April 4th. Since the above was written the patient has gained strength and has left the hospital. He is very emaciated and the malignant growth is rapidly increasing, but he has no abdominal pain and no sickness, and takes ordinary food. The button has probably dropped back into the disused portion of the intestine.

REMARKS ON THE USE OF THE BUTTON AND THE TREATMENT OF INTESTINAL OBSTRUCTION.

Mr. Mitchell Banks, in the BRITISH MEDICAL JOURNAL of February 23rd, has referred to Murphy's paper in the New York *Medical Record*, and to the few recorded cases in which the button has been used in this country, and pointed out its advantages, so that it only remains for me to add my testimony in its favour as a mechanical appliance. The case which I now record shows that even during intestinal obstruction an anastomosis can be successfully performed by its aid. Murphy advises an end-to-end approximation wherever possible rather than a lateral. In this case I chose the latter, as it avoided the necessity of suturing the divided ends of both the large and small intestine, a proceeding which would have made the operation a lengthy one. It is interesting to note that my patient is even younger than Dr. Hamilton's, one of the cases recorded in the JOURNAL of February 23rd, in which Murphy's button was used after excision of cancer of the colon, in which the patient was 33 years of age. I showed at the Pathological Society in 1893¹ a columnar epithelioma of the small intestine from a young woman only 23 years of age.

The importance of not masking the symptoms of intestinal obstruction with opium, or at any rate of not being misled by the effect of opium on the symptoms to which Mr. Mitchell Banks calls attention,² is again and again overlooked, and patients die because, until they are practically moribund, they are not considered bad enough to be operated on. Then, when without pain or vomiting, prostration reaches its climax, the death is called a sudden one, and the practitioner asks, "Who could have expected it?" The symptoms were not urgent, because subdued by the morphine, although the abdominal distension may have been increasing all the time. Dr. Hamilton³ quotes Murphy's statement that in cases of intestinal obstruction waiting for indications for operation generally means "criminal procrastination." It is a strong term, but it may perhaps call attention to the fact that an acute intestinal obstruction needs surgical interference at once, as surely as a strangulated hernia, whether the pulse seems good or not, and that waiting for indications of advancing prostration, or increase of symptoms is in most cases putting aside the one chance left to the patient—early operation.

NOTES OF A CASE OF ENTERECTOMY FOR GANGRENOUS INTESTINE IN WHICH THE BUTTON OF MURPHY, OF CHICAGO, WAS SUCCESSFULLY EMPLOYED.

By JAMES MURPHY, M.A., M.D.,
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Mrs. E. C., aged 27, married seven years, nullipara. was sent in to the Sunderland Infirmary by Dr. Spencer, of Hetton-le-Hole on October 31st, 1894, having had symptoms of acute intestinal obstruction for six days. She had obstinately refused operation.

Her previous history was to the effect that she was confined to bed three years previously for three weeks with pain in the left loin, and for seven weeks more she was unfit for her household work. Twelve months later she was again confined to bed for three weeks, owing to pain in the front and left side of the abdomen, and, after getting up, her legs swelled for some time. In neither attack had she any symptom of obstruction. Three weeks previous to her admission to the Sunderland Infirmary she had acute pain about the umbilicus, which lasted for a few minutes and was relieved by fomentation. On October 25th, at 9 P.M., severe pain set in

in the umbilical region, vomiting occurred freely, she was much collapsed, and there was slight action of the bowels. The latter had acted naturally on the previous day. After this there was no further passage of fæces or flatus; there was constant vomiting of brown fluid, with an offensive but not faecal odour. The collapse continued and the pain was severe, being acerbated by paroxysms every now and then. Her abdomen was distended, but not distressingly so; there was no rigidity of the abdominal muscles and no visible coils; the pulse was fairly good; the tongue was dry and brown; the temperature slightly subnormal. No tumour could be felt on palpation, and percussion gave a resonant note all over, including the flanks.

Shortly after admission an incision 2 inches long was made in the middle line of the abdomen midway between the umbilicus and pubes, and exit was given to some 30 ounces of blood-stained serum. On introducing two fingers, a loop of small intestine about 6 inches long was found strangulated by a tight band. It was impossible to bring the band to the surface, and it was gently torn through with the finger-nail. The strangulated loop was then brought outside the abdomen, when it was found to be gangrenous and perforated in three places, the largest perforation being at the point of strangulation. It was also found that about a tablespoonful of fluid fæces escaped through the perforation into the abdomen after the separation of the band. The fæces were immediately sponged out and the abdomen irrigated. Lane's clamps were introduced 2 inches above and below the gangrenous portion. An end-to-end anastomosis was then formed by means of Murphy's button, the bleeding points in the mesentery were secured, and its divided portions were brought together by means of a few sutures. The intestine thus united, the clamps having been removed, was returned into the abdomen, which was again thoroughly washed out, a glass drainage tube introduced, and the abdomen closed. The time occupied in excising the gangrenous portion of the intestine, inserting and fastening the button, sewing the mesentery, and securing bleeding points was four minutes and a-half. She was in such a collapsed condition that she could not be removed from the operating table for some time. Brandy was administered by enema and she passed a restless night.

Next day she was collapsed and suffered a good deal of pain. She passed flatus on the second day, the tube was removed on November 4th and all went well till November 9th, when she was seized with intense abdominal pain and collapse, and looked as if she were about to die. After a full dose of morphine she got relief; there was nothing to record till November 18th, that is, the nineteenth day after operation, when she passed the button, which she had felt in the rectum for several hours. The button was passed sideways with an adherent mass of fæces. All the holes of the button were blocked by fæces, and the two chromicised catgut ligatures were still *in situ*, but there was no portion of intestinal slough. She was allowed out of bed in a few days, and in a week's time she left the infirmary, the wound, which was less than 2 inches, had healed firmly.

The button used was the largest size for the small intestine. This is the only case in which I have so far used the button, but I was exceedingly pleased with the easy and rapid manner in which it can be used, and its efficiency is shown by the result. The great saving of time is the most important feature of this exceedingly ingenious instrument. Owing to the state of collapse this woman was in she could not have stood an enterectomy by any of the older methods, and therefore she owes her life, not to Murphy of Sunderland, but to his distinguished namesake of Chicago.

CASE OF ENTERECTOMY IN WHICH MURPHY'S BUTTON WAS USED.

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MURPHY'S button is being widely recommended, and cases in which it has been used should be laid before the profession, whether wholly or partially successful. In the BRITISH MEDICAL JOURNAL of February 23rd two cases are

¹ *Trans. of Path. Soc.*, 1893.

² *Loc. cit.*

³ *Loc. cit.*