worse, internal deposits in the liver, and probably in the pleura, also appeared, and ultimately the patient died towards the end of October.

In this case one could not say that there was the slightest beneficial result from the oöphorectomy. In the first case, however, the oöphorectomy had undoubtedly a very marked effect on the growth of the cancer, and led to very distinct breaking down or absorption of portions of the growth. The interesting point, however, is that the effect of the oöphorectomy gradually passed off, so that at the end of about six months the disease began to grow again, and has since made marked strides. The result of these two cases, which were typical cases in young women where the ovaries were still active, and where therefore their removal, if of advantage, should have produced the most marked results, is extremely discouraging, and I doubt if it is worth while going on with the procedure. Nevertheless, as a scientific fact it is clear, especially taken in conjunction with Dr. Beatson's first case and one reported by Mr. Boyd,¹ that there is a distinct connection not only between the normal epithelium of the breast and the ovaries, but also between cancerous epithelium of the breast and the ovaries. But unfortunately in all the cases it appears that the effect of the removal of the ovarian influence is only more or less transitory, while in many cases no effect is produced at all.

If one were to perform the operation again I think it would be well, either at the same time, or possibly better later, to remove as much of the noticeable disease as possible. This has already been suggested by Dr. Beatson, and Mr. Boyd in one of his cases removed the ovaries, breast, and glands at the same time; sufficient time has not yet elapsed in his case to form any opinion of the result. If the result of removal of the ovarian influence is to lead to atrophy of epithelium originating from the mamma, it would clearly be of advantage to have as little epithelium present as possible. It is quite probable that if too much epithelium is present the removal of the ovarian influence might not produce sufficient alteration in the body to overcome all the disease.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, October 2nd, 1897.

GASTRO-JEJUNOSTOMY FOR PYLORIC CARCINOMA.

By F. C. WALLIS, F.R.C.S.,

Assistant Surgeon to Charing Cross Hospital and Surgeon to the Metropolitan Hospital.

S.B., aged 59, was admitted into the Metropolitan Hospital on March 24th, 1898, with carcinoma of the pylorus.

Previous History.—For four or five years she had pain about two hours after food, and emaciation and occasional vomiting for the last twelve months. Vomiting had been more frequent lately, but she had no pain except after food. A swelling was first noticed by a doctor on November 22nd, 1897.

Condition on Admission.—She was a small, sallow-complexioned woman, considerably wasted. A freely-movable, hard, nodular, irregular mass, about the size of a small fist, could be felt superficially, just above and a little to the right of the umbilicus. There was a second hard, rather fixed swelling, situated below the ensiform cartilage. On the night of admission she vomited about 0.1 of brownish fluid. On March 26th the stomach was washed out with boracic lotion. She was much relieved by this, but on March 30th the stomach was greatly distended. It was again washed out.

Operation.—On April 1st the stomach was washed out at about 12 midday, and at 2.30 P.M. a 4 per cent. solution of eucaïne was injected under the skin along a line running from the ensiform cartilage to the umbilicus. An incision 5 inches long was at once made along the line of injection, and the peritoneum was reached and divided. The stomach, with the large growth at the pylorus, was found and pulled forward. The gastro-hepatic omentum was found to be extensively infiltrated with the growth. The transverse colon was now drawn to the right, and the jejunum found and pulled forwards. Up to this period the patient had felt no pain, and spoke cheerfully to those around her. She now began to feel a little faint, so ether was administered, but the

steps of the operation were not discontinued. The jejunum was brought up to the stomach, until about 5 inches lay along the viscus quite loosely. Intestinal clamps were passed through the mesentery 2 inches beyond this limit on either side. The intestine was now anchored to the stomach at either end by two Halsted sutures. Two curved rows of Halsted sutures were next made to unite the intestine to the stomach. The stitches were placed one-sixth of an inch from each other. The lower row was first put in and tied, then the top row was placed in position, but not tied and kept wide apart. The stomach was now pulled well up and incised for 1½ inch; the same was done with the jejunum. No contents escaped. The top row of sutures was now tied up, particular care being taken about the angles of union, and a few additional sutures were placed at these situations. The whole of the mass was well washed with warm boracic lotion, then everything was returned to the abdomen after removal of the intestinal clamps. The wound was sewn up by two rows of sutures. Fine silk was used for the anastomosis. The operation lasted two and a-half hours. The condition of the patient at the end of the operation was excellent.

After-treatment.—A teaspoonful of hot water was given by mouth every hour for the first twenty-four hours. Nutrient rectal enemata (4 ounces) were given every four hours, and were well retained. Small quantities of milk and tea were given by the mouth on third day. The patient sat up on the eighth day, and began solid food; she got up on the eighteenth day, and has been about ever since. Flatus was passed on the second day. The bowels were opened on the fourth day after an enema, and acted most copiously after enemata. The temperature never rose to 100°, and the pulse ranged between 85 and 95. The patient has been most comfortable since the operation, and has not vomited at all.

Remarks.—The eucaïne injection in this case was quite a success as far as it went, and shortened the general anaesthesia by twenty minutes. About 3jv of the 4 per cent. solution were injected, and the knife was used immediately. It was my original intention to use some sort of button here, but this was not possible owing to the great thickness of the stomach wall. The Halsted stitches answered admirably, the one drawback being the time that is necessarily taken in placing them. The immediate and complete relief that the operation afforded to the patient was delightful to see, and gave one a great opinion of the value of the operation. My best thanks are due to my colleague, Mr. Percy Furnivall, for his able assistance; in fact, the success of the operation is mainly due to him.

RECORD OF ONE HUNDRED CONSECUTIVE CASES OF APPENDICITIS TREATED AT PRINCE ALFRED HOSPITAL, SYDNEY.

By J. C. HALLIDAY, M.B., CH.M.,
Late Resident Surgeon to the Hospital.

THE following record is taken from 100 consecutive cases treated during the last five years. The cases are divided into three classes:

	Cases.
A. Simple appendicitis without suppuration ...	64
B. Appendicitis with abscess formation ...	22
C. Acute perforative appendicitis, with general purulent peritonitis ...	14
Total ...	100

Taking all the cases together we have the following percentages: Males, 74; under 10 years, 4; between 10 years and 40 years, 80; operated upon, 55; mortality, 20.

Of the 64 cases in Class A the appendix was removed during an interval in 25, and 1 case was fatal, giving a mortality of 1.6 per cent.

Of the 22 cases in Class B, 17 recovered and 5 died, giving a mortality of 23 per cent.; 15 cases were between the ages of 10 and 30 years, and in 10 cases the attack was the first. In 1 case the abscess recurred after some months, and in 2 the appendix had to be removed subsequently for recurrent simple attacks.

The 14 cases in Class C were all fatal. The most noticeable features about this class are that out of the 14 cases 10