very much improved. After one month's time she was able to perform her household duties and has been apparently in normal health ever since she was operated upon, which was over two years ago. Her urine still contains albumin.

Case No. 44247, Touré Infirmary.—E. C., age 8 years. Admitted August 24. Discharged September 13, 1914. Referred by Dr. Hava, of New Orleans, La.

Diagnosis: Chronic Parenchymatous Nephritis. Family History: Father, mother and one brother living. None dead.

Previous History: Measles, mumps and whooping cough. Influenza in December, 1912.

Present Illness: Ever since December, 1912, at which time he was suffering from influenza, he complained of severe headaches the greater part of the time. Feet and hands began to swell and abdominal ascites developed until he measured thirty-eight inches around the waist. Has suffered with nausea and vomiting constantly, and with dizziness. From December, 1912, to September, 1913, he had been treated by a number of able internists and given the usual treatment in this class of cases. Continued to go from bad to worse and was brought to hospital in ambulance. He had general anasarca, and was pale and anemic. He had an appearance of tallow over his entire body. Temperature 99°, pulse 128, respiration 40, with a systolic blow at the apex. He had been tapped repeated, and from one to two gallons of fluid removed each time. His condition was desperate and he was passing 1½ ounces of urine every twenty-four hours, containing 76% albumin, hyaline and granular casts in blood.

The operation was proposed to the parents and readily accepted. He was immediately operated upon, doing the Edebohls decapsulation under gas anesthesia. Both kidneys were delivered, which were very large and tense. Time of operation, twenty-one minutes. He stood it well and began to improve immediately, passing 13 ounces of urine in the first twenty-four hours, with 74% albumin; passing 20 ounces the second twenty-four hours, and on the fourth day 120 ounces. At the end of the first week he was passing between 40 and 50 ounces within twenty-four hours with a gradual diminution of albumin and casts. His general condition improved, his blood pressure gradually became normal, his appetite improved, and the swelling disappeared entirely from the body. At the end of three weeks he was practically normal and was out in the yard playing. It has been now about fourteen months since the operation and he is apparently normal in every way, but still has albumin in his urine.

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DISCUSSION.

Dr. C. E. Cantrell, Greenville, Tex.—Even if the surgeons of this country have not adopted Edebohls' course and plan of operation, there are

some cases in which surgeons could derive great benefit by following that practice. For instance, in the acute cases of eruptive fever, or where there is suppression of the urine in obstetric cases, even if one can not subscribe to operating upon old cases of Bright's disease—the cases in which Edebohls operated upon and in which he reported such brilliant results. We ought not to conclude that we should not operate just because they are going to die. They might live longer if left alone unless a successful operation is done. We have been doing this Edebohls operation for quite a while, and now have something more than fifty cases. Nearly all are improved. There were very few deaths.

A young railroad man, a check clerk, was thrown from the side of a car. In about four or five days he had congestion of the kidneys, and seven days afterward complete suppression for several hours, very little urine for twenty-four hours, and convulsions. He was put upon the operating table. Very much swollen capsules, and the kidneys could not work because of the tension. Such cases as those are easily operated upon, as the essayist says. Plenty of urine the first twenty-four hours. The man made a good recovery.

That kind of case will be perfectly well. The old cases will not do so well. You know the capsule of the kidney is just like fibrous tissue in any part of the body. The only property it has outside of holding things together is to contract when it is inflamed, and it cuts the blood out of the kidney and becomes so tense that there can be no action. Split it, if you do nothing else. But do not go into these old cases.

Many times you can not get the kidneys up out of the incision. If you can not and can see what you are doing, why, remove the capsule by splitting it with a knife, or any way you can, and let new blood into the kidney. You can not relieve them in any other way.

Dr. W. W. Crawford, Hattiesburg, Miss.—Appreciating, as we do, that trauma is a source of suppression, it seems advisable that a double decapsulation should not be done in any given case. I should think a very much better way, and that most advantageously followed, would be to decapsulate one kidney, and when you have had a perfect restoration, at some later date decapsulate the other kidney. I can attest the consistency of this view in at least one case.

Dr. Stone (closing).—This operation should not be done indiscriminately. In diffuse nephritis and in granular kidneys it is not indicated. It is only in the immense, swollen kidneys that it is of value.

SURGERY OF THE COLON.*

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In the limited time of this paper it is not practical to go into a discussion of the colon in all its phases. We shall,

*Read in Section on Surgery, Southern Medical Association, Ninth Annual Meeting, Dallas, Tex., Nov. 8-11, 1915.

therefore, limit our remarks to emphasizing special conditions and phases of colonic disease. All phases of abdominal surgery have broadened, and ultimate results have been more gratifying during the past few years. If you will note, this advancement is the outcome of more careful study from the anatomical standpoint interweaving anatomy and operative surgery. In considering the colon, our most important factor is that of an adequate blood supply to any part which may remain after operative manipulations. Again, the lymphatic system presents a picture by which we may judge ultimate results and to a degree guide our knife in an attempt to eradicate the disease.

Our first consideration is early diagnosis. Cancer, a most dreaded disease, when found early is invariably curable. The big problem for us is to get the disease when symptoms first appear. Early treatment promises success and is most gratifying to the surgeon.

In cancer of the colon a history of pre-operative obstruction is obtained in approximately 65% of the patients, as emphasized by McGlannan in a study of 93 cases. Of these cases there is a mortality of approximately 60% (from the literature since 1900). Of the cases not complicated with ileus, the mortality of recent years is from 10 to 12% as compared with 25% up to five years ago. In a series of over 700 cases of cancer of the colon (studied by R. Bastianelli, *Rivista Ospedaliere*, Rome), only 29 have survived for three years, and only 10% were permanently cured. Among this series one, two and three-stage operations were performed. Within the last two years the one-stage colectomy is the method of choice, as summarized from the results of various surgeons, and should be done except where intestinal drainage can not be established through natural channels before operation.

A patient in question, as you will note from the following history, showed signs of definite obstruction and only by repeated efforts were we able to establish what we considered satisfactory drainage.

Mrs. E., No. 692, age 69, married. Entered the hospital in May, 1914, complaining of pain in the bowels (continuous) and constipation. Family history unimportant. Personal history: Menopause

at 46. General health good. Always constipated. Six months ago (December, 1913) patient had an attack of abdominal cramps and vomiting; relieved by enemas and medicine. Three months ago (March, 1914) was in a hospital for similar condition. Again relieved by enemas. During the two months following her stay in the hospital she relieved this abdominal pain and discomfort by repeated enemas, the attacks coming on every one to two weeks. During the past month the patient has used enemas every one or two days and the abdominal pain has remained almost constant. There is no jaundice and no urinary disturbance. Patient has lost about twenty pounds during the past six months. Eats small amount of food, as it causes abdominal disturbances.

Examination: Good color, blood pressure 160 (diastolic). Heart and lungs clear. Slight general abdominal tenderness. No mass visible or palpable. Bimanual and rectal examinations reveal no masses and no tenderness. With repeated enemas every day patient has kept fairly comfortable and is able to eat a moderate amount of soft food without a great deal of disturbance. Partial intestinal obstruction due to a malignant growth, was a provisional diagnosis and exploratory laparotomy suggested.

Operation May 20, 1914, under ether anesthesia; median high incision; resection six inches transverse colon with omentum, etc., followed by lateral anastomosis (double thumb method of Bloodgood), with inverted ends stitched in wound. Small protective drain.

Operative Note.—Tumor was an adenocarcinoma (annular) of the transverse colon, the lumen of which would just admit the end of a slate pencil. The tumor was practically free of adhesions. The omentum contained enlarged glands. A margin of about one-half inch was left on either side of the tumor. Bowel was divided between clamps by cautery. The divided ends closed with cat gut and silk and the double thumb anastomosis made in the usual way.

Recovery was uneventful until the end of the second week, when the gall bladder, which was full of stones, began giving quite serious trouble. Through a right rectus incision the stones were removed and drainage was established. Convalescence was slow following the second operation. There was also some drainage from the proximal end of the divided colon beginning about the eighth day. The gall bladder drainage continued until August. By this time the patient had gained considerable strength and was ready to leave the hospital. Drainage from the bowel was small in amount. After leaving hospital patient did not return until December, when the fistula was permanently closed. Patient is now well, eighteen months following the operation.

I wish to emphasize the double thumb (method of Bloodgood) anastomosis for the reason of frequent leakage following large bowel sutures. By bringing both ends of the anastomosis up into the wound the operator is relieved of that suspense of intra-abdominal pus pockets should he use the end to end, lateral or Murphy but-

ton method. The slight leakage, in the case just reported, gave us practically no concern, as it immediately made its appearance on the abdominal wall and the patient felt practically no inconvenience.

A second patient, Mr. A. J. A., No. 857, age 55, married, complained of pain and swelling in the right side of the abdomen. Family history unimportant. Personal history: Strong man until three and a half years ago, when he suffered an acute attack of pain in the right side of the abdomen, about the level of the umbilicus. There was nausea but no vomiting. Does not remember intestinal condition. Diagnosis of kidney trouble made at this time. One year later had a similar attack, when there was a palpable mass in the same region, supposedly the right kidney, though the urinary examination seemingly was negative. One year ago patient felt a mass in the right lower abdomen about the region of McBurney's point. This was slightly tender. At this time there was no acute attack, and no fever. Patient experienced considerable difficulty in lying on right side. There was a diagnosis of appendix abscess. During the past three or four months this mass has constantly ached and now has a burning sensation. There has been constipation, but no history obtained of intermittent diarrhea. Has lost about thirty pounds in the last six months. Diet is limited, as food causes some abdominal uneasiness. Ten days ago patient had a rough ride in a lumber wagon, after which he experienced severe pain in the abdomen and marked tenderness of this mass. This continued for about a week, necessitating the patient to remain in bed most of the time.

Examination: Emaciated man, pale, loud systolic murmur heard all over cardiac area with an occasional skipping of pulse beat. Blood pressure 90 and 120. Lungs clear. Abdomen scaphoid. Mass size of small coccanut in the right lower quadrant. The mass is firm, quite tender on pressure and is more or less movable. There is much gas in the intestines. Provisional diagnosis: Carcinoma of the head of the cecum. Patient was allowed to remain in hospital four days.

Operation, under ether anesthesia: long right rectus incision made. Resection of two inches of the ilium, cecum, ascending colon and the hepatic flexure. Lateral anastomosis ileum to transverse colon, double thumb method.

Operative Note.—The mass was free from all parietal peritoneum except at the posterior fold behind the ascending colon. These adhesions passed posteriorly, and held the hepatic flexure in close contact with the duodenum, gall bladder, and a little lower held a loop of the upper ileum in close contact with the mass. The loop of bowel was easily separated, though the dissection in the region of the duodenum was very tedious. The mass was contracted upon itself in such a way that it was impossible to follow the course of the bowel except by dissection of the mass after removal. One could hardly imagine how food might pass with so few signs of severe obstruction. The great omentum was also included in this mass, which necessitated its removal.

There were a few enlarged glands in the region of the duodenum, which I was able to remove, otherwise I was unable to palpate any glandular involvement.

The ends of the bowel were closed with cat gut and silk and an ileocolic lateral anastomosis was done. Small tube drain was removed from the wound on the third day. Small amount of serum drainage only.

Patient made an uneventful recovery, and is now comfortable, eight months following the operation. Has gained between 30 and 35 pounds.

This is purely a case of delayed surgery due, not so much to the ignorance of the patient as to the mistaken diagnosis and lack of persuasive powers for exploratory operation on the part of the physician. How long this man will remain well is a question. However, from present appearances one would consider him a cured case. What we have thought about is the comfort of the patient, whatever else may intervene.

In conclusion, I would like to emphasize the importance of early exploration. One may not be able to establish a definite diagnosis in all cases, but we can be sure whether or not an operation is indicated, and if we shall gain the confidence of our patients they will, with a very few exceptions, grant us permission to treat them as we deem wise, and when the disease is in a curable stage. The public is learning to attack tuberculosis in its incipency, and yet cancer kills almost twice as many people in a year as tuberculosis. One must talk cancer and write cancer for the good of humanity.

LOCAL ANESTHESIA*.

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We have been interested in local anesthesia from the standpoint of adding to our armamentarium a method of applying anesthesia to certain patients where local anesthesia is imperative.

I wish to emphasize that local anesthesia is an implement of great value in cases which cannot be safely operated upon by any other form of anesthetic. Local anes-

*Read in Section on Surgery, Southern Medical Association, Ninth Annual Meeting, Dallas, Tex., Nov. 8-11, 1915.