cholepsy. We must not forget that we find comparable phenomena in the normal and especially in the pathologic forms of sleep, in dreams, in exhaustion, and particularly in the emotional states. The psychologic and physiologic study of these facts is far from finished, and it appears to me indispensable for the explanation of the phenomena presented by our patients. Hence if there be anything of importance in what I have brought to your attention this evening, it is the clinical description of certain curious mental troubles which I have endeavored to compare and connect, in order to show you that the mental degradation which paves the way for the obsessions and which must even play a part in the genesis of certain deliria, is not always effected gradually, but may come on abruptly and constitute a genuine psycholeptic crisis.

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- ² Lad. Haskovec: *Contrib. à la connaissance des idées obsédantes*, xiiième Congrès de Médecine à Paris, 1900; section de Psychiatrie, p. 121.
- ³ Pick: *Brain*, 1903, p. 242.
- ⁴ Les Obsessions et la Psychasténie, 1903, vol. i, p. 504.
- ⁵ A more complete study of these two and other similar cases may be found in my work, "Obsessions et la Psychasténie," vol. i, p. 506, and vol. ii, p. 54. I have also recently presented my observations on an analogous trouble in an epileptic before the Société de Psychologie: *Bulletin de l'Institut Psychologique*, 1904, p. 215.
- ⁶ Ball: *Revue Scientifique*, 1882, ii, p. 42.
- ⁷ Névroses et idées fixes, 1898, ii, p. 61.
- ⁸ Ségas: *Leçons sur les maladies mentales*, 1895, p. 70.
- ⁹ Obsessions et psychasténie: Les périodes psychasténiques, i, pp. 439, 441.
- ¹⁰ *Op. cit.*, ii, p. 424.
- ¹¹ Névroses et idées fixes, ii, pp. 63, 71. Obsessions et psychasténie, i, p. 319.
- ¹² *Op. cit.*, i, p. 252.

GASTRO-ENTEROSTOMY.

(A PRELIMINARY NOTE.)

BY JAMES G. MUMFORD, M.D., BOSTON,

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OPERATIONS on the stomach were undertaken fearfully and carried out timidly for many years. We have not yet outgrown that mental attitude. Apparently the feeling has been, if you open the digestive tract you are doing a dangerous thing; do as little damage as possible and get the visceral wounds closed as soon as you can.

Experience with operations for malignant disease of the stomach first opened our eyes to the fallacy of this over-cautious view. There are two operations usual in the case of gastric cancer, — partial gastrectomy and gastro-enterostomy. At first sight one would suppose gastro-enterostomy to be far the more formidable, but operators have learned that in the long run, gastro-enterostomy for malignant disease results in a higher mortality than does gastrectomy.

Setting aside the consideration of, and in the case of "benign" disease, looking for a radical operation for stomach drainage, for an operation which shall return the parts to an anatomical condition essentially normal, one sees that some form of gastro-enterostomy must be done. Finney's operation is valuable, for it returns the parts to a condition approximating the normal, but Finney's operation is not always applicable. Rodman's partial gastrectomy, combined with

all cases of gastro-enterostomy, returns the parts essentially to the normal, but Rodman's operation seems needlessly radical for routine practice.

None of the other operations, as ordinarily performed, regularly restores the parts to anything like a normal condition.

The object of this communication is to urge an operation I have practiced of late, an operation elaborated out of the well-known procedure of Chaput. As originally done by Chaput, that operation consisted of:

(1) Posterior gastro-enterostomy with the long loop; (2) Entero-enterostomy; (3) Section of the afferent loop between the two anastomoses.

So far as it goes that operation is very satisfactory, but it does not restore the parts to their normal relations. Vicious circle sometimes ensues, the pylorus may resume its functions; the new gastric stoma may close.

I advocate a fourth step, — invariable, routine, (4) Section of the pylorus. That adds nothing to the risks; vicious circle is rendered impossible; the duodenum, now side-tracked, becomes a mere duct, a continuation of the common bile duct.

Doubtless this method of operating is not original, and it would be preposterous to describe it as a novelty; but since it offers a certain solution of the vicious circle problem, since it leaves the parts much as nature intended and since it is easy of accomplishment, I am urging it as a routine measure.

THE PROPHYLAXIS OF SYPHILIS.*

BY WM. G. MACDONALD, M.D., BOSTON,
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AT the last Charitable Conference held at Boston, one of the speakers said something to this effect: "We will never accomplish much along some lines of charitable work, until we recognize the fact that certain diseases exist, and are willing to discuss them and their consequences as openly and as freely as we now argue other and kindred matters." These were not his exact words, but they express the lesson he intended to teach.

Public health and public charity cannot be disassociated. They walk hand-in-hand, and deal always with the same individual. Almost the whole of charitable work comes down to the preservation of health, the care of the sick, or the burial of the dead. Our hospitals are managed by health experts, but are founded, endowed and supported by charity. Yet, on the one question of venereal disease, charity closes its delicate ears with its daintily gloved finger tips, looks inexpressibly shocked and a little bit bored, and refers the whole matter to public health. The excuse is that these diseases are self-inflicted and can only come about by the depravity of the individual. Even if this be true, what matters it? When the Samaritan saw a stranger lying by the roadside, naked, bleeding and senseless, he did not ask who started the fight. Not at all; his every effort was devoted to the care of the sick man. But, in point of fact, the charge is not

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