They may possibly consult us, having generally become engaged first. In many cases, where the predisposition is strong and the individual manifestly unhealthy and neurotic, we should certainly not advise marriage, especially if means are small. We should recommend a close investigation of the family history of the intended, and the avoidance of a connection between cousins. As I have said, marriage is more serious for a woman than for a man. Some with feeble health and frail physique we should advise never to marry; and all who have insanity in their families marry at their peril. They ought not to marry poor men, and have the burden of narrow means, the care of a family, and insufficient nourishment for all.

Can a man or a woman do anything to prevent insanity? This is a question sometimes put, more frequently, however, with reference to the prevention of a recurrence in those who have already suffered from an attack. In many the insanity occurs at so early an age, and is so manifestly due to heredity, that it is to be feared that no advice that we can give will enable the individual to escape. Nevertheless, the direction to be followed is not hard to point out. It is important that a man or woman should correct, as far as in them lies, the tendency to egoism, self-consciousness, and selfishness which so often ends in insanity. They should adjust themselves to their surroundings, should not live for themselves, but feel sympathy for others, and help and defend them. This may be difficult for a man to do who has never done it hitherto. It is less difficult to train a child in such direction. All children should be so guided, and especially those predisposed to neurotic disorder. One has seen such at school, eccentric boys who are peculiar in their dress and ways, but possibly clever in some things. They are rarely gregarious. They lead for the most part solitary lives, just as do the insane. It is one of the advantages of the enforced games of a public school that a check is thereby put to the solitary wanderings of such boys, and for a time, at any rate, they have to congregate with their fellows.

INTESTINAL OBSTRUCTION DUE TO MALIGNANT GROWTH TREATED BY ANASTOMOSIS BY MEANS OF MURPHY'S BUTTON.

By CHARLES A. MORTON, F.R.C.S.ENG.,

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History.—W. S., aged 27, was admitted into the Bristol General Hospital on October 15th, 1894, with the following history. For five months he had been subject, every few weeks, to attacks of pain in the right iliac fossa, lasting a few hours and accompanied by the presence of a round, firm swelling the size of a hen's egg, which appeared midway between the anterior superior spine and the umbilicus, and always disappeared as the pain ceased. A fortnight before admission general abdominal pain and vomiting set in. The bowels acted for the first week, but there had been complete obstruction (no flatus having been passed) during the last.

Condition on Admission.—He was very emaciated. The abdomen was considerably and uniformly distended, and every few minutes distended coils became visible, and a very hard swelling formed in the right iliac region which felt like a solid mass, but it subsided with the cessation of peristalsis, and was evidently an extreme condition of localised intestinal distension. No lumps could be felt through the abdominal wall, but a small nodule was detected lying outside the rectum.

First Operation.—No satisfactory action of the bowels could be obtained by enemata, and on October 17th I explored the abdomen by a median incision and found that the portion of intestine which became so greatly distended during peristalsis in the right iliac fossa was the distended cæcum and that the sigmoid flexure was empty. I then made an incision over the cæcum and discovered a constricting mass of new growth at the junction of the cæcum and ascending colon which tied the bowel to the deep wall of the iliac fossa and could not be removed. The cæcum was stitched to the abdominal wall and opened. He rapidly improved and gained

flesh and was discharged on December 18th. For some time after the colotomy the discharge of liquid fæces caused much excoriation of the abdominal wall, but the skin became thickened, and this trouble ceased, though, owing to the liquid character of the fæces, there was a constant discharge which all kinds of mechanical contrivances failed to retain. However, when he left the hospital at the end of December he was well nourished and very comfortable and intended to return to work.

Second Onset of the Obstruction.—On January 20th he was readmitted with the history of a week's constant vomiting, very little fæcal matter had come from the artificial anus, and distension of the abdomen had again set in, with severe pain. He had lost much flesh, the abdomen was considerably distended, and with peristalsis distended coils became visible. Only mucus came from the artificial anus. In the cicatrix of the median incision three small nodules could be felt, and the nodule felt *per rectum* on his first admission was a little larger. On introducing the finger into the artificial anus it was found unobstructed by the growth in the cæcum though this had enlarged. The rectum was empty and greatly contracted.

The Second Operation; Intestinal Anastomosis.—It seemed probable that some new mass of growth was blocking the intestine on the proximal side of the artificial anus. As he had suffered so much inconvenience from the artificial anus, he decided to run the increased risk of an intestinal anastomosis. This I decided to make between the sigmoid flexure and the distended portion of small intestine lying near it, which could be reached by the same incision. There was no evidence to show how much of the colon might be obstructed by a mass of growth; but the lower end of the rectum could be felt to be free; hence I decided to anastomose as near to it as possible. Had I had any evidence that there was no growth in the colon beyond the cæcal mass, I should have preferred to have operated on the right side and joined the small intestine, as near the valve as I could get, to the ascending or transverse colon, so as to be certain of getting a full length of small intestine, supposing the growth was near the valve. I made Harrison Cripps's incision for inguinal colotomy. The sigmoid flexure was very contracted. The finger followed its course into the pelvis without discovering any new growth obstructing it, though several small nodules were felt in the parietal peritoneum. The contraction of the sigmoid flexure was so great that it was only drawn into the wound with considerable difficulty. Portions of the distended small intestine and the sigmoid flexure were isolated by means of Arbuthnot Lane's clamps, and a 1-inch button was inserted. It worked perfectly, and so securely was the junction effected it seemed almost impossible it should leak, at any rate until the button began to destroy the compressed portion of bowel. Several Lembert's sutures were placed around the junction, as I was not sure whether Murphy used sutures. As the clamps were removed, the large bowel began very slowly to fill; it was too contracted to fill rapidly. The abdominal wound was united, and no drain employed. There was no shock attending the operation, which took a little longer than an hour, but could have been done in half the time had I not used the sutures; and I only put in as many because his condition was so good as to make it unnecessary to bring the operation to a speedy termination.

Progress after the Anastomosis.—There was no vomiting after the operation, and a copious liquid evacuation took place in less than twelve hours, and continued at short intervals for many days. The abdominal distension slowly subsided. The abdomen has, however, never become quite flat as it did after the colotomy, and lately there has been distinct distension again, with a few visible coils at intervals, but he takes his food well, and vomits only rarely. For some time he was fed on milk only, but now he takes meat and other solids, and generally is free from abdominal pain. Loud gurgling has been marked in the region of the anastomosis, and when one or two coils become distended for a few seconds this loud gurgling accompanies their subsidence. He has become very emaciated, but is strong enough to sit up for a short time daily. The growth in the cæcum has begun to invade the skin around the colotomy opening, and the right inguinal glands are much enlarged. The button has not been seen although carefully looked for.

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.*