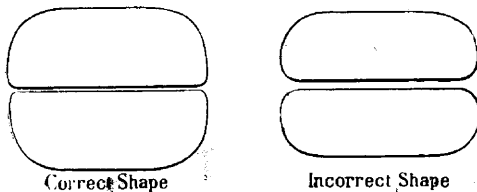


closely to that of the Murphy button, and the idea of having absorbable ends is a good one; but we have to place our entire dependence on a piece of rubber tubing, the strength and elasticity of which we are not capable of judging, and which varies with age. The decalcified bone ends are sometimes found warped out of shape and cannot then approximate as accurately as they should. In one of my cases in which I used the coupler there was slight leakage at the point of mesenteric junction, which caused a localized abscess to form; fortunately, however, it did not cause death.

The cause of the leakage was insufficient pressure on the folded-in mesentery, just after the completion of the operation; the exudation of lymph, which occurred shortly after, evidently closed the interstices between the mesenteric layers, because the line of union was found to be perfect except at that point, and the infectious material was found completely encapsulated. It will be remembered that the special stitch which is taken through the mesentery draws in an extra fold of peritoneum, increasing the thickness of the gut at that point, and in the case of the coupler making it a source of danger at that spot, as the rubber may not be sufficiently strong to press the layers tight enough to prevent leakage.

With regard to the apposition of the coats of the bowel, the Frank coupler gives as good results as any other method, but the device as made at present is not as safe as the Murphy button.

One point that was noted in my work was that fewer adhesions were found at the line of union in the button, than in the suture cases; this is due to the fact that in



all suture operations the stitches pass through the outer coats of the intestine and there is always some slight oozing of blood at the stitch holes, which increases the tendency to adhesion. On the contrary, in the button cases there is never any bleeding at the line of union and no exposure of sutures to tend toward the production of adhesions.

One thing to be observed in using mechanical devices is to use the largest size which can be easily introduced into the bowel, as it must necessarily follow that the diameter of the opening left by the button will be slightly smaller than the button itself, and if we use any device whose diameter is considerably less than that of the intestine we are sure to have contraction follow.

The conclusions which I have deduced from my experiments are as follows:

1. It is possible to make a safe and satisfactory end-to-end anastomosis.
2. With practice, a surgeon can, with nothing but a needle and thread, sew a divided bowel together and obtain a result which will almost equal that obtained by the use of the Murphy button.
3. The result obtained by the Murphy button is superior to that of any suture method yet devised.
4. The Murphy button and Frank coupler give the same anatomic result.
5. Contraction following end-to-end anastomosis is usually due to faulty technic.
6. The Murphy button is much safer and more reliable than the Frank coupler.

7. A perfect Murphy button, properly introduced, is the quickest, safest, and most reliable means of obtaining an anastomosis between any two viscera.

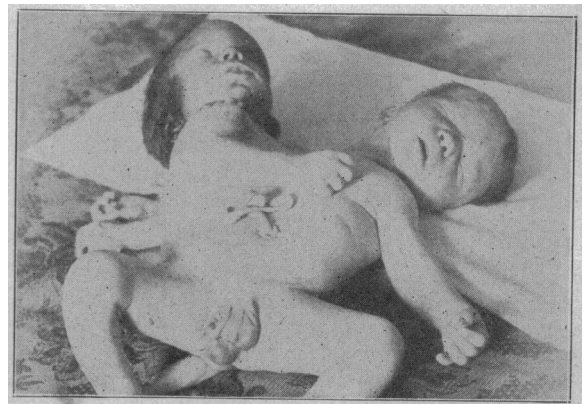
8. All devices which are used to support the gut in suture operations are unnecessary, and as good, if not better results, may be obtained without them.

My thanks are due to Drs. F. B. Carpenter, George H. Evans and Wm. Barbat for their able assistance in the work on which the paper is based.

MONSTROSITY OR DOUBLE FETUS.

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Myself and father, Dr. E. A. Benton, were called in consultation by Dr. W. N. Hunt of this city at 1 p.m., June 15, 1899, in the case of Mrs. D., a multipara in her fourth confinement. She had been in labor for about twelve hours with a vertex presentation in the first position, and strong labor pains for several hours after complete dilation of the os had failed to advance the head beyond the lower third of the pelvis. From



external examination and the history of the case, twin pregnancy was diagnosed, and under chloroform, forceps were applied and the head brought down with considerable difficulty through the external parts; but no more progress could be made toward delivery. We then concluded we had to deal with some kind of monstrosity. We amputated the head and tried to turn or bring it in position to deliver, but failed. We then brought down arms and shoulder and amputated all, but failed to deliver. We commenced hasty preparations for a



Cesarean section, but patient began sinking rapidly and died in less than an hour, although every effort was made to sustain the heart action. There was no hemorrhage or assignable cause for death other than shock. Post-mortem was made two hours after death and the monstrosity removed; amputated parts were stitched on. The accompanying photographs show the peculiar formation as much as possible, and it explains nearly all. The sex could not be determined. The caudal appendage so plainly seen in back view is undoubtedly a rudimentary development of a leg, it contained a bone and joint, evidently a knee-joint. The weight of the monstrosity was twelve pounds.