

of the resident physicians, to whom is intrusted in so great a degree the care of the sick and wounded collected within its walls. It is probably true that the interests of a hospital would in the long run be best subserved by selecting a school known to be possessed of high facilities for undergraduate teaching in all lines, making a close affiliation with that school for a period of years, and relying upon the recommendations of the school officials for the choice of internes. The resulting benefit would be twofold—a marked stimulus to educational effort on the part of the school, since the loss of such hospital affiliation after it had once been established would reflect upon the teaching methods; and the impulse toward improving the average type of hospital resident throughout the country.

It is not unjust to either the medical schools—some of which are equal to any to be found in the world—or to hospital residents generally—many of whom are already everything that could be expected, and some of whom are as good as could be desired—to say that taken comprehensively, both schools and residents are susceptible of improvement, and many need it urgently and imperatively.

ROLAND G. CURTIN.

TECHNIC FOR A TEMPORARY ENTEROSTOMY.

EDITOR ANNALS OF SURGERY:

An enterostomy is always dreaded by the surgeon as well as by the patient because of the difficulty experienced in controlling the fecal discharge,—so that any change in technic that tends to improvement will not be unwelcome. One of the principal disadvantages of the artificial anus, especially in the small intestine, has been the difficulty experienced in regulating the escape of the contents of the bowel that keep the dressings of the unfortunate patient saturated almost constantly with liquid fæces. If the opening is allowed to remain for any length of time excoriations that are very painful often result. Attempts to control the fecal discharge have been confined principally to the descending and pelvic colon and these efforts have been partially successful. However, when the fecal current has been more or less successfully controlled there is frequently a marked prolapse of the mucosa. To avoid this difficulty the opening has been made

higher up in the colon; but the annoyance is obviated at the expense of fecal control.

I have recently performed an enterostomy of the ileum a few inches above the cæcum for a rectovesical fistula due to an intestinal amœbiasis, and I have had the happy experience during the two months that the artificial anus has been functioning, to see the skin of the patient's abdomen remain *absolutely* free from the slightest trace of moisture. This result, as far as I have been able to learn, has not been attained with the methods in general use.

In connection with this operation, a point of interest in the treatment of amœbiasis by making the enterostomy in the ileum, is worthy of mention. Dr. J. D. Long of the U. S. Marine Hospital Service, who has been associated with me in this case, suggested that the opening be placed in the ileum because of the great advantage that an enterostomy in this region possesses over the appendicostomy on account of the ease with which this part of the intestine can be irrigated; such irrigation is otherwise not possible.

In the technic about to be described, artificial anus of the small intestine is shorn of most of its horrors, at the same time a more complete cure of conditions calling for its employment, especially amœbiasis, may become possible.

Technic of the Operation.—A large loop of the intestine, preferably ileum, is drawn out and a spur is made according to any of the accepted methods; the skin is sutured in the ordinary way, and the loop is permitted to remain undisturbed until it is to be opened. Before the intestinal lumen is entered a small slit is made on one side of the centre of a large sheet of rubber dam such as is employed by dentists; this opening is stretched with the fingers, and while tense it is slipped over the loop of the intestine to its base. The rubber encircles the gut closely, just as it does when the dentist applies it over the tooth preliminary to a filling. The hole must be so large that the gut will not be strangled when the rubber contracts. The lower part of the rubber sheet that covers the side of the patient's body is directed into a bucket in which a small quantity of formalin has been placed; in the trough that is formed by the rubber sheet the fecal discharge passes into the container, so that the skin surrounding the artificial anus remains free from moisture.

As I have stated above, the skin of the patient referred to has never been moist, and he has not suffered the inconvenience and disgust that is usually associated with this kind of operation. Whenever soiling occurs from fæces, the rubber sheet and the exposed gut are easily cleansed by flushing with water poured from a pitcher. The important part of the technic is that the intestine is not to be cut flush with the skin, as is usually done, but it is allowed to remain indefinitely. The loop of the intestine exposed has remained normal in appearance and presents no evidence of sloughing.

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