A CASE OF ABSCESS IN AN OLD HERNIAL SAC, ACCOMPANIED BY AN INTRAPERITONEAL ABSCESS, CAUSING INTESTINAL OBSTRUCTION, AND SIMULATING A STRANGULATED HERNIA.

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PRIVATE S., 1st South Wales Borderers, was admitted to the Station Hospital, Mian Mir, on February 25th, 1904. He had been sent in from an out-station, where it was impossible to render him surgical assistance. The following history was given:—He had suffered from a rupture, and had been fitted with a truss in July, 1903. This, however, he did not wear regularly.

The rupture frequently came down, but he was able to reduce it, until about a month previous to his admission to hospital, when it came down, and has remained down since, in spite of his efforts to reduce it.

On February 14th he was admitted to hospital suffering from dysentery. He had pain in the abdomen, chiefly in the epigastric region, and was passing frequent stools, consisting of blood and mucus. The temperature was a little raised. He was treated with magnesium sulphate, and the dysentery ceased in five days. Some tenderness, however, remained in the right iliac fossa, and some resistance was felt there, like a coil of distended intestine. His bowels became confined, and on February 23rd abdominal pain was again complained of, on this occasion chiefly in the right iliac region. The swelling in the inguinal region (which the patient had not previously mentioned) was now, for the first time, noticed. It occupied the situation of, and was diagnosed as, a right direct inguinal hernia. An attempt was made to reduce it under chloroform, and this failing, he was sent to Mian Mir.

On arrival he looked pale and somewhat exhausted. His tongue was furred, and his temperature 100° F. He complained of pain in the right groin, and lay in bed with his legs drawn up. On examination, a pyriform swelling, about 3 inches long, was found occupying the right side of the scrotum, and extending up the cord to the external abdominal ring. The swelling was hard, tense, and very tender, and the skin over it was hot and reddened. There was some fluctuation, but it was not translucent. There was no impulse on coughing. The testicle lay below and behind the swelling, which occupied the site of a direct inguinal hernia. The condition appeared to be one of inflamed and irreducible epiplocele, with effusion of fluid into the sac.

It was decided to perform a radical cure as soon as the inflammation had subsided. An ice bag was applied, and the foot of the bed raised. The bowels were opened by an enema. On the two following days the condition remained the same. The temperature kept up, the highest

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Clinical and other Notes

The reading being 102° F. The bowels were opened naturally twice each day.

On February 28th the patient complained of pain in the abdomen. The latter was distended and tympanitic. The bowels were confined, and he was unable to pass flatus. At 10.30 p.m. he began to vomit and hiccup. The pulse was rapid and small. In view of these symptoms, which indicated strangulation, it was decided to operate immediately. Assistance was therefore summoned, and the operation immediately commenced at 1.30 a.m. The patient was anaesthetised, and an incision made over the upper part of the swelling. On cutting down and opening the sac, the walls of which were very thick, a quantity of thin purulent fluid escaped. A finger inserted into the sac reached upwards as far as the external abdominal ring, and downwards as far as the bottom of the scrotum. There was no omentum or intestine in the sac, and there was no communication between it and the abdominal cavity. The sac was cleansed and drained, and the wound closed. It was thought possible that the irritation caused by the abscess might have induced the symptoms, and that it would be better to await developments before doing anything further.

On the following days the patient's condition did not improve much. His bowels were open twice, and he felt more comfortable. Pulse 90° F. Temperature subnormal. Respirations 20. The vomiting, however, continued.

On March 2nd the patient complained of great pain in the abdomen; the bowels were confined, and an enema had no result. The vomiting continued, and was of a bilious character.

On March 3rd the symptoms were similar but more aggravated, the vomiting and hiccup were severe, and the vomited matter was brownish and had a faecal odour. It was brought up in small quantities of an ounce or two at a time. The urine was scanty; pulse 116, small and wiry. The condition now appeared to be one of obstruction, due probably to inflammation spreading from the abscess to the general peritoneum, and causing peritonitis and adhesions, under a band of which the intestine had become strangulated. With the object of removing such a cause of obstruction, if present, an exploratory laparotomy was undertaken. The abdomen was opened in the middle line below the umbilicus, and the iliac regions explored. The coils of intestine that came in sight were much distended and inflamed. There were many recent adhesions between coils and between the intestines and the parietal peritoneum. There were none discovered, however, of sufficient strength to cause strangulation. There was no hernia.

The patient's condition had now become so serious that further measures were impossible. The peritoneal cavity was, therefore, flushed out, the wound closed, and the patient returned to bed. Restoratives were applied, and the patient recovered from the collapse. But the
symptoms of obstruction continued, and he died twelve hours after the operation.

Post-mortem appearances.—On opening the abdomen the small intestine was found to be greatly distended with gas and fluid. The large intestine was empty. There were well-marked signs of peritonitis over the lower part of the abdominal cavity. The peritoneum was red and injected, and the great omentum was closely adherent to the brim of the pelvis. There were numerous adhesions between coils of intestines, and the cæcum and vermiform appendix were firmly bound down to the abdominal wall. The vermiform appendix appeared healthy. At the brim of the pelvis the intestines were closely matted together, and on separating them, an abscess containing about 4 ounces of creamy, greenish pus, was discovered, lying in a cavity formed by the adherent coils of small intestine. The abscess was in contact with the upper part of the rectum. There was no palpation of the intestine. On opening the intestines, no ulcers, dysenteric or other, were found, and there was no perforation. The liver and spleen were enlarged.

Remarks.—The interest of the case lay in its strong resemblance to a case of strangulated hernia. All the general symptoms pointed to intestinal obstruction, while the local condition resembled a hernia. The history, too, of a hernia having previously existed, gave support to the view that the condition was one of strangulated hernia. The causation of the intraperitoneal abscess was also a matter of interest. The dysentery, which was apparently the beginning of his illness, might be supposed to have been the exciting cause. But in the absence of any signs of ulceration or perforation, it seems more probable that the abscess, involving, as it did, the rectum, was the cause of the dysenteric symptoms. In this case the abscess in the pelvis may have been secondary to the abscess in the hernial sac, either by a spread of inflammation along the peritoneum, or more likely by actual leakage from the abscess into the general peritoneal cavity, the leak becoming obliterated subsequently by adhesions.