

nant lymphomata is well recognized and Firkin & Blackburn (1958) regard the condition as a mild form of reticulosis.

Acknowledgment: I am very grateful to Dr A G Stansfeld for the histological examination of the lymph-node biopsy.

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Carotid-cavernous Arteriovenous Fistula

A E J Mullins FRCS (for Leslie Oliver FRCS)

K G, female, aged 65

History: Loud noises in right ear since October 1962, increasing in intensity and noted by her as being synchronous with heart beats. December 1962: Developed diplopia and found to have right external rectus palsy. No paræsthesia in the face. No headache, nausea or vomiting.

On examination: Obvious external rectus palsy. No exophthalmos or visible ocular pulsation. Visual fields normal. No papilloedema. V, VII, IX, X, XI and XII cranial nerves normal. Hearing impaired on the right. Bone conduction is more efficient than air conduction. Limbs normal. Blood pressure 270/115. Bruit can be heard loudest on the right side of her head but is clearly audible in all areas.

Clinical diagnosis (confirmed by angiography): A fistulous aneurysm of the internal carotid artery within the cavernous sinus.

It is proposed to carry out ligation of the right common carotid artery following the usual precautions and later, if pulsation returns in the neck, to perform ligation of the internal carotid artery.

Strangulated Femoral Hernia Appendix with Perforated Sigmoid Diverticulitis

Leslie Wise FRCS
(for Norman Tanner FRCS)

Mrs R B, aged 71

History: Admitted to St James's Hospital on 4.4.63 with colicky lower abdominal pain associated with nausea, but no vomiting. She had no bowel movement over the previous two days, but was still passing flatus. She had been given an

enema on the day preceding admission. No other symptoms.

Past history: No history of hernia. In 1956 she had a valved Balfour gastrectomy for chronic duodenal ulcer with excellent result, except for orange bolus obstruction of the small bowel in 1960 which settled on conservative treatment.

On examination: An elderly, obese woman, slightly dehydrated and obviously in pain. Apyrexial. Pulse 88. Strangulated right femoral hernia (tense, tender, irreducible and without cough impulse). Rebound tenderness in lower abdomen. Bowel sounds present but reduced.

Investigations: Hb 82%. Electrolytes: no gross abnormality. X-ray of abdomen: no fluid levels.

A clinical diagnosis of strangulated femoral hernia was made.

Operation (4.4.63): (1) Repair of right femoral hernia using low approach. The only content of the hernial sac was a turgid, red appendix. The strangulation was caused by the tight neck of the hernial sac. This required digital dilatation to free the appendix. As the cæcum could not be brought down the appendix was pushed back into the peritoneal cavity, the sac excised and the hernia repaired with nylon sutures.

(2) Routine appendicectomy, using grid-iron approach; on exploration of the peritoneal cavity a large mass was felt round the sigmoid colon and faecal matter found free in the pelvis.

(3) Left Rutherford Morison incision revealed perforated sigmoid diverticulitis with faecal peritonitis. Procedure: Exteriorization of the sigmoid colon without resection owing to the poor general condition. Two days later diathermy excision of the affected bowel was carried out, followed in two months by closure of the colostomy and restoration of bowel continuity.

Comment

The subject of appendix in a hernial sac is not only of clinical but also of historical interest in that the first successful appendicectomy was performed by Claudius Amyand at St George's Hospital, London, in 1735, when he removed an acute perforated appendix from a right inguinal hernia in a boy aged 11 (Rose 1954). Femoral hernia appendicitis was recorded in 1731 by De Garengot (Garland 1955). Since that time in a period of 232 years only 233 cases of appendix in a femoral hernia have been reported (Kia-Nouri 1962). The incidence of appendices in femoral hernial sacs varies in different reports (Table 1).

Table 1
Incidence of appendices in femoral hernial sacs

Author	No. of femoral hernias	No. of cases with appendix in sac	State of appendix
Cooley (1908)	140	0	
Gault & Baylis (1936)	230	2	2 inflamed
Koontz (1952)	139	2	1 inflamed
McClure & Fallis (1939)	90	2	1 gangrenous
Rogers (1959)	170	1	1 strangulated
Rose (1954)	30	1	1 inflamed
Shawan & Altman (1935)	97	3	1 strangulated
Wakeley (1938)	610	3	1 inflamed

Table 1 shows that appendix can be expected in femoral hernia in about 1% of patients and is strangulated or inflamed in about 0.5%. Even when the sac is opened it may be difficult to differentiate between a 'strangulated' and an 'acutely inflamed' appendix although it should be removed in either case.

In the case reported here, not only did the patient have a strangulated appendix within the hernial sac, but also a coincidental perforated sigmoid diverticulitis. It is possible that the perfora-

tion was secondary to the enema administered the day before her admission.

No previous report of a strangulated femoral appendix occurring simultaneously with a perforated sigmoid diverticulitis has been found.

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The following cases were also shown:

Paroxysmal Nocturnal Hæmoglobinuria
 Dr G Hamilton Fairley

Tetralogy of Fallot
 Dr D A Chamberlain (for Dr David Weitzman)

Spinal Meningioma
 Mr A E J Mullins (for Mr Leslie Oliver)