was difficult; sudden local pain and slight enlargement of the spleen helped in their detection. In the cases of enlarged spleen a real "spleno-hepatic asystole" was induced and is characterized, contrary to the usual form, by a regularity of the pulse, absence of venous stasis, cyanosis, or oliguria, while, instead of the classical red and hard œdema, the œdema is white and soft. There was also pallor and frequent epistaxis, the latter sometimes being so severe as to require tamponing. Barié says: "Besides the pallor and the severe epistaxis, the progressive debility is the third chief important symptom in this 'splenohepatic asystole.'"

SURGERY.

UNDER THE CHARGE OF

J. WILLIAM WHITE, M.D.,

JOHN RHEA BARTON PROFESSOR OF SURGERY IN THE UNIVERSITY OF PENNSYLVANIA;
SURGEON TO THE UNIVERSITY HOSPITAL,

AND

T. TURNER THOMAS, M.D.,

ASSISTANT SURGEON TO THE UNIVERSITY AND THE PHILADELPHIA GENERAL HOSPITALS, AND
INSTRUCTOR IN SURGERY IN THE UNIVERSITY OF PENNSYLVANIA.

Internal Intestinal Fistulæ.—HOFMEISTER (*Beit. zur klin. Chir.*, 1907, liv, 745) says that abnormal communications between two small intestines or between a small and a large intestine are rare, aside from those produced by operative anastomoses. They have been found, chiefly, postmortem. In life they have been recognized in rare cases, as when a relatively free communication existed between an upper and a lower intestine. This might give symptoms that would render a diagnosis possible. Usually, however, the symptoms produced are not sufficiently definite to aid in the diagnosis. Among the causes of these internal fistulæ, according to Hilgreiner, are: tuberculous peritonitis, abscesses around a foreign body, actinomycotic abscesses, the breaking through of the closed end of a Meckel diverticulum. In the fistulæ between the small and large intestines carcinoma plays an important part. The peptic jejunal ulcer following gastro-enterostomy is of interest especially with regard to the possibilities of diagnosis and treatment. Hofmeister reports a typical case that has not hitherto been reported, in which the intestinal fistula had a traumatic origin. A boy, aged six years, suffered from many attacks of severe, paroxysmal, abdominal pain, difficult defecation, and frequent passages of blood in the form of lumps or masses. He became so emaciated, apparently from a deep-stated ulcerating stenosis of the intestine resistant to internal treatment, that one had to choose between leaving him to his fate or risking a fatal termination by operation, with the object of putting out of function the diseased portion of the intestine. This was done, but it did not help materially in the diagnosis, i. e., of establishing the presence of a communication between the portion above and that below the artificial anus.

The mother had said that from time to time, since the artificial anus had been present, a movement by the rectum had occurred, but this fact had been overlooked. A second operation was done and a mass of adherent intestine was resected. This showed a fistula in that portion of the intestine leading to the artificial anus. An ileocolostomy was then performed, which was followed by undisturbed healing. The kick which the patient had received in the abdomen had evidently produced a wound of the intestine which led to a localized peritonitis with abscess formation between the neighboring intestines and perforation of the abscess on three sides. Healing of the abscess followed, but there was persistence of the fistula opening into three portions of the intestine.

The Technique of Pancreatectomy.—DESJARDINS (*Revue de chir.*, 1907, xxvii, 945) says that the pancreas for surgeons is *noli tangere*, since they do not dare to remove it as they do other organs. It should not be regarded as so inaccessible as formerly, with the advantage of Mayo-Robson's cushion and his or Kehr's incision. The control of hemorrhage is better understood, so that the fear of the important bloodvessels associated with this organ should not be so great. Desjardins says that the removal of the pancreas is not incompatible with life, and that the biliary passages can be reestablished without undue loss of time. Billroth, in 1894, and Franke, in 1901, have done the only 2 total pancreatectomies, both with success. Neither patient, afterward, presented any troubles due to loss of the organ.

Many partial pancreatectomies have been performed. Of 30 collected cases, there were 9 partial resections of the tail, all but 3 for malignant tumors. There were 2 complete resections of the head, and these alone, Desjardins calls true partial pancreatectomies. There was one in which the body of the pancreas was removed, leaving the head, which avoided sectioning the common bile-duct, and left the tail. This was done for a chronic sclerotic pancreatitis.

Of the 30 cases, there were 16 operative cures and 14 deaths. Of the 2 total pancreatectomies, both were cured; of the resection of the tail, 7 cures and 3 deaths; of the partial of the head, 7 cures and 9 deaths; of the total of the head, 2 deaths. In spite of the good results in Billroth's and Franke's cases, Desjardins does not think that we have a right to do total pancreatectomies, the partial alone being justified by physiology. It is necessary to remove the corresponding part of the duodenum with the head of the pancreas, since both are supplied by the same bloodvessels, they are intimately adherent to each other, and since it is necessary to remove also the retroduodenal lymph glands. The three dangerous zones are: first, where the ascending colon is adherent to the second part of the duodenum. It is necessary here to avoid wounding the colon. The second zone is where the mesenteric arteries emerge from the border of the pancreas, passing in front of the duodenum. The middle colic artery may here be wounded, giving rise to gangrene of the transverse colon. The third danger zone is posterior, where the portal vein and inferior cava are in danger. All three zones can with care be avoided. The careful detachment of the parts is the key to the success of the operation. The head of the pancreas and the duodenum surrounding it are detached en bloc, the