SUMMARY.

	REGIMENT X.			REGIMENT Z.		
Total strength ...	1198			991		
Inoculated once ...	384	or	32·0%	289	or	22·2%
Inoculated twice ...	408	or	34·0%	21	or	2·1%
Inoculated thrice ..	20	or	1·7%	0	or	0·6%
Inoculated total ...	812	or	67·7%	310	or	32·2%
Protected ...	428	or	35·7%	21	or	2·1%
Partially protected ...	381	or	31·8%	289	or	29·1%
Unprotected ...	386	or	32·2%	681	or	68·7%

A Mirror of Hospital Practice.

DOUBLE INGUINAL HERNIA.

BY N. K. BASU, M.B.,

Resident Sergeon, S. N. Pandit Hopital, Calcutta.

I AM sending you a report of a case of double inguinal hernia complicated with hernia of the bladder on the right side. I think it may interest readers of the *Gazette* to read the record of this rare condition, if you consider this short note worthy of publication.

The patient, Hindu male, aged 48 years, was admitted into this hospital on 21st April, 1916, for double inguinal hernia. There was no suspicion at the time of any complication. He was thin, emaciated, with lax abdominal walls. Urine was normal. The herniæ came down a little beyond the external abdominal ring. They were of five years' duration, and the man was extremely anxious to have them operated on.

I operated on him on 25th April, 1916, and did the left side first with a transverse incision in the inter-spinous fold. This hernia was straightforward and gave no trouble.

The right side was next opened at the same sitting, by a similar transverse incision. The sac was exposed and was being isolated by gauze dissection when a very thin walled second sac adherent to the hernial sac on its inner side was found to tear, and water came out from it. On putting in the finger I found it was the bladder. The bladder could not be detached as it was also fixed to the inguinal canal. The hernial sac was isolated and transfixed in the usual manner. As the bladder could not be separated, I left a suprapubic opening in the bladder in the inguinal region. In order to do this I carried an oblique incision towards the pubic spine from the inner end of the transverse incision, closed the inguinal canal in its upper part, stitched up the transverse incisions, and fixed the bladder wall to the edges of the oblique one. Some urine escaped into the peritoneal cavity through the hernial sac which had been torn during separation from bladder.

Towards the end of the operation the patient's condition became very low, and he was given a saline transfusion.

The bladder was drained through the inguinal opening. The patient's temperature went up to 102° the same evening. Next day it was 99·6°, but his abdomen was distended, tender, with consequent embarrassment of respiration. He was placed in Fowler's position, was given an injection of pituitrin 1 c.c. and sodi. bicarb. drink *ad lib.* On the third day his temperature came down to normal, and the bowels started acting. His urgent symptoms gradually disappeared. After this the patient made an uninterrupted recovery. The bladder closed up by granulation. He was discharged completely cured on the 2nd June, 1916.

"EPIGASTRIC HERNIA" IN SEPOYS.

BY N. W. MACKWORTH, F.R.C.S. (Ed.),

MAJOR, I.M.S.,

I. E. Force "D."

THIS type of ventral hernia might well be termed "sepoy's hernia." As far as I am aware "Thompson and Miles" is the only authority who gives this form of ventral hernia a special name, *viz.*:—"*Epigastric.*" All the text-books mention, of course, that a ventral hernia may occur in this region.

It affects sepoys more frequently than any other community. Several other I. M. S. officers have also informed me that they have noted this condition when examining abdomens.

I have operated on eleven cases and have noted its presence in possibly as many more sepoys when examining them for other abdominal complaints.

The tumour is never large, varying in size from a hazel-nut to a hen's egg. In the great majority of cases this hernia is simply a protrusion of preperitoneal fat, through the loose aponeurotic tissue, near the linea alba, somewhere between the xiphisternum and the umbilicus. A peritoneal sac covered with fat containing omentum or gut may be met with, but this is rarely so. In two cases out of the eleven a peritoneal sac was encountered. In one of these the sac contained omentum, the other a knuckle of intestine.

When fat alone is present the tumour might be mistaken for a lipoma, but its deeper origin is manifested by the blood vessels entering its base, which pierce the abdominal wall.

No doubt this protrusion of preperitoneal tissue undergoes lipomatous growth c.f. lipomas in other hernial regions. I dare say even the slighter forms of this hernia cause a certain amount of discomfort; at any rate, it is an excuse for going sick.

It affects adolescents, middle-aged, sparely-built, and well-nourished men in equal proportions. I am at a loss to account for its prevalence in Indian troops.