CASES DEMONSTRATED AT THE F.R.C.S. CLASS

Irreducible Femoral Omentocele.

A female patient aged 38 was presented. For eight years continuously she had a lump in the left groin. The swelling had not varied until one week previously, when it became slightly larger and somewhat painful.

The lump in question was, in fact, an irreducible femoral omentocele, slightly overlapping Poupart’s ligament, as these swellings are wont to do.

Only one male candidate made the correct diagnosis, and he arrived late and examined the patient by himself. One female candidate made a very good diagnosis of hydrocele of the femoral hernial sac. The latter condition could be ruled out by non-translucency. A hydrocele of the canal of Nuck was suggested by many candidates. The swelling was non-translucent and was not in the inguinal canal, nor at the external abdominal ring, so this diagnosis could be eliminated readily. Many of the candidates considered the swelling to be a lipoma. “If it is a lipoma,” they were asked, “in what plane is it situated?” The answer given was “in the subcutaneous tissue.” The reply was if it was in the subcutaneous tissue the swelling should be movable upon the deep fascia. Unfortunately the whole of this swelling could not be made so to move. Other suggestions were, that the lump was an ectopic ovary or a psoas abscess. As it happened this patient had got an old healed Pott’s disease of the fourth lumbar spine, but the candidate who made the diagnosis of psoas abscess had not looked at her back.

On October 6th, I performed Lotheisen’s operation. The femoral sac was full of omentum and this was excised. Herniotomy was performed in the usual manner.

Case presented by Hamilton Bailey, F.R.C.S.

Hydatid Disease.

Mr. G. K. Aet 60. Occupation: House Painter.

History.—This patient, who, so far as is known, had never been associated with dogs or farm life, was operated upon some 30 years ago for hydatid cyst of the groin. Three years later, a second cyst was found in the liver, and in Guy’s Hospital a further operation was undertaken. In 1929, he was admitted to the Royal Northern Hospital where, it is said, a huge cyst was found in the abdominal wall extending on the one hand upwards into the liver, and on the other, downwards into the pelvis, causing pressure on the bladder and rectum. (Demonstrated by cystoscopy and sigmoidoscopy.) An attempt was made to remove the cyst lining, but with only partial success.

He remained free from symptoms for two years, but in 1931, he presented himself at the West London Hospital where it was found that he had cysts in the following situations:—Right lobe of liver, right inguinal canal, previous
operation scar, peritoneum. In the latter situation, they were numerous, two being firmly adherent to the bladder. The majority of the cysts were removed, but the liver and pelvic cysts were, perforce, left behind.

Again he enjoyed comparative freedom from symptoms until early this year, when several small cysts were excised from the abdominal wall and peritoneum.

Throughout his long illness, there had been comparatively few attacks of anaphylaxis, although from time to time he had suffered from bouts of faintness, vomiting and urticarial rash. Nor had obstructive or pressure symptoms been much in evidence, and suppuration had only once occurred.

Physical Signs.—A well nourished man, presenting a much scarred abdomen. Inspection revealed a large rounded swelling in the left lower quadrant of the abdomen, a small rounded swelling below and to the right of the umbilicus, and a prominence beneath the right costal margin. On palpation, the swelling on the left was found to be cystic, firmly fixed to the posterior abdominal wall, but free from attachment to the ventral varieties. The small swelling on the right also fluctuated and was actually within the anterior abdominal wall.

The mass beneath the right costal margin projected downwards for some two inches, was firm and had a definite margin. It was evidently composed of liver and other cysts.

X-Ray Examination.—Showed a large mass projecting upwards from the upper surface of the right lobe of the liver. It was rounded in contour and some four inches in diameter.

Special Examinations.—Hydatid skin test: Not performed.
Eosinophilia: 4 per cent.

Comments.—In surgical practice, there are very few conditions for which it is necessary to open the abdomen more than two or three times. Abdominal hydatid disease may warrant this however, as in this instance; for the cysts, either by their size, situation or tendency to secondary echinococcosis by leakage or rupture may be dangerous to hosts indeed. If neglected, the difficulties of operation increase, and in the meantime, the patient is in continual danger of complications. In the case above quoted, radical cure cannot be expected. The best that can be done, is to keep him as free as possible.

The greater part of the swelling beneath the right costal margin, was due to a large cyst in the upper part of the right lobe of the liver. In all probability it would be impossible to dissect away all its lining and marsupialization would therefore become the method of choice for its treatment. Pleural infection must be carefully guarded against.

When this case was demonstrated, the findings at the various operations were withheld so that the candidates might be allowed to make their diagnosis merely from the physical signs and X-Rays. It was noteworthy that not more than three of the twenty-five present mentioned hydatid disease.

Case presented by Donald Barlow, M.S., F.R.C.S.
(By kind permission of Mr. Oswald Addison, F.R.C.S.)
Cases Demonstrated at the F.R.C.S. Class

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