in the right groin. She called her husband's attention to it, and he, having a rupture himself, thought that his wife's condition was similar to his own, and tried to reduce the mass by rubbing, but without success. Hot bags and other local applications were also tried.

I saw the case at 7 p. m., just twelve hours after the onset, and found the patient suffering intense spasmodic pain in the right groin, radiating up to the abdomen and back. The pain in the back caused more distress than the others. I mention this particularly because I believe that the backache which she had previously was due to the dragging on the meso-appendix during the formation of the hernia, which I think existed some time before its discovery, but which had never been apparent on account of the thick layer of fat. The patient had vomited once shortly after the beginning of the attack. The temperature was 101 F. and the pulse 100.

Examination disclosed a small mass about one and one-half inches in diameter just below Poupart's ligament, and directly over the saphenous opening, which was very tender and hard. I made a diagnosis of strangulated femoral hernia, and had the patient removed to the hospital at once for operation. When the sac was opened about two drams of odorless bloody serum ran out. It was seen at a glance that the contents of the sac consisted of the appendix doubled on itself and strangulated at the external ring. The tip was above the constriction and could not be pulled down until the ring was cut through, when the whole appendix could be pulled down with ease.

An interesting feature here presented itself: it was found that the tip of the appendix was almost gangrenous, while the rest was only intensely injected, showing that the double constriction had caused an earlier strangulation than the single constriction near the base. By carefully pulling on the appendix the cecum was drawn through the ring, the appendix removed in the usual manner, and the stump inverted according to Dawbarn. The femoral canal was closed by passing a few chromicized catgut sutures from the pectineal fascia to the under surface of Poupart's ligament, and the external wound closed in tiers. Recovery was perfect.

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Clinical Report.

A CASE OF UNDESCENDED TESTICLE.

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DETROIT.

The scarcity of literature on the subject of undescended testicles leads me to believe that possibly many cases are overlooked. The article of Dr. Bevan[1] on this subject is not only timely but very interesting and instructive, as it shows very clearly the technic of this operation, which in most cases is so important for the full development of the male child.

I agree perfectly with Dr. Bevan that the rule should be to operate and transplant to its normal position in the scrotum every undescended testicle which can be palpated. I also believe that every case of undescended testicle at the age of puberty should be operated on. The operation should be done as early as possible, and in every case before the age of 19. In several cases I have made the operation much as Dr. Bevan suggests, and in each case have had most satisfactory results. They were, however, with the single exception given below, under the age of 17.

History.—Walter W. aged 28, unmarried, called on me Feb. 15, 1902, complaining of a nervous condition which was

1. THE JOURNAL A. M. A., Sept. 19, 1903.