2. Insertion of a Davis gag and opening it to the maximum extent produced a dislocation of the jaw, which served to fix it in place and also to bring the inferior dental foramen into the most forward possible position. Most of the operation was then carried out without a gag, but with medial and lateral retraction of the tongue and cheek. No packing was placed in the pharynx; continuous suction was used, and the blood remained a nice bright colour throughout.

3. A vertical incision was made through the muco-periosteum of the jaw; it extended from near the tip of the coronoid process along the crest of the alveolar ridge to the region of the first bicuspid tooth.

4. A short external incision was made along the lower border of the jaw just posterior to the mental foramen.

5. The whole of the periosteum of the jaw was stripped from the bone, except the upper part of the ascending ramus and the region of the inferior dental foramen.

6. With good retraction inwards of the internal pterygoid muscle, local illumination, and blunt dissection, the artery, vein, and nerve entering the bone were soon located, identified, and isolated.

7. A clamp was placed on the whole bundle, silk ligatures were passed above and below and tied, and division was made on removal of the clamp; there was no sign of haemorrhage, and the jaw became visible on its inner aspect right down to the angle.

8. The ascending ramus was then divided partly with a Gigli saw and partly with bone shears, about $\frac{1}{4}$ in. (1.9 cm.) below the condyle.

9. The anterior end of the bone was next divided by a saw-cut posterior to the mental foramen and the section of jaw removed. The dislocation was then reduced without difficulty. This left a fairly dry cavity lined with periosteum.

The patient's recovery was quite placid and painless. She remembers nothing of the operation, during which she slept motionless. Penicillin was given prophylactically for a few days.

In selected cases of surgery involving the ascending ramus of the jaw this procedure may prove useful. Ligation of the nerve as well as the vessels should be sound practice in view of recent experiments by M. P. Chenilleau (*Int. Abstr. Surg.*, 1948, 86, 351), which showed that ligation of nerve-ends in animals prevented the formation of painful neuromas and also of trophic ulcers, particularly if linen thread was used instead of catgut.

I am indebted to my wife for skilful assistance. She was in fact the first to see the vessels at the foramen and to call my attention to the fact: they were even a little further forward and a little higher up than I had anticipated. I had just bypassed them on the lower side.

It is proposed to submit a fuller account of this case, illustrated by radiographs of the subsequent bone graft, for publication at a later date.

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Heterotopic Pancreatic Tissue in the Ileum Causing Intussusception

Heterotopic pancreatic tissue in the wall of the ileum is rare; records of only thirteen cases can be found in the literature. Fourteen cases in which the pancreatic tissue was present in a diverticulum from the ileum are also recorded. The details of the ileal-wall cases are scanty, but intussusception occurred in three. I record a further case of intussusception caused by heterotopic pancreatic tissue in the ileum.

CASE REPORT

On Feb. 21, 1947, I was asked by Dr. J. W. Wilson, of Stirling, to see a girl aged 9 $\frac{1}{2}$. At 2 p.m. that day she had been seized by sudden severe abdominal pain so intense as to cause fainting. The pain, colicky in nature, was felt mostly in the central abdomen and was accompanied by continued vomiting. One year previously she had had a similar but less severe attack which passed off in twenty-four hours. Examination showed slight fullness of the upper abdomen and marked tenderness and slight rigidity in the right side of the abdomen; a mass about the size of an orange was palpable to the right of and just below the umbilicus. Immediate operation was advised and the patient was admitted to Stirling Royal Infirmary.

On opening the abdomen some five hours after the onset of symptoms an ileo-ileal intussusception was found some 3 ft. (0.9 m.) up from the ileo-caecal junction. The intussusception was easily reduced. At the apex of the intussusceptum a well-defined plaque of tissue 2 by 1 cm. and some 2 mm. thick was found on the anti-mesenteric border of the bowel. This clearly had excited the intussusception. The plaque was resected, but so much narrowing of the

bowel resulted from suture that it was thought wiser to resect a small segment of the ileum. This was done, and the abdomen was closed after an end-to-end anastomosis. Recovery was uneventful.

Pathological Report.—Dr. W. W. Park, of the Royal College of Physicians Laboratory, Edinburgh, supplied the following report on the specimen: "The specimen consists of a piece of compressed tissue, 2 by 1 cm. Microscopical examination shows: (1) Large masses of well-developed glandular tissue (Fig. 1) lying closely adjacent to the gut wall, and in places growing up to and even into the muscular layers. (2) The tissue is highly differentiated into acinar structures with well-formed ducts and ductules (Fig. 2). The

FIG. 1.—Glandular tissue. ($\times 150$.)

FIG. 2.—Glandular tissue. ($\times 400$.)

cell type is uniform and moderately large, and there are no mitoses. There is no evidence of malignancy. (3) This type of growth is to be regarded as a developmental error, hamartomatous in type. Conventionally, tissue of this nature is designated heterotopic pancreatic tissue, although in this case, where there is no sign of any islet tissue, it would be more correct to regard it as non-specific developmental overgrowth."

I am indebted to Mr. Stanley Hay, Dr. Park's technical supervisor, for the photomicrographs.

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