ture normal; wound almost entirely healed, except a small spot near the temple. A few days later it had entirely healed.

The last of December, during my convalescence from typhoid fever, the wound opened again with symptoms of necrosed bone and septic absorption. At the request of the family the child was placed in the Children's Hospital, at Boston. While there Dr. E. A. Bradford removed the external plate of the hinged piece, which was now wholly detached and necrosed. The result of the operation was successful. The child remained in the hospital a month, came home in good health, and has remained bright and active up to this time, with no tenderness, dizziness, headache or untoward symptom. Previous to the accident she was subject to fits, or spasms, occurring with no regularity, sometimes weekly, sometimes monthly. Since then she has enjoyed complete immunity from them. I saw the child in October, 1891. The opening presented an irregular surface, and was filled in with bony tissue, except a small space in the temporal region as large as a nickel; no pain on pressure.

I do not report the case as a phenomenon of surgical skill, or of unique technique on my part, but simply to impress the fact of the wonderful reparative processes of nature. Three physicians stood beside that child, and each and all were firmly convinced that death was inevitable. It seemed to me that in surgical interference lay her only hope, and considering the crude instruments at my command I have often wondered at her recovery.

Drs. Marsh and Oviatt rendered important service by their advice and assistance. To the latter I am indebted for the clinical history.

CHOLECYSTOTOMY FOLLOWED BY CHOLECYST-ENTEROSTOMY.¹

BY GEORGE W. JONES, M.D., OF CAMBRIDGE, MASS.

M. C., had had repeated attacks of colic, usually without jaundice, bile, however, had been found in the urine, and she was distinctly yellow during one attack. The attacks became so frequent that she was unable to attend to her usual vocation. A diagnosis of gall-stones was made by Dr. E. P. Hurd, of Newburyport, and at his suggestion an attempt to relieve the condition was made.

The primary operation was performed by Drs. Jones and Tuttle at the Anna Jacques Hospital, Newburyport. After making an incision along the border of the ribs, over the site of the gall-bladder, that organ was hooked up with the fingers in a collapsed condition and drawn out of the abdominal wound. It was stitched with a continuous suture of kangaroo tendon to the whole periphery of the opening in the abdomen so as to completely close the peritoneal cavity, and then opened. Several gall-stones were removed. The wound healed, with the exception of a small fistulous opening, which, after several unsuccessful attempts to close, was dilated, and an effort made to probe the common duct. The latter was partially closed, so that the instrument could not pass through the seat of stricture, and believing any attempt to forcibly dilate

the constriction contraindicated in so dangerous a region, it was considered wiser to establish a new passage for the discharge of bile. The attempts to close the fistula had failed, not from the want of union of the parts, but because the accumulation of bile in the gall-bladder periodically distended this receptacle to such painful and uncomfortable dimensions that the patient sought relief at her own hands by perforating the closed fistula with a darning needle.

The operation for cholecyst-enterostomy was performed in January, 1893, by a novel method, with the able assistance of Drs. A. H. Tuttle and E. P. Hurd, Dr. Colcord, of Seabrook, being also present, about one year after the first operation, at a private residence in Newburyport. After cutting away the old scar, the fistula was dilated until it would admit two fingers, and the gall-bladder washed out with sterilized hot water. A three-inch-long incision was then made in the median line of the abdomen, on a level with the fistula, and carried through into the peritoneal cavity; the gall-bladder was evaginated through the old fistulous track (now dilated) by means of a finger passed through the median incision into the peritoneal cavity, behind this organ; two sutures were inserted into the everted wall of the bladder for the purpose of traction, and an incision made between them about three-quarters of an inch long. The operator's finger was now passed through the fistula into the gall-bladder, through the opening in its deep wall into the peritoneal cavity, and out through the median incision. While the latter opening was maintained patent by traction on two sutures, one on either side, a coil of small intestines was drawn out by the assistant, folded over his index finger, and pressed between his and the guiding finger of the operator, and carried in this manner back into the abdomen to the opening in the gall-bladder, through which it was passed, at the same time partially everting this organ through the fistulous opening as far as the surface of the abdomen. As a result of this manœuvre the fistulous opening presented the following appearance: an outer ring made up of the abdominal incision, including skin, muscles, fascia and peritoneum; a ring inside of this, composed of the old external incision into the gall-bladder; another ring inside the latter, formed from the internal incision, which was occupied by the surface of the intestine. In this manner the peritoneal surfaces of the intestine, and inner wall of the gall-bladder were brought into apposition and united by a line of continuous sutures, taken with fine kangaroo tendon, about the edge of the opening in the deep wall of the gall-bladder. The gut was then perforated, a drain made out of silkworm gut, inserted into it, and the deep wall of the gall-bladder with intestines, dropped back into place. The opening into the gall-bladder was packed lightly with gauze, the central abdominal incision closed and sealed with colodion, and a swathe fastened about the abdomen.

There was no shock, and rapid healing without any untoward symptom followed. After the communication between the gut and the gall-bladder was fully established, there were slight ejections of fecal matter at times; and to hasten the healing of the external wound which had greatly contracted, a few stitches were inserted after refreshing the edges.

It must be remembered that this was a particularly favorable case to operate upon, as the gall bladder, by repeated distention with bile, had become of cup-size dimensions.

¹ Notes of Secretary, taken from a preliminary report of the case read before the Boston Gynaecological Society, February 9, 1893.