Dr. Murphy's button has been in use for about two years and a-half in America, and in a paper published by him in the *New York Medical Record* for June, 1894, he refers to sixty-five cases that he had collected. The success seems to have been astonishing. Of course one must always remember that on the introduction of any new surgical procedure the successes attributed to it are very remarkable. This arises from the modern practice on the part of surgeons of recording their successful and saying nothing about their unsuccessful cases. It is a miserable and dishonest habit, and causes much of our recent surgical literature to be very untrustworthy. But even if one were to deduct a considerable percentage for unsuccessful cases not reported there would still remain such a mass of splendid work as to compel the serious attention of all persons interested in abdominal surgery. To those who wish to look into the literature of the subject, Dr. Murphy's papers in the *New York Medical Record* (just referred to), and in the *Lancet* of September 15th, 1894, will give a vast amount of information. So far as I can gather from the journals the button has been used in this country on three occasions; at any rate, I cannot find reports of other cases. In the *Lancet* of April 21st, 1894, Mr. Arbuthnot Lane described a case of sarcoma of the sigmoid, where the tumour was removed along with 12 inches of the large intestine, the bowel being approximated end to end. The button was passed on the eighth day. There was some slight feculent leakage, but it escaped into the wound, which was conveniently situated for its exit. In the *Lancet* of October 20th, 1894, Mr. Paul Swain narrates a case of non-malignant stricture of the small gut in a lad aged 15, the result of injury, which he removed along with 5 inches of intestine. The button passed on the thirteenth day. In the *BRITISH MEDICAL JOURNAL* in January, 1895, a brief reference is made to a case of removal of gangrenous intestine by Dr. Murphy, of Sunderland. Mr. Lane spoke in praise of the button, and Mr. Swain wrote as follows: "The great objection to all intestinal resection is the length of time spent in securely suturing the ends of the gut. I was surprised at the facility with which the operation was performed. I was only familiar with the use of the button from the description I had read, and yet I found the reunion of the gut a very easy process. The adaptation of the serous surfaces was so perfect that it was with entire confidence that I returned the bowel into the abdominal cavity."

In abdominal surgery two great factors make for success—maintenance of an absolutely aseptic condition of the peritoneum, and rapidity in the actual performance of the operation. In ovariectomy and uterine laparotomies this second condition is not so important as in operations for intestinal obstruction, for the patient of the gynaecologist, although often very worn and emaciated, is, at all events, seldom in a condition of general poisoning, whereas the victim of intestinal obstruction, by reason of faecal auto-infection, is in a thoroughly poisoned state, and almost infallibly succumbs to a protracted operation. Any means, therefore, that will shorten the duration of time occupied in joining intestines together is of moment. I think the general testimony is that Murphy's button fulfils this requirement.

The first of the two patients whose cases I have recorded lost her life through the fact that she was so weak, that the time necessary for the performance of the operation undertaken for her relief was not sufficient to enable that operation to be done satisfactorily. This, by the way, was her own fault, as she objected to an operation until too late. But, although my experience has long ago made me thoroughly alive to the importance of operating before the patient has arrived at the last gasp, still I cannot quite agree with Dr. Murphy in the serious charges he brings against physicians of trifling away the lives of their patients by vain attempts at general treatment, charges which are constantly being made by surgeons of the end-of-the-century type. In the operative treatment of intestinal obstruction there will always be two difficulties: one is the uncertainty that, in spite of all our improvement in diagnosis, will ever surround the exact pathological condition of the patient; and the other is the fact that every surgeon and physician of experience can call to memory plenty of cases presenting all the characteristic symptoms of obstruction which have, nevertheless, recovered without operation. While I hail,

then, with pleasure every operation which will increase the safety of intestinal operations and so enable us with a good conscience to operate as early as possible, still I cannot throw in my lot with those gentlemen who want to open every man's belly after he has been constipated for a week.

For my own part I cannot help thinking that a serious cause of the delay in operating has not so much been any rooted objection to surgical proceedings on the part of physicians as the fact that they (and surgeons too) have been too indiscriminate in the use of opiates in cases of obstruction, and have commenced their administration too early in the progress of their case. It is true that under their use the patient lies in a torpid and painless state, not complaining of much except nausea and vomiting when food is put into him; but this same opium completely masks the symptoms of the disease, and hinders all just attempts at diagnosis. It must without doubt be valuable in cases where there is no mechanical obstruction of the gut of such a kind as Nature cannot undo, but in the case of all other mechanical obstructions we are apt to be lured into viewing our patient as not in very great danger because he is lying tranquil and not complaining much, whereas all the time he is quietly dozing away to his doom. Again, the temperature, the pulse, nay, even the tongue, are no measures at all of the danger in a case of obstruction if it be one of a subacute or chronic kind; and I have often found it most difficult to convince my fellow practitioners that a man may be lying with a slightly sub-normal temperature, a slow pulse, and nothing worse than a white, furred tongue, while at that moment he is near his end.

Returning, finally, to the question of Murphy's button, I will not say that (to use the customary phrase) it has "revolutionised" intestinal approximation, but I do regard it as the best all-round mechanical implement that we have at present for the union of the divided bowel. The *primæ facie* objection that the button would stick somewhere on its journey downwards is answered by the fact that no such case has occurred. As to its producing stricture subsequently, it is less likely to do that than any other method of approximation, because it punches out all the superfluity of the inverted intestinal diaphragm and leaves only a narrow ring, along which union takes place. I cannot make any statement as regards other mechanical means, because each inventor gets used to his own apparatus and can manipulate it quickly, but I can testify to much greater ease and rapidity in uniting bowel by the use of the button than by the simple Czerny-Lembert suture. By this last method I have removed portions of gangrenous hernial small bowel on three occasions, the first case dating as far back as 1883. The history of it is to be found in the *Transactions of the Medical Society of London* for 1885. It was a great success, but the next two cases ended fatally, and I came to think that the safest plan was to make an artificial anus at the site of hernia and trust to uniting the bowel by some means or other at a subsequent date. I may come to change my mind on this point now.

CARCINOMATOUS STRICTURE OF TRANSVERSE MESOCOLON: SUCCESSFUL END-TO-END APPROXIMATION BY MURPHY'S ONE AND A-HALF INCH BUTTON.

By GEORGE G. HAMILTON, M.B., F.R.C.S.ED.,
Late Honorary Surgeon, Northern Hospital; Assistant Surgeon, Royal
Infirmary, Liverpool.

THE end-to-end approximation of the small intestine has for some time been a moderately successful operation, formerly by suture, and now by various mechanical means, but similar operations on the large bowel have in most cases been very disastrous.

It is with pleasure, therefore, that I relate the main features of a case of carcinomatous stricture of the transverse mesocolon in which four inches of great bowel were removed, and end-to-end approximation effected by Murphy's one and a-half inch button.

On December 13th, 1894, Dr. Sugden, of Aintree, sent me a man, 33 years of age, a locomotive fireman, who had suffered from symptoms of subacute intestinal obstruction, which had commenced suddenly with pain in the left iliac fossa, while he was turning his engine on a turntable twelve days previously. The doctor reduced a left inguinal hernia for him, and, as his symptoms did not improve, naturally concluded that the hernia had been reduced *en bloc*, and sent him to hospital.

The only physical sign of such being the case was a feeling of resistance over a small area to the right of the umbilicus which appeared at the time, and was afterwards proved to be a scybalum.

The patient thus described his pain: "The wind seems to collect in the upper part of the abdomen, and then to run downwards with a gurgling sensation; the pain is most acute when the advancing wind reaches the centre of the belly; it then diminishes as the wind passes on."

While he was starved he got on very well for some three weeks, but as soon as even a little rice pudding was given him his vomiting and other symptoms of obstruction recurred. I therefore explored his abdomen through a 3-inch wound, commencing an inch below the umbilicus, and extending downwards. After a good deal of searching and examining the right and left inguinal canals, the caput cæcum, sigmoid flexure, and pelvic organs, on running my hand along the large intestine I came upon what felt like a large-sized empty cotton reel exactly in the centre of the transverse colon. I was able to pull this out of the wound, the abdominal cavity being protected by means of a sponge placed underneath. The removal of the carcinomatous stricture and approximation being effected, five Lembert's sutures were applied, the transverse mesocolon being adjusted by stitches as far as was possible. The time, including chloroform administration and exploration, was fifty minutes, the actual operation taking under half an hour.

Mr. Thomas, who came into the operation room while I was exploring the abdomen, kindly helped me with the latter part of the operation.

× Carcinomatous stricture of mesocolon. A, Red-frilled edge of new growth. B, Healthy mucous membrane.

The specimen shows a tight stricture half an inch in length, barely admitting an ordinary probe, the red frilled edge of new growth invading the mucous membrane on each side of the stricture being very well marked.

The patient is young for cancer, but it is our experience in Liverpool that general cancer affects both males and females at a much earlier age than was formerly the case. After operation he made an uneventful recovery, was perfectly comfortable, passed his first motion on the tenth, and the button unaided on the twenty-fourth day. I had examined his rectum the same day, and could feel nothing of the button.

His diet after operation consisted of 3 ounces of beef-tea and 3 ounces of hot water every hour alternately for the first

week, after which milk, and at the end of a fortnight rice pudding and biscuits were added.

The case under consideration illustrates what abdominal surgeons in every journal are urging physicians to see, namely, that where an *exact* diagnosis of the cause of obstruction is not made, the symptoms should not be masked by opium, or waiting for a tumour or further distension, but that the surgeon should be consulted.

Murphy states that the so-called conservatism in many cases amounts to criminal procrastination. I am not one of those who have a great anxiety to open the abdomen in all cases of intestinal obstruction; I have seen too many get well without operation ever to make that mistake, but surely the operator who is constantly handling these cases must become more than a mere cutting man.

No case requires more judgment and experience than one of early intestinal obstruction; two opinions are better than one, and chloroform often facilitates the diagnosis. I trust the practice of calling the surgeon in only when some cutting is indicated will soon be a thing of the past. Early excision of carcinoma of the bowel is not such a hopeless operation as excision of cancer in other parts. Bidwell relates two cases where patients are alive after the operation of removing a carcinomatous tumour of the sigmoid and cæcum, the former two and the latter four years ago.

A word in conclusion about the buttons. It has been proved beyond a doubt that they pass even the ileo-cæcal valve without any harm or difficulty. They, in my experience, are a great improvement on the suture, bone plates, or bone tubes. I believe this to be the first case where the one and a-half inch button has been used for the large intestine. It gives no trouble and is very easy to adapt to the bowel. I should advise everyone who is going to use the buttons to practise in the *post-mortem* room, as considerable dexterity can be acquired, and valuable time gained, after a little practice.

I completed the operation in the *post-mortem* room in seven minutes, and after tying up one end of the bowel, put on the full force of the main water pipe, and no leak took place at the button.

THE LETTSOMIAN LECTURES ON THE COMBINATIONS OF MORBID CONDITIONS OF THE CHEST.

Delivered before the Medical Society of London.

By FREDERICK T. ROBERTS, M.D.,

Professor of Materia Medica and Therapeutics at University College;
Physician and Professor of Clinical Medicine at University College
Hospital; Consulting Physician to the Brompton Hospital
for Consumption and Diseases of the Chest

LECTURE III. SYMPTOMATOLOGY.

DR. ROBERTS, in commencing his third lecture, observed that it was a dangerous error to take account only of physical signs, and to neglect to study the symptoms of intrathoracic diseases. In some cases there might be no obvious symptoms, and this negative fact was of importance as giving an indication of the pathological nature of the changes present. The symptoms presented by complicated cases must be studied on a thoroughly comprehensive basis. In acute cases the severity and character of the pain, the kind of disturbance of breathing, and the sounds by which it was accompanied were to be noted. The characters of the cough and expectoration, and the variety of dyspnoea present demanded special study, the more that in some cases the patient's general condition did not permit systematic physical examination to be made. In chronic cases physical examination should be followed by a systematic study of the symptoms. A single symptom might often be of great value in diagnosis—such symptoms as the sudden discharge of a quantity of pus due to the bursting of an empyema into the lung, or of certain kinds of abscess into the air passages. The sense of smell might lead to an immediate diagnosis, as, for instance, the foetid odour of the expired air, especially after a vigorous cough, revealing