

removed. A rubber catheter was passed into the bladder, the wall of the sac was partially excised and sutured in three layers with catgut. Wound closed in layers with a drain *in situ*.

Commentary.—An unusual case of diverticulum in the floor of the bulbous portion of the urethra is described. As regards its causation there are two possibilities: (a) That a small congenital diverticulum existed, leading to sedimentation and consequent calculus formation and as more and more calculi formed the sacculation increased in dimensions. (b) That a small impacted stone in the urethra led to its dilatation in the direction of the least resistance and with the formation of fresh stones the dilatation continued in the floor of the urethra.

The dribbling of urine after the act of micturition even at the age of one year is more in favour of its being originally a congenital defect.

P.S.—As regards the result, the patient was still under treatment when the article was written. The wound healed up completely later on and there was no more trouble.

I am indebted to Lieut.-Colonel A. K. Dev, I.M.S./I.A.M.C., Officer in charge, Surgical Division, for permitting me to operate on and report this case.

AN UNUSUAL CASE OF LUMBAR HERNIA THROUGH PETIT'S TRIANGLE

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PATIENT 'S', female, aged 28 years, unmarried, occupation tailoring, admitted into the Medical College Hospital on 28th October, 1947.

Complaints—(1) swelling in the right lumbar region, duration 6 years, and (2) pain in the swelling, duration 2 years.

History of the illness—for 6 years she noticed a swelling appearing in the right lumbar region above the iliac bone. The swelling used to appear on straining or standing and disappear on lying down on the left side or by pressure. The swelling is gradually increasing in size. For the last two years, the patient has felt a dragging pain in the swelling. No history of fever during this period nor any other illness. She has been using a hernia belt for the last 2 years without any effect.

On examination:

General build and nutrition—fair. Liver and spleen—not palpable. Heart and lungs—nothing abnormal detected.

Local—a hemispherical swelling 6 inches in diameter situated in the back of the right lumbar region over the triangle of Petit extruding above to the last rib, below to the upper part of the gluteal region (2 inches below the iliac crest), medially to near the middle line, and laterally to the right anterior axillary line. It has a fairly well-defined outline except anteriorly (figure 1, plate XIII). It increases in size on coughing with expansile impulse and diminishes

when the patient lies on the left-side, and is fully reduced on pressure. The swelling feels soft and boggy through which coils of intestine can be felt. Margins of the Petit's triangle are very well-felt and the gap admits 3 fingers deep into it. The swelling is tympanitic on percussion.

Patient has slight kypho-scoliosis with pigeon breast (rachitic) and multiple neuro-fibromatosis with pigmentation.

Treatment—operation of hernioplasty was done.

Anæsthesia—nitrous oxide gas and oxygen.

A curved incision 5 inches long was made over the swelling parallel to and 2 inches above the iliac crest. Subcutaneous fat was incised in the same line. Posterior margin of external oblique muscle was seen. Latissimus dorsi muscle was markedly atrophied and was practically not visible. No muscle was seen in the floor of the triangle. Lateral margin of erector spinæ muscle was well-defined and formed the medial border of the gap. There was a fascial sac which was incised and true sac exposed. The sac was opened and cæcum, ascending colon, terminal ileum were found to be its contents. It was a sliding or gliding type of hernia, the sac forming the anterolateral part and the cæcum and ascending colon forming the posterior part. Appendix was removed. The sac anterolateral to colon was ligated by a purse-string suture of catgut and excised. The so-called fascial sac was also excised and shortened. The gap was repaired by fascial sutures taken from fascia lata of the right thigh, sutures placed between external oblique and erector spinæ muscle repair was reinforced in places by a few thick silk sutures. Skin was sutured by interrupted silkworm gut (figure 2, plate XIII). A narrow corrugated rubber sheet drain was left in the subcutaneous tissue through the posterior end of the incision, as the thick subcutaneous tissue showed a slightly oozing surface.

Drain was removed in 48 hours and sutures in 10 days with good union. There was some hæmatoma in the thigh wound (from where fascial sutures were taken) for which the stitches had to be removed earlier, collection let out and the wound allowed to heal by granulation. There was a rise of temperature for a few days during the post-operative period. It was controlled by penicillin and sulphadiazine.

The patient was discharged from the hospital on 18th December, 1947.

Comment

Lumbar hernia is divided into two groups:—

(1) Spontaneous, (2) traumatic.

1. Spontaneous lumbar hernia or the congenital form is a very rare variety of hernia and is less common of the two. It appears in two situations:—

(a) Through the triangle of Petit bounded below by the crest of the ileum, anteriorly by the posterior border of external oblique muscle,

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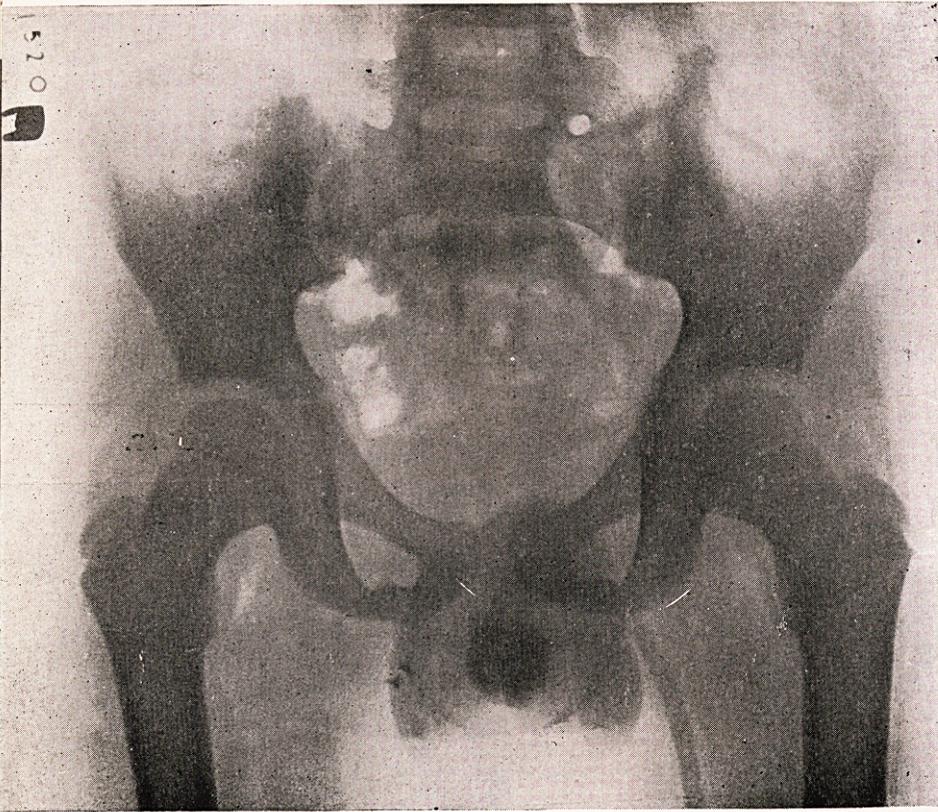


Fig. 1.

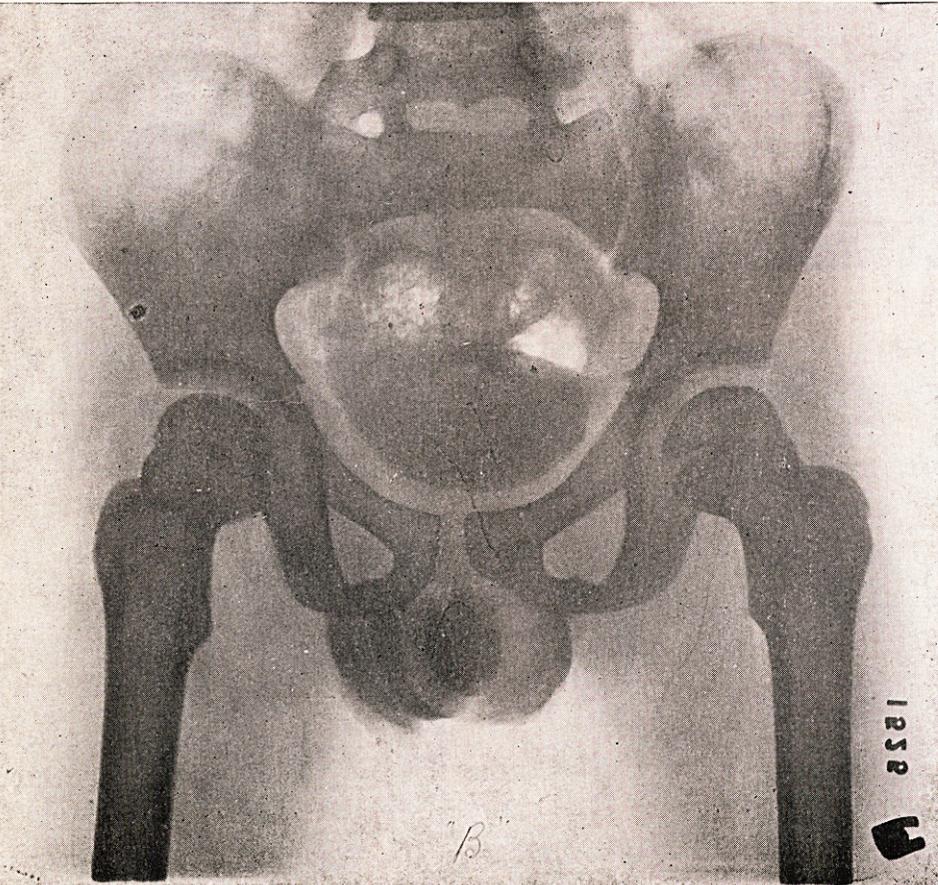


Fig. 2.

URETHRAL DIVERTICULUM IN
THE SCROTUM WITH CALCULI :
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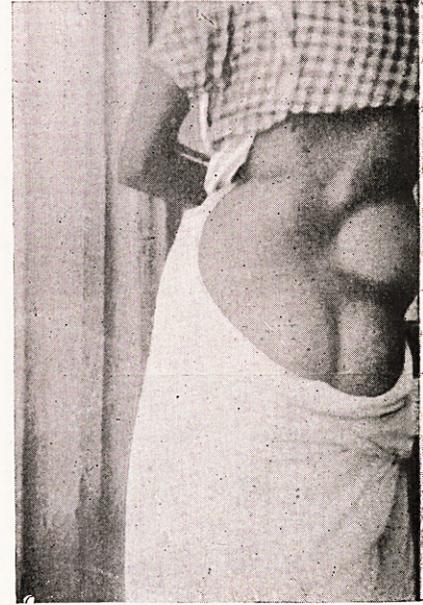


Fig. 1.

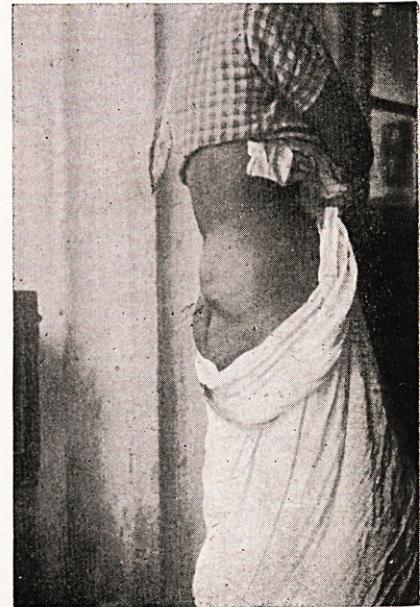


Fig. 2.

posteriorly by the anterior border of Latissimus dorsi muscle.

Only when there is a distinct deficiency in the extent of origin of these muscles can the triangle be said to exist.

The hernia is rarely more than a slight bulging. It causes no symptoms. Of whatever variety, the lumbar hernia rarely contains anything but omentum and ascending or descending colon. The sac resembles that of other ventral hernias, being ultimately incorporated with the integuments (the case under consideration differed in this respect). In one case of Russel Howard, the hernia was preceded by the formation of a properitoneal fatty hernia. Strangulation has been described. The hernia is said to be more common on the left side in men.

(b) Behind the posterior axillary line and just beneath the last rib. This is less common of the two although it is a frequent site of a lumbar abscess.

2. Traumatic lumbar hernia is commoner than the spontaneous variety. It usually follows:—

(a) Operations on the kidney owing to transverse division of muscle fibres and frequent necessity for drainage, or suppuration occurring in the wound.

(b) After opening and drainage of a lumbar abscess.

(c) After gun-shot injury where efficient repair cannot be effected or suppuration follows repair. A case of traumatic lumbar hernia came to my notice 2 months after a gun-shot injury in the right lumbar region.

The hernia may attain a very large size and the bulging occupies the whole space between the last rib and iliac crest. Patient complains of a sense of weakness in the part which is disabling. Strangulation is rare.

The case under review differed from the usual spontaneous form in the following: (i) it was very big in size, (ii) it did not contain omentum, (iii) it produced symptoms of dragging pain, and (iv) the sac was not adherent in the integuments.

Treatment

I. Spontaneous type—by using a belt with a flat pad over the site of hernia.

If big in size—radical operation with repair by fascial suture.

II. Traumatic type—by using a suitable belt or re-suture of the wound in layers after dissecting away all scar tissue.

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Therapeutic Notes

NOTES ON SOME REMEDIES

XX.—DRUGS IN ANÆMIAS, Part IV

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II. MACROCYTIC ANÆMIAS

1. Pernicious anæmia*

(Low red cell count, macrocytes, normal saturation of hæmoglobin; high colour index; histamine-fast achlorhydria, megaloblastic bone marrow, central nervous lesions are common.)

Treatment consists in supplying the hæmopoietic principle to bring the blood count up to normal level and then to maintain it at this level for life. Intramuscular liver is most commonly used. In the relapse stage when the blood count is low, an extract is injected at first daily, the dose varying from 2 to 5 c.c., then on alternate days until the red cells reach 3 million per c.mm. and thereafter once a week until the normal level is reached. The more concentrated extracts require smaller and less frequent injections. Striking changes in the blood occur with the institution of treatment, and the more anæmic is the patient, the more effective is the action of liver. Reticulocytes start increasing about the third day, reaching the peak within the next two or three days and subsiding again to normal by the fourteenth day. When there is no reticulocyte increase, the dosage of liver should be increased. If still no response occur then probably the preparation is not potent and should be changed. Three or four days after the reticulocytes have begun to increase, the red cell count itself begins to rise with the hæmoglobin lagging a little behind. The increase of red cells is not uniform but is maximum during the first two or three weeks of treatment, thereafter becoming less and less the nearer the count approximates the normal, which it takes about two months to reach. Absence of macrocytes is a good index of the adequacy of treatment, so cell volume determination should be part of routine blood examination. With the changes in the blood there is a rapid improvement in the condition of the patient.

Only in exceptional cases is it necessary to give an initial blood transfusion or liver intravenously. Both can be given together in the same injection.

* Pernicious anæmia is rare among Indians, but is given in some detail as a general guide to treatment of macrocytic anæmias.