wound having healed by first intention. He had the apparatus (shown in Fig. 1) applied in August and he returned to Australia quite well in September.

CASE 2.—A man, aged 31 years, was, on March 11th, 1899, admitted under my care into the Leeds Infirmary with tuberculous disease of the body of the scapula and shoulder joint, osteo-myelitis of the humerus, and tuberculous disease of the elbow joint, with sinuses in the axilla over the back of the shoulder and scapula and over the elbow. He had been in hospital on several occasions and had been frequently operated on during the previous three years. As he was much pulled down with pain, which was worse at night, and with discharge from the sinuses, and as it was quite impossible to amputate at the shoulder joint and remove the disease or obtain a skin covering, interscapulo-thoracic amputation was performed on March 23rd.

FIG. 3.

Back view of patient after operation.

The following is the description of the operation furnished by my dresser, Mr. Greenwood. Ether was given and with the patient lying on his left side an incision was made as in the diagram (Fig. 4), the flap being taken from the front of the upper arm. Bleeding was checked by pressure on the subclavian above the clavicle with a pair of forceps padded at the end with lint. The flap was first raised, taking only skin and superficial fascia, and the muscles were then divided down to the clavicle which was divided by bone forceps. The axillary vessels were now clamped and divided. The other vessels were taken up with pressure forceps as they were cut and very little blood was lost. Then by rotating the arm the scapula was forced forward and outward, the muscles attaching it to the trunk were divided, and the limb was removed. The vessels were then tied and pressure was removed from the subclavian. One or two large glands were removed from the axilla. The wound, which had been contaminated with pus from the diseased part, was thoroughly washed with perchloride lotion. A drainage-tube was inserted through the flap by a stab puncture in the postero-inferior part of the wound. The wound was then

closed and a dressing was applied. The flap covered the wound readily without tension. The after course was quite uneventful and the wound healed by first intention. The

FIG. 4.

O.S. and O.S. indicate old sinuses. L.I. marks the line of incision, dotted to show its course beneath the arm.

patient was up on the eleventh day and returned home on April 10th. When seen in July he had regained his old weight and colour and was well in every respect.

Leeds.

A CASE OF ACUTE INTESTINAL OBSTRUCTION; LAPAROTOMY; RECOVERY.

BY EDW. R. C. EARLE, M.B. LOND., M.R.C.S. ENG.,
L.R.C.P. LOND.,

GOVERNMENT MEDICAL OFFICER, LUCCA, JAMAICA.

ON Sept. 15th, 1898, I was called in consultation by Dr. Phillips to a patient, aged 42 years, who was suffering from abdominal pain and a history of seven days' constipation. He had during this period been taking purgatives without effect and also enemata. When I saw him he was evidently in great distress; the abdomen was very much distended and he had been vomiting a green-coloured fluid; there was not much pain at the time, but the distress was due to the enormous distension of the abdomen. The tongue was coated and the pulse was slow, regular, and fairly strong. There was an anxious expression on the countenance and the features were drawn and the cheeks were sunken. By rectal examination nothing whatever could be felt; the rectum was empty as far as the finger could reach, but a few small piles were detected. He was removed by my advice to the Lucca Hospital immediately. On admission large enemata composed of one ounce of glycerine, one ounce of sulphate of magnesia, one and a half ounces of olive oil, and boiling water to 20 ounces were administered in the genu-pectoral position every third hour. Hot linseed-meal poultices were applied to the abdomen from 4 P.M. to 10 P.M. and after that hot olive oil was applied. The enemata were returned unchanged, there being no trace of faecal matter in them. He slept fairly well during the night. On the 16th nourishment was given by enema, two ounces at a time. He had vomited twice during the previous day, but there was no faecal odour in the vomit. He also had an attack of hiccough. Large enemata were again tried every third hour, composed of one ounce of oil of turpentine, one ounce of olive oil, one ounce of glycerine, and soap and water to 20 ounces, and turpentine stupes were applied to the abdomen, but with no result. No history could be got from the patient to account for his present condition and as he was evidently getting weaker each day it was decided to operate and thus find out the nature and seat of the obstruction.

On Sept. 17th, after an ounce of brandy had been given, the patient was put under chloroform and the abdomen was opened by a four-inch incision in the middle line below the umbilicus, the bladder having been previously emptied by a catheter. The intestines were found to be very much distended with gas and fæces. A loop of small intestine was brought out of the wound and punctured and a large quantity of gas and fluid fæces were removed. After the distension had been relieved in this way the puncture was closed by two fine silk sutures and the gut returned. On exploring the abdominal cavity with the hand a tight obstruction was found in the upper part of the rectum on a level with the pelvic brim. The nature of the contents of the gut and the character of the stricture could not be made out with certainty as the gut could not be brought into the wound on account of the short mesocolon. The obstruction could not be moved either upwards or downwards; it had an irregular feel and gave one the impression that some firm substance with irregularities on its surface simulating large seeds had become impacted in the lumen of the bowel. As it was found to be impossible to remove the obstruction without seriously injuring the walls of the bowel the peritoneal cavity was washed out with boric acid solution and a loop of the large bowel above the obstruction was brought into the wound and united to the peritoneum by five fine silk sutures. Two thick silk sutures were passed on either side through the peritoneal and muscular coats of the bowel and the whole thickness of the abdominal wall in order to keep the gut in firm contact with the edges of the wound. The peritoneum was then closed by a fine continuous silk suture and the abdominal wound was closed by silk sutures except the part opposite the attached gut. The intestine was then opened and a very large quantity of fluid fæces and gas made their escape. No hard masses were passed and the fæcal fluid was of a dark colour. A large pad of tow was then placed over the opening and an abdominal band was applied to keep it in position. A morphia suppository (half a grain) was put into the rectum and the patient was replaced in bed. He was rather weak after the operation and hot bottles were placed on each side and he was wrapped in blankets. At 5 P.M. the temperature was 100° F. About three ounces of fæcal fluid had passed through the opening and also a great deal of gas. There was no pain. The pulse was fairly strong (80). Lime-water and hot milk were given by the mouth. On the 18th the morning temperature was 101°. The patient slept well during the night. He had no pain but slight soreness in the vicinity of the wound. Fæcal matter escaped through the opening in small quantities. The patient was cheerful and looked bright. He took nourishment well. The evening temperature was 100·6°. On the 19th he slept fairly well. He complained during the night of acidity. This was relieved by one dose of bicarbonate of soda. There was no pain but slight soreness. The patient was comfortable and took nourishment eagerly. The morning temperature was 99·8° and the evening temperature was 98·4°. On the 20th the morning temperature was 98·4°. He had passed no fæces since the evening of the 19th. The abdomen was slightly distended. The patient passed a good deal of wind. He did not sleep well. The evening temperature was 98·4°. He was given a Seidlitz powder. On the 21st the morning temperature was 99°. The patient slept well. The distension was relieved. There was no pain. He passed a good deal of wind. No fæces were passed. The wound was looking well. The evening temperature was 99°. From the day of the operation the bowel had been washed out both upwards and downwards by a douche of weak warm boric acid lotion, and the rectum also below the obstruction was kept clean in the same way. On the 22nd the morning temperature was 98·4°. A small quantity of fæces was discharged, also a good deal of wind. All the visible stitches were removed. There was slight suppuration around the stitches owing to tension. During the whole period since the operation tension had been relieved as much as possible by two broad pieces of strapping applied across the abdomen above and below the wound. The evening temperature was 98·4°. On the 23rd the morning temperature was 99°. He slept well on the previous night. He had there large actions yesterday and two very large ones during the night through the abdominal opening. There was no pain. The evening temperature was 99°. During the afternoon there came on a copious bloody discharge from the wound. There was a large bloody slough blocking the opening and the edges

of the wound were inflamed. He passed fæces twice during the day through the wound. On the morning of the 24th the wound looked better. The morning temperature was 98·4°. The patient slept at intervals during the night. The evening temperature was 99°. On the 25th the morning temperature was 98·4° and the evening temperature was 98·4°. The wound was looking well. A small amount of fæces was passed. From Sept. 26th until Oct. 7th the patient continued to improve, the temperature never rising above normal, and the fæces passing through the abdominal wound. The bowel was regularly washed out by a warm douche of weak boric acid lotion upwards and downwards every morning and the rectum was washed out every second day. There was a considerable amount of granulation tissue around the wound which was touched with caustic every morning and gradually decreased. On Oct. 7th, on administering the rectal douche, a considerable amount of fluid fæces came away. This evidently showed that some fæcal matter must have passed the obstruction. The patient's condition was very good. On the 8th he passed five formed stools per rectum yesterday; the stools were dark brown and minute gritty particles were noticed in them. On the 9th he passed one formed stool yesterday of the same character as those on the 7th. On the 10th he passed another stool. On the 12th he passed a large natural stool. On the 15th he passed a large natural stool about three-quarters of an inch in diameter. From this time until his discharge on Oct. 30th the patient continued to pass his stools by the anus in the natural manner. The abdominal wound was kept open for 17 days after the first stool passed per vias naturales and then it was allowed to close gradually. On the day he left the hospital the abdominal wound had almost completely closed, a small sinus at the lower end scarcely large enough to admit a slate pencil only remaining.

It is a matter for regret that the first stools passed per rectum and which had been passed during the night were by an oversight not kept for examination but were thrown away before I paid my usual visit to the hospital. All opportunity of ascertaining the exact nature of their contents was thereby lost. I saw the patient some days after he left the hospital. He was then doing well and the abdominal sinus had nearly closed. He would not remain in the hospital until the wound had quite closed as he was anxious to get home and was feeling quite well and comfortable. On July 1st, 1899, the patient was alive and had had no recurrence of the obstruction since the operation 10 months ago. In conclusion, I desire to thank Dr. C. M. Phillips for his assistance.

Lucca, Jamaica.

PULMONARY EMBOLISM FOLLOWING ABDOMINAL OPERATION; RECOVERY.

By EDWARD JOSEPH BLACKETT, M.R.C.S. ENG.,
L.R.C.P. LOND.

PULMONARY embolism is, as far as I know, a very rare and uncommon complication in abdominal operations, and cases of recovery after pulmonary embolism are also rather the exception than the rule. Therefore the following notes of a case illustrating these points may be of some degree of interest.

The patient was a woman, aged 35 years, who for seven years had suffered from repeated attacks of appendicitis. I first saw her in September, 1898, during one of these attacks. Her general health was otherwise good, though there was a family history of tubercle and gout, and the patient had herself suffered from gout and on several occasions had passed "gravel" in her urine. On Feb. 2nd, 1899, Mr. Frederick Treves removed the appendix, and as there were no adhesions between the appendix and the surrounding parts the previous attacks could not have been of a very severe character, and beyond the fact that the patient was rather stout no difficulty was met with at the operation. The appendix was as thick as a little finger and about six inches in length. A small cyst in the right ovary was found and dealt with, and there was also a fibroid in the uterus making that organ about equal in size to a pregnancy of four months. The patient did not take the anæsthetic (gas and ether)