cavity was washed out with hot water and some iodoform emulsion injected into it. A large rubber drain was inserted.

Immediately after the operation the temperature, which had been 103.8°, fell to normal, and the patient rapidly became convalescent. She was discharged on December 27th. On the fourth day after operation the left chest was aspirated and half a pint of serum evacuated. At the time of discharge the heart had regained its natural position, and air was freely entering the base of the left lung.

REMARKS BY DR WOOD.

It is interesting that the abscess drained so perfectly through the epigastric incision, as it seemed likely at the time of operation that it might be necessary later on to make an opening at a more dependent spot. The patient's very grave condition prevented this being done at the time.

FOUR CASES IN WHICH THE MURPHY BUTTON WAS USED.

By G. P. NEWBOLT, F.R.C.S.

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DURING the last three years I have used the Murphy button in four cases. In three of these the result was all that could be wished for; in the fourth the patient died so soon after the operation that it had no trial. My limited experience, therefore, is in favour of the button, for these cases comprise the only instances in which I have used the appliance.

CASE I.—A boy, aged 4, was admitted to the Stanley Hospital under my care on January 7th, 1898, suffering from an intussusception. He had been ill for two weeks and was very much collapsed: his pulse was 110, his abdomen distended, his pupils were contracted, and he was drowsy from the opium which he had been taking. I could feel the intussusception both *per rectum* and through the abdominal wall. He had vomited for several days and had passed blood and mucus *per anum*. I opened the abdomen in the middle line, but was unable to get at the tumour without turning out some of the distended intestines. Being unable to reduce the last portion I resected the gut and put in a button. I had, however, to open and evacuate the distended intestines before I could return them into the abdomen. The patient rallied at first from the operation, but died twelve hours later. An examination of the resected intestine showed that the approximation was perfectly good; but, as I have said, the button had no trial. I cite the case as one in which I used the button without success.

CASE II.—B. G., aged 70, a widow, was admitted to the Royal Southern Hospital on May 15th, 1900, suffering from a strangulated femoral hernia on the left side. She was an old woman of spare habit, and had been taken ill on May 12th with vomiting and pain in the abdomen. No motion or flatus had passed for three days. To her knowledge she had had no rupture before, but she had been working hard previously. On examination there was found a tense globular swelling both tender and painful in the left femoral region. Her abdomen was slightly distended, her pulse 94, small and irregular, her respirations 24. There was a trace of albumen in the urine. Altogether the case did not look a very favourable one. I cut down on the swelling, and on opening the sac exposed a piece of black, dull-looking, cedematous gut. I next divided the stricture, which was very tight, and drew down the bowel until a healthy part was exposed. The wound being packed off with gauze, my house-surgeon held the bowel on each side of the gangrenous portion with his fingers whilst I removed the damaged piece of gut. There was very little bleeding from the divided parts, as I removed hardly any mesentery. The button was now inserted in the usual way, and the two ends of the intestine brought together. Some Lembert sutures were passed after drawing together the ends of the bowel so as to take tension off the button. After irrigating the parts the bowel was returned into the abdomen, but before doing this the ring had to be enlarged. The sac was next removed and the stump tied up to Poupart's ligament, the wound being closed. The after-progress of the case was quite satisfactory. The patient was kept on water, brandy, and beef-tea for a week: her bowels acted on the seventh day after an enema, and the button passed on the eighteenth day. There was slight suppuration in the external wound. Patient went home seven weeks after her admission, and is at present working.

CASE III.—R. W., aged 49, a cotton porter, was admitted to the Royal Southern Hospital under the care of Dr. William Williams on May 21st, 1900. He had been ill for eight months before admission, complaining of constant vomiting, of wasting, and of pain in the abdomen. Patient was a spare-looking man, much wasted; there were large veins over the abdomen, and a doubtful mass could be felt in the region of the pylorus. On May 22nd, 1900, the patient being under chloroform, I made an incision 3 inches long in the middle line midway between the ensiform cartilage and umbilicus. On opening the peritoneal cavity, the stomach presented, and the pylorus was seen to be involved in a large mass about 3 inches long; the glands were enlarged both in front and behind the growth. The stomach was pulled partly out of the wound, and after dodging the colon a piece of intestine as near as possible to the duodenum was brought out and held near the stomach. An incision having been made into the stomach, one-half of the button was inserted and a suture run around it; a similar proceeding was carried out with the intestine, the parts were brought together, a few sutures being inserted to make all secure. The stomach and intestine were then returned to the abdomen, and the wound was closed. An inch button was used. The man made an excellent recovery, and never vomited after the operation. In a short time he was able to take solid food, but could not digest potatoes, nor was meat always eaten without discomfort. He put on flesh, and though he had some lumbar pain and flatulence at first, he eventually became very comfortable, and considered himself well. We

never saw the button, and I do not think it passed. In October, 1900, the following note was made: "He is well, has no pain, does not vomit, and enjoys his food, but says he does not get stronger, and he is certainly not gaining flesh. As far as the anastomosis goes, the result is good, but of course the relief can only be temporary." He died seven months after operation.

CASE IV.—P. C., a stableman, aged 41, was admitted to the Royal Southern Hospital on September 18th, 1900, suffering from a strangulated femoral hernia on the left side. He had noticed a lump in the left groin for six years. This had gradually increased in size, but was easily reducible until two months before, when it came down, and was only reduced with the greatest difficulty. At 10 A.M. on the morning of admission, whilst working in the stable, the lump came down bigger than ever and he began to vomit. On examination at 4 P.M. there was a hard, tense swelling the size of an egg in the left femoral region, and the patient was vomiting brown fluid, not stercoraceous. I cut down and opened a sac containing a large mass of doubtful-looking omentum and a piece of small intestine. I divided the stricture, drew down and removed the omentum, and then examined the gut. It was shiny, but very black, and did not bleed when incised superficially. In spite of the stricture being freely divided there was no evidence of any circulation going on in the damaged gut. I therefore excised it, as in the second case, with the exception that I removed a V-shaped piece of mesentery, and for my trouble got a good deal of bleeding from the cut edges. The button was put in the gut, being held by the fingers of an assistant, and no clamps were used. I again had to enlarge the opening into the abdomen before the gut and button could be returned. The sac was removed and the wound closed as in the first case. The patient made a perfect recovery, passed flatus next day, and his bowels acted after an enema on the eighth day. On the twenty-third day after an aperient he experienced pain in the rectum, and on examination I detected the button, of which after a glycerine enema he was safely delivered on the twenty-fourth day after operation. There was slight suppuration also in the external wound as in the other case.

My experience, therefore, of the button as far as it goes is favourable. In Cases I and II, in which I was anxious to get my patients off the table as soon as possible, I was able to operate fairly quickly by means of it. I must say that in each instance I used Lembert sutures over the button, though this is not held to be necessary; but it only takes a few minutes, and by so doing a good deal of tension is taken off that portion of intestine which curves over the button. There is no doubt in my mind that this is an additional safeguard. In both cases of hernia I had to enlarge the ring pretty freely in order to reduce the gut containing the button. This is a drawback as it weakens the parts afterwards. I do not think it likely that any patient would get rid of the button without knowing it had passed, as there was in both of my cases in which it came away a good deal of discomfort. In Case III I presume the button fell into the stomach, though an x-ray photograph did not show it.

A CASE OF ACUTE INTESTINAL OBSTRUCTION DUE TO A PAPILLOMATOUS OVARIAN CYST AND A CARCINOMA OF SMALL INTESTINE,

TREATED BY OVARIOTOMY AND ENTERECTOMY: RECOVERY.

BY

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WE have been unable to find any record of a similar combination of tumours, either of which might alone have given rise to the symptoms of intestinal obstruction which occurred in this case.

At the beginning of June, 1900, Mrs. G., a widow, aged 45, believing she was in perfect health, rode a bicycle from Bedford to London, some 50 miles, in one day. On June 26th she rode the return journey against a stiff wind, and when nearing Bedford was seized with severe pain in the abdomen. On reaching home she went to bed, and vomited several times. When seen twenty-four hours later she exhibited all the signs of acute intestinal obstruction. The abdomen was distended, and its lower part occupied by a fluid swelling which rose from the pelvis, reached to the umbilicus, and lay chiefly to the left of the middle line. *Per vaginam* a large solid mass could be felt in the pelvis to the left of the uterus. The tumour was extremely tender, particularly on its left side; the vomiting was not severe; but the bowels had not acted, and no flatus had been passed for twenty-four hours.

A diagnosis was made of a partly solid, partly cystic,