VIII.—FRANCIS IMLACH, M.D.

DR. IMLACH, referring to the question which had been raised as to nephrectomy or nephrotomy in pyonephrosis and hydronephrosis, pointed out that Mr. Morris's success in the minor operation in cases of pyonephrosis told rather against his argument in favour of nephrectomy in the first instance. His own experience in four cases was in the same direction. No doubt where the kidney was riddled with pus it was best to remove it, but this was not a common condition. In hydronephrosis, where the kidney grew as large as any ovarian tumour, it was customary to remove the organ. It was an easy and safe operation, but emptying and drainage might be sufficient. A large proportion of the renal tissue remained healthy though it was spread out, and such a kidney was by itself an efficient excretory organ.

He had experience of a case in which the other kidney was no bigger than a bean. Drainage might leave a useful kidney; and he thought the disastrous effects of the ancient practice of drainage of ovarian tumours had no analogous lesson.

CASE OF GASTRO-ENTEROSTOMY WITH THE AID OF DECALCIFIED BONE PLATES.

By T. KILNER CLARKE, M.A., F.R.C.S.,

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ONE of the most interesting and, from a practical standpoint, probably the most valuable of the reports made to the Scientific Grants Committee of the British Medical Association is the Report on Intestinal Surgery by Mr. Frederick B. Jessett. It is given at full length in the *BRITISH MEDICAL JOURNAL* of July 27th, 1889, and consists mainly of the results and experiences Mr. Jessett has gained in investigating the mode of operation suggested by Dr. Senn.

Gastro-enterostomy, by means of approximation plates, is there so lucidly described and illustrated that I would refer the reader to that paper for the full details of the operation. I wish rather, in recording my own case, to dwell on the points where it is possible to go wrong. According to the tables published by Mr. Herbert Page, gastro-enterostomy has been performed thirty-six times with twenty-one recoveries. Of the English cases, three in number, Mr. Barker's and Mr. Page's recovered, and lived some considerable time; Mr. Jessett's died on the tenth day, not from the operation, which was perfectly successful, as the *post-mortem* examination showed, but from kinking of the bowel occurring five days after operation.

The following case is the first, I believe, which has been done by means of the bone plates.

J. C., aged 48, pattern weaver by trade, an anæmic, emaciated, slightly built man, consulted me on September 17th. He stated that his illness began fourteen weeks before with pains in the small of the back, between the shoulder-blades and under the middle of the sternum; that he had vomited all solid food since the beginning of his illness, and had lost much flesh and strength. On examining the abdomen, I found a movable tumour, two inches and a half in the horizontal diameter by one inch and a half in its vertical, reaching as low as the navel, four-fifths of it being on the right of the middle line. Attached to it was the dilated stomach, stretching downwards to the left. This tumour existed in all probability before giving rise to any marked symptoms, as his medical attendant, Dr. Orr, had discovered it in the early part of his illness. Diagnosing the case as one of cancer of the pylorus, I advised an exploratory incision and further operation if the diagnosis proved correct. I operated on September 20th, assisted by Dr. Orr, Mr. Dyson, and Dr. Scougal, who gave the anæsthetic, which was one part chloroform and two parts ether.

Carrying my incision, three inches in length, in the middle line to the level of the lower edge of the navel, I came down at once on the thickened and enlarged pylorus. The next step, and the only difficult part of the proceeding, was to get hold of the jejunum. The way to make certain of this is to follow with the finger the gut from the duodenum downwards until it can be readily pulled out of the abdominal cavity. Pulling the bowel out of the wound I emptied by gentle pressure about four inches of it, and isolated this by means of two ligatures of rubber tubing passed through the mesentery at its attachment to the bowel. The gut was then opened to the extent of an inch, the opening washed clean, bleeding points stopped, and the decalcified bone plate slipped inside and fastened in position by its attached threaded needles. A

portion of the stomach was then pulled out of the abdomen, and the second plate was fixed in position, about one inch and a half from the pylorus and the same distance from the greater curvature. The two plates were now placed in apposition, and the corresponding threads of fine Chinese silk tied. A few Lembert sutures of catgut were introduced round the edges of the plates and the parts were returned into the abdomen. Before closing the abdominal incision, I carefully spread out beneath it a layer of omentum. No toilet of the peritoneum was needed, and cleanliness was the only antiseptic. The wound was dressed with Gamgee tissue, and a thick pad of towel bound firmly over it.

The patient's condition when put back into bed was good. An enema of beef-tea and brandy was given. The subsequent progress of the case was as follows:—

September 21st. Patient's condition very good; very little pain. Pulse 86; temperature 98.4°; is being fed by nutrient enemata.

September 22nd. Removed the thick pad, and began feeding by the mouth with wine, whey, and veal broth. Pulse 84; temperature normal.

September 24th, 10 A.M. Abdominal wound healed, stitches removed. Pulse 84; temperature 98.4°. Passed a good formed motion; taking plenty of fluid food. 3 P.M., attack of dyspnoea. I did not see him till 10 P.M., when I found his temperature 101° and pulse 120, and the heart's action feeble and intermittent. There was dulness of the lower half of the right lung and tubular breathing at the base. I ordered poultices and ten drops of tincture of digitalis, with acetate of ammonia and nitrate of potash, every two hours.

September 27th. Much better; says he "feels a young man again." Sputa offensive; ordered carbolic acid to be sprinkled all over the room.

September 28th. Pulse 72; temperature 98.4°; less sputa; cough troublesome at night. Wound gaping somewhat. Ordered egg and stale teacake.

October 2nd. Doing well. Cough slight and sputa scanty. Has taken during the last twenty-four hours—milk two pints, beef-tea one pint, with Valentin's beef-juice; fish, bread and butter, an egg, and bitter beer.

October 11th. Feels to be gaining strength; complains that solid food causes flatulence and discomfort; no vomiting since the operation, very little sputa or cough.

October 29th. Doing very well, and gaining flesh and strength.

The points to be more especially remembered and those in which it would be most easy to err in doing this operation are: (1) to bring plenty of stomach outside the abdomen, so that the assistant may grasp it easily and without stretching it, behind the plate when the latter is *in situ*; (2) to have some six inches of intestine outside when making the connection; (3) not to make too large incisions into the stomach and intestine; and (4) to be careful to tie the rubber tubing very loosely round the bowel. It is, I think, a needless expenditure of time to tie all the bleeding points. A spouting vessel may be tied; the pressure of the plates will stop the rest.

The plates, kindly sent me by Mr. Jessett, were of the following dimensions—namely, two inches and a half long by one inch wide and one-eighth of an inch thick, having an oval opening in the centre three-fourths of an inch long by half an inch wide. It would be a convenience if Messrs. Maw, Son, and Thompson, of Aldersgate Street, who keep the bone plates, would send them decalcified and fitted with Chinese silk.

ENTERECTOMY FOR ARTIFICIAL ANUS: RECOVERY.

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SINCE the publication of a short account of a jejunal enterectomy in the *BRITISH MEDICAL JOURNAL* of June 2nd, 1888, another opportunity has been afforded me of resecting the intestine for artificial anus, again with a satisfactory result.

Fifteen months before the operation, the patient, a young man, aged 20, states he had a severe illness, and, from his description of it, there can be no doubt that he suffered from strangulated inguinal hernia on the right side. Admitted into another hospital, he declined herniotomy until he had endured a week. The bowel, a portion of the ileum, was found gangrenous at the time of the herniotomy, and his surgical advisers of that time left it