between her discharge from the hospital and the final operation, she enjoyed very fair health. The outlook was desperate from the start.

Two women reported between three and four years after operation. The first is perfectly well and the pelvic examination is negative. This infection was undoubtedly gonorrheal. The second was again admitted to our wards a short time ago, with a large exudate behind the uterus; but by rest and depletion, operation was avoided. She considered herself as perfectly well until three weeks previous to entrance. The original septic process started from a miscarriage, and it seems rather probable that the second infection was of a different nature.

Only one patient has reported after four years, a probable gonorrheal infection. She declares herself comfortable. At the time of leaving the ward, her weight was 86 pounds. It is now 140 pounds. The uterus is quite firmly fixed in the pelvis, and in good position. There is a slightly movable tubo-ovarian mass on one side, an old vaginal scar on the other.

In none of our cases has pregnancy occurred since the operation.

Four report themselves as in good health after periods of from six months to two years; but the data concerning them are insufficient.

Conclusion. — Our cases, few in number, show this operation gives what appear to be good results. One has died, not as the result of the operation itself, but because of an effort to correct the consequences of an operation upon a metastatic abscess.

Two other unfavorable results are reported: one finally cured of pain by removal of one tube and ovary; the other still with some pain and exudate, owing principally to lack of proper care.

Thirteen on our list are free from pain, and four others, reporting by letter, claim to be well. The remainder have some pain at times, but the discomfort is apparently slight, even if some exudate, thickening, or tubo-ovarian masses remain. It will be noticed, also, that with exudate there is not always pain or even tenderness. If we could compel our patients to follow after-treatment with care and enable them to accept the opportunities offered for rest, the results would be far better.*

A NEW OPERATION FOR CORRECTION OF THE NASAL SEPTUM.

BY ROCKWELL A. COFFIN, M.D.,

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PERHAPS the most objectionable feature of the present submucous "window operation" is the length of time it requires to perform it, together with the strain on both patient and operator. Both of these disagreeable features are overcome by the operation herein described.

*The writer is indebted to Dr. D. D. Scannell for details of some private cases.

In the usual operation, after separating the mucous membrane and perichondrium from one side of the septum, it is often very difficult to free the opposite mucous membrane through the septum without causing a perforation. This part of the operation is also most fatiguing for both patient and surgeon.

The author's operation is divided into two short sittings, which many patients are able to tolerate, rather than one long one which is exceedingly nerve racking and even quite impossible for the more sensitive.

It is not suggested that this operation take the place of other "window operations," but rather it is one to be used when the conditions are unfavorable for prolonged surgical procedures. The author can, perhaps, best explain the technique by describing the first case operated on, as it was typical of those cases for which this operation is especially adapted.

On examination of the nose, the septum was found deviated as in Fig. 1, that is, the cartilaginous septum was in contact with the lower left turbinate. Only a small piece of the bony septum was involved. A more or less perpendicular incision was made in the right nostril anterior to the deviation, after first applying cocaine and adrenalin, and sterilizing the cavity with a weak solution of corrosive sublimate.

The periosteum elevator was then introduced through the incision beneath the periosteum and perichondrium and worked backward, upward and downward, until they were free from the septum as far as the edges of the deviation. The space thus made was injected with sterilized vaseline, and the nose allowed to heal for one week. It may be seen that the mucous membrane and perichondrium, instead of following the line of the septum as in Fig. 1, were held away from the septum by the vaseline and took the line C D, as in Fig. 2.

After one week the opposite side was prepared for operation in the same way as the first, and an incision similar to the one on the right side, only somewhat more anterior, was made. This last incision was made more anterior in order that it would not come opposite the other and increase the liability to perforation in case the first was not entirely healed. In the same way as before the perichondrium and mucous membrane were separated from the septum. With the mucous membrane and perichondrium on the right, tak-

ing the direction C D (Fig. 2), we had the simple problem of removing a submucous spur. This was accomplished by the use of a straight, blunt knife, and the author's submucous gouge. A light pledget of antiseptic cotton was then introduced into the left nostril and drawn forward in order to hold the perichondrium and mucous membrane in the median line. Fig. 3 represents approximately the position of the septum at the end of the second half of the operation.

This was allowed to remain about twenty-four hours, when it was removed, and the nasal cavity irrigated with a very mild antiseptic solution. The patient was given a wash of Dobell's solution and mild citrine ointment to use twice daily.

Where the deviation is long and narrow the author has obtained excellent results by treating the second part of the operation as a simple spur, and has removed it with the saw. This not only saves time, but the result, in most cases, is quite as satisfactory.

It is the author's opinion that in doing this operation, one is more likely to obtain true cartilage in the new septum than in the usual "window operation," for the reason that both cartilage cells and perichondrium are present during the time intervening between the first and second operations. Time alone can demonstrate if this is a fact.

New Instrument.

GASTRO-ENTEROSTOMY IN INFANTS. A NEW INSTRUMENT.

BY CHARLES L. SCUDDER, M.D., BOSTON.

IN those cases of stenosis of the pylorus in infancy, which come to the surgeon for operation, it is important that technical difficulties be eliminated so far as possible from the chosen procedure. The operation to be successful must be performed with speed, the handling of the gut must be reduced to a minimum. A gastro-enterostomy (posterior) is the operation of choice in these cases.

FIG. 1. Baby clamp for gastro-enterostomy. Rubber covered when in use.

I have had made for me, by Codman and Shurtleff, a clamp similar to the gastro-enterostomy clamp for adults, but much smaller. (See Fig. 1.) This "baby clamp" is slender and very light, it is well adapted to facilitate the

technique of the rather delicate operation of gastro-enterostomy in young babies.

GASTRECTOMY. A NEW INSTRUMENT.

In the operation of partial gastrectomy following the most satisfactory technique, perfected by Hartmann and Mayo, Kocher's crushing stomach clamp is applied to the portion of the stomach

FIG. 2. Stomach clamp for compression in gastrectomy. Rubber covered when in use.

FIG. 3. Stomach clamp for compression in gastrectomy. Straight instrument. Rubber covered when in use.

to be excised. In order to control the portion of the stomach left behind, a clamp to compress without crushing is needed. Kocher's clamp, covered with rubber tubing, is sometimes used for this purpose, but the bite of this instrument is too powerful. I have had made an instrument similar in shape to Kocher's which, when rubber covered, very effectually compresses the stomach walls without damaging them. (See Fig. 2.) A straight pattern of this instrument has also been made. (See Fig. 3.)

The clamp is simply constructed, the appearance of the lock at the tip of the two blades is accurately shown in the accompanying drawings. (See Fig. 2.)

In order to prevent any retraction or slipping of the compressed stomach walls from between the rubber covered blades of the clamp it is wise to catch the projecting edges at two or three points with ordinary hemostatic forceps. The application of these forceps precludes the possibility of slipping of the stomach before the occluding sutures are placed. The employment of this clamp adds much to the ease of gastrectomy.

THE PHILADELPHIA POLYCLINIC AND COLLEGE FOR GRADUATES IN MEDICINE is at present engaged in extending its plant by the erection of a building to the east of the present property, which will be devoted entirely to the out-patient department. — *New York Med. Jour.*