appearance of the vermiform appendix when the peritoneum was opened. The intussusception had evidently been a very chronic one as there were no inflammatory adhesions. The divided ileum was sutured to one angle of the divided colon and the rest of the colon wound closed, the line of junction being returned into the rectum. The patient, who appeared to be little disturbed by the operation, suddenly sat up in bed some ten hours afterwards, and fell back dead.

Besides the mere recognition of the disease, much more must be made out at the preliminary examination. First, as to mobility: We can recognize three degrees of mobility of the tumour. First it is freely mobile, and can be pushed up and down in the pelvis; this is highly important, as indicating that the disease is still confined to the rectal tunic, and is eminently satisfactory for surgical treatment. Secondly, it can be moved to a more limited extent, apparently carrying with it some of the other pelvic structures; this indicates that the disease has spread through the coats of the bowel, and if this has occurred to only a limited extent there is a possibility of removing the tumour, but the prognosis is not at all as good in reference to recurrence as in the first case. In the third case the disease is absolutely fixed, indicating that the disease has spread so far that the bony pelvis has become involved; when this has occurred, it usually means that attempts at complete removal will be quite futile.

Next to the character of the growth itself, the condition of the surrounding structures in the pelvis have to be examined—notably the hollow of the sacrum searched for enlarged lymphatic glands, the condition of the prostate in the male, and the uterus and adnexa in the female. Lastly, as the finger is being withdrawn, the length of healthy tissue below the disease and the condition of the anal canal should be estimated. Having completed the digital examination of the rectum, the abdomen should be carefully palpated, secondary tumours in the liver sought for, and also enlarged glands along the course of the iliac vessels; finally, the patient's general condition, especially the state of the kidneys, is to be inquired into, and having completed this the surgeon is in a position to express an opinion as to whether the case is one suitable for excision. If freely movable, and no enlarged glands or metastatic growths can be felt, no matter how high up the disease is situated, provided the general condition of the patient is good, the case is one eminently suitable for removal. If there is limited adhesion to the vagina, or portion of the pelvic diaphragm, or if lymphatic involvement is confined to a few small glands in the hollow of the sacrum, operation may be undertaken although the prognosis as to recurrence must be estimated as unfavourable, while if the disease has involved the prostate, bladder, or uterus; has widely involved the lateral or posterior aspects of the pelvis; is attended with extensive involvement of the lymphatic system; or still more if metastatic growths can be detected in the abdomen, operation must be absolutely declined.

SCHOOL HYGIENE IN FRANCE.—The French League of Medical Practitioners and Families for the Improvement of the Physical and Intellectual Hygiene of Schools, the formation of which was announced in the *BRITISH MEDICAL JOURNAL* some time ago, recently held its first annual meeting, under the presidency of Dr. P. Le Gendre, who was assisted by Dr. A. Mathieu, the General Secretary. The Minister of Public Instruction was represented by M. Rabier, Director of Secondary Education. The meeting passed the following resolutions: (1) That an official organ of the League, to be entitled *L'Hygiène Scolaire*, should be founded; (2) that a National Congress of Physiological Paedagogy should be organized; and (3) that the Committee of the League should be instructed to urge on the Departmental Councils the need for the effective organization of medical inspection of schools in all departments in which, notwithstanding the obligation imposed by the law of 1886 and a decree of 1887, no such inspection exists. M. Rabier congratulated the organizers of the League on the success of their undertaking, and assured them that their representations would always receive favourable attention.

An Irish patriotic banquet will be held at the Trocadero Restaurant, W., on Monday, March 16th, the eve of St. Patrick. The chair will be taken by Dr. C. J. Barry, who has practised in London for the last twenty-five years, and is a member of the Fulham Board of Guardians. Tickets for the banquet, at which the usual loyal toasts will be given, may be obtained at Keith, Prowse, and Co.'s box office; or from Mr. David Barry, 449, Fulham Road, S.W. The price of letters to admit lady or gentleman is half a guinea.

CASE OF DILATATION OF THE PYLORUS FOR SIMPLE STRICTURE.

By HORATIO P. SYMONDS, F.R.C.S. EDIN.,
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THE case to be described was that of a man, aged 40, who was admitted to the Radcliffe Infirmary, Oxford, on March 15th, 1902, suffering from dilatation of the stomach. He had been ill, off and on, for eleven years, suffering from great flatulent distension of the stomach, with sickness. The latter symptom did not occur frequently, but when it did, the vomit was great in amount, and had a very putrid smell. When it happened it usually came on a little time after taking food. The patient also suffered from chronic constipation; the bowels never being properly relieved except after the use of an enema. He had constantly to leave off work. He was a fairly well nourished man. No tumour could be felt in the abdomen, but by percussion the stomach was found to be very much distended. There was no history of vomiting of blood. This last fact, together with the long continuance of the symptoms, appeared to exclude malignant disease and to point to a simple stricture of the pylorus.

The man's condition of discomfort was so great that he asked if no operation could be undertaken for his relief, and I therefore determined to try the effect of dilatation of the pylorus. For a week previous to the operation the patient was kept on a bland diet, and received 8 gr. of benzoc-naphthol every four hours.

On March 25th the abdomen was opened through the rectus muscle below the xiphoid cartilage. The stomach was found markedly distended. The pylorus was steadied with the left hand, and with the index and middle fingers of the right a portion of the anterior wall of the stomach was invaginated through the pyloric orifice, and dilatation of the latter was carefully accomplished by separating the fingers. The anterior wall of the stomach was then drawn out through the abdominal wound, and a longitudinal tuck was run in it by a continuous suture of the applied peritoneal coats. This tuck included that part of the stomach which had been used in the invagination manipulation. The abdominal wound was then closed. The following day the patient vomited a little blood, but otherwise made an uneventful recovery. He remained in hospital for a month on a careful diet, and then went home. Since the middle of August he has been at work, has had no stomach symptoms, and expresses himself as feeling a different man.

The operation for dilatation of the pylorus for simple stricture is usually associated with the name of Loreta, who seems to have used two procedures. In the operation as usually attributed to him the viscus is opened and the pylorus dilated by the direct introduction of the finger into it. Wharton and Curtis in their *Surgery*, however describe Loreta's operation as having been performed by him in the manner in which I operated in the above case. Loreta is said to have performed the operation thirty times. It has been twice performed with a fatal result in New York, and Mr. Hagyard has recorded a successful case in which the operation was performed by himself. In this case the stomach was opened and there was some troublesome bleeding from the dilated pylorus. The patient made a good recovery, but there appears to have been little relief of symptoms. Cheyne and Burghard, in mentioning the operation, condemn the invagination method on account of the serious results which may follow in that part of the stomach which has been pushed through the pylorus. As I performed the operation, however, the invaginated part is included in the tuck which is run in the stomach wall, and as it no doubt becomes digested and thus destroyed, no evil effects can follow so long as the suturing of the peritoneum in the tuck has been properly performed.

A SIMPLE METHOD OF OPERATING ON PILES.

By A. B. MITCHELL, M.B., F.R.C.S.I.,

Surgeon to the Royal Victoria Hospital, Belfast, and to the Ulster Hospital for Children and Women.

THE following method of operating on haemorrhoids, which I have employed for the past four years, has in my hands proved both simple and efficient. It is quite possible that other operators have adopted the same principle, but I have never seen it described.

The sphincter having been dilated and the piles brought fully into view, the mucous membrane is sponged with a solution of corrosive sublimate 1 in 1,000.

(a) A pile is then clamped in a long narrow-bladed forceps (Fig. 1) (Kocher's artery forceps answer admirably).

Fig. 1.

(b) The redundant mucous membrane and pile is cut away by scissors (Fig. 2).

Fig. 4.

Fig. 2

(c) A curved needle threaded with catgut hardened in formalin is then inserted immediately above the clamp and the end of the catgut secured by a knot (Fig. 2).

(d) A continuous suture is next rapidly applied round the clamp (Fig. 3).

Fig. 3.

(e) The clamp is withdrawn (this can be done without the slightest difficulty) and the suture tightened, leaving a vertical line of continuous sutures within the rectum (Fig. 4). The upper end of the ligature, which is left long for the purpose, should be held firmly in the left hand whilst the lower end is being tightened, so as to prevent puckering.

(f) Each pile is treated similarly in turn.

The advantages of this method are that it can be very rapidly carried out; there is no loss of blood; the suture, being continuous, is an efficient haemostatic after the forceps have been removed; it cannot possibly slip, so there is no danger of subsequent haemorrhage. No raw surface being left, the bowels are encouraged to act regularly from the first. As a rule patients are up and about at the end of a week. The catgut is absorbed in eight to ten days and does not require removal.

NOTE ON INTESTINAL ANASTOMOSIS: SPECIAL FORCEPS.

By T. CARWARDINE, M.S., F.R.C.S.,
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THE accompanying illustrations represent some anastomosis forceps which were made for me by Messrs. Down Brothers, and which other surgeons may find useful. They consist of two forceps each $6\frac{1}{2}$ in. long, with very slender well-tempered spring-arched blades three-sixteenths of an inch wide. These may be covered with indiarubber tubing, and the compressing force is so slight and yielding that the gut is not injured by their application. To one forceps a thumbscrew is attached, concave on the surface, and $\frac{1}{2}$ in. in diameter. It is so made as not to become completely detached and therefore cannot be mislaid. The other forceps has a slot and depression corresponding to and receiving the thumbscrew when the two forceps are combined (Fig. 1).

For use, the gut beyond the part for removal is clamped by the separate forceps and the diseased bowel excised, leaving