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Bilateral Perineal Hernia

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of strongyle larvae. The walls of the anterior mesenteric artery and its branches were one cm. thick and contained abscesses up to three mm. in diameter. Thrombi containing *Strongylus vulgaris* were present. The small intestine contained about 100 ascarids, the stomach about 100 *Gasterophilus intestinalis* larvae and the same number of *G. nasalis* larvae were in the duodenum.

This was the worst invasion of the caeco-colic mucosa by larval strongyles ever seen on autopsy here at the clinic.

*J. R. Terry '52*

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**Bilateral Perineal Hernia.** On March 30, 1951 an 8-year-old Boston Terrier male was admitted to Stange Memorial Clinic. The history was one of constant straining. Examination revealed a large swelling surrounding the anus. A catheter was passed up the urethra and into the bladder without difficulty; hence it seemed doubtful if the bladder was contained in the hernial sac. A diagnosis of bilateral perineal hernia was made.

The patient was given 1½ gr. of morphine sulphate and 1/40 gr. of atropine sulfate as preanesthetic medication. An enema was given. He was then placed on the table in sternal recumbency and the area surrounding the rectum was shaved, defatted with ether, and sprayed with 50 percent isopropyl alcohol. A purse string suture of catgut was placed in the anal mucosa closing the anus.

Ether was administered by inhalation to the stage of light surgical anesthesia. An incision was made on each side of the anus in the form of an arc. These incisions were approximately 2 in. from the anus and 3½ in. long.

The urinary bladder was found to comprise the contents of the hernial sac. The bladder could not be returned to the abdominal cavity due to its distension with urine. A hypodermic needle was inserted into the bladder and urine drained off and away from the area by means of a piece of rubber tubing coupled to the needle. The empty bladder was readily returned to the abdominal cavity.

By blunt dissection, the rectum was separated from the surrounding tissue except for the most dorsal aspect. Using No. 2 chromic catgut and a full curve needle, simple interrupted sutures were placed in the muscularis of the rectum, including as much of the perirectal tissue as possible. A small diverticulum of the rectum was tied off by inclusion in one of these sutures. The skin was closed with nylon suture material. The purse string suture was removed from the anus.

Since the prostate gland was found to be enlarged, the surgeon considered it to be a contributing factor, if not the cause, of the straining which produced the hernia. A classical castration was performed in an attempt to secure reduction in the size of the prostate gland.

The patient made an uneventful recovery except for a large perirectal blood clot. Two sutures of the right incision were removed and the clot grasped with blunt forceps. The following severe arterial hemorrhage was stopped by forcing a large sterile pack into the cavity and suturing the skin. This gauze pack was removed two days later. The patient was discharged from the clinic on April 25, 1951.

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