the transverse colon, and the jejunum felt. With the finger still in place, forceps or a curved haemostat is passed along the finger, and the chosen loop of bowel pulled into the wound. In every instance, one is practically sure of grasping the jejunum or at least a loop of intestine, high enough for all purposes. A few interrupted catgut sutures are then placed, uniting the intestine to the parietal peritoneum. Next, double purse-string sutures are taken and one loose knot tied in each. The gut is opened and the catheter introduced. Of late, I have been using a self-retaining catheter, about No. 18 French in size. This will not pull out as easily as an ordinary one. The catheter having been introduced, the inner purse-string suture is tied. The catheter is then pushed in a trifle, thus enfolding the intestine, and the second suture tied. This suture is carried through the catheter walls with a needle, and again tied, the catheter thus being made secure. With care, one may keep the self-retaining catheter in place a considerable period of time, removing it simply by cutting off the bulbous end and allowing this portion to drop into the intestine, where it is carried along the intestinal canal and finally passed. If the ordinary catheter be used, it will be found to remain in place about six days, at which time it will become loosened and fall out.

Ordinarily, jejunostomy will have served its purpose in six days. Where the jejunostomy is done by simple suture of the intestine to the parietal peritoneum, no attempt should be made to close the wound, as leakage is sure to take place after a few days. This leakage can be better cared for with an open wound than where the wound has been closed by layer sutures. With the Witzel-Mayo method, there is less chance of leakage, so that more detail can be carried out in closure of the wound. After the catheter has been removed, there is always some digestion of the abdominal wall by gastric and pancreatic secretions. Frequent dressings and irrigations of the wound, combined with the use of a preparation of compound tincture of benzoin and zinc oxide ointment on the skin, will usually keep this annoyance at a minimum.

In the successful cases of jejunostomy, the sinus usually closed without subsequent operations in from sixteen days to four months. Should the latter be necessary, a comparatively slight operation for intestinal repair can easily be done and the sinus closed. Of course, one should not include too large a section of the intestine within the suture line, lest sloughing of this area lead to a permanent fistula.

CONCLUSION.

Jejunostomy is a simple surgical procedure, by which intestinal gas and toxic material can

be well cared for in cases of obstruction; through which nutrition, drugs, and fluids can be introduced, and which, if utilized in time, is a life-saving measure.

CAESAREAN SECTION—DEATH ON THE TENTH DAY FROM CEREBRAL HEMORRHAGE.*

By R. S. TITUS, M.D., BOSTON.

CASE 6. Multipara. Second pregnancy. Age, 30. Past History—Negative, save for attack of pyelitis in 1917. First Pregnancy—Normal. Membranes ruptured before labor on the twenty-third of June, 1919, and after several hours of active labor, Caesarean Section was done because head remained high. Convalescence following the Caesarean perfectly normal. Second Pregnancy—Perfectly normal, save for an unusual amount of sleeplessness. Second Caesarean done on July 24, 1921, after labor had started. The operation was a classical Caesarean; the abdomen when opened showed omentum adherent to the top of the fundus. This was tied and cut. There were no other adhesions. Male child weighing 10¼ pounds delivered. After the delivery of the baby, there was somewhat freer flowing than normal, but not enough to occasion worry. There was no vomiting at all after delivery. On the third day after operation her pulse in the afternoon was about 130, temperature a little over 99; her abdomen was soft with only moderate distention, but the stomach seemed distended enough to require lavage. The convalescence after this was perfectly normal until 10 o'clock in the evening of the thirty-first of July. When the baby was brought to her at this time to nurse, it was noticed that the patient showed no interest at all in the baby, looked straight ahead in a starey fashion and would in no way respond to questions. There was also possibly a little less motion in the right arm than in the left, but this was very slight, if any. For the previous two evenings the patient had had considerable headache. Her temperature at this time was perfectly normal and her pulse was 96. I thought the condition dementia. When seen the following morning, the patient lay in bed with a fixed expression, she opened her eyes at unexpected noises, swallowed food when put in her mouth, used both hands, the right possibly a trifle less than the left, and there were no other localizing signs. Her bowels and bladder were incontinent. Her temperature during this day was normal and her pulse was 92.

The following morning the patient's temperature was normal and her pulse 90. She seemed very much better, smiled and recognized the nurse, as was evidenced by her pressing the nurse's hand. She ate a large dish of cereal.

I had a medical man see her, to see if he could

* Reported at meeting of the Obstetrical Society of Boston, October 25, 1921.

make a definite diagnosis. His report is as follows:

Physical Examination—Lying comfortably in bed. No dyspnea, no cyanosis. Makes no reply to questions, but when asked to put out her tongue does so. Is sensitive to pain; example, pin prick—face, arms, soles of feet. No asymmetry of face. Seems able to move all of limbs. Eyes—Pupils equal and react. Fundi normal. Ears—Both drums normal. Throat—Negative. Tongue shows no tremor, protrudes in median line. Lymphnodes—No enlargement of cervical, axillary, or inguinal. Lungs—Resonant throughout. No râles, no broncho-vesicular breathing. Fremitus normal. Heart—2-9.5 cm. Apex fifth space inside nipple line. Rate 96, regular, no murmurs. Pulses equal 96. Blood pressure 100/65. Abdomen (Recent incision covered by dressings)—soft, no tenderness, no masses. Liver, spleen, kidneys not felt. Extremities—No Kernig. Knee-jerks normal. Plantar reflexes normal. Urine—Not obtained. Blood—White count 1,600. Differential, neutrophils 86%, lymphocytes 14%. Lumbar puncture done because of white count, and 30 c.c. of bloody fluid obtained not under increased pressure. Wassermanns on blood and spine fluid negative.

About 1.45 in the afternoon of this day, after she had had three convulsions, I saw the patient, at which time her legs and arms were rigid, she was breathing normally and her pulse was under 100. Cerebral hemorrhage was naturally considered, but the reason for this hemorrhage in a person so young was hard to find. The patient remained unconscious and about 2.30 P.M. her pulse became much more rapid, and death occurred shortly after 3 P.M. The heart continued beating some time after respiration ceased. It was with a great deal of satisfaction that the family consented to an autopsy, which was performed four hours post mortem by Dr. R. N. Nye, from Dr. Mallory's Laboratory of the Boston City Hospital.

The autopsy findings were normal until one gets to the brain.

Brain—Calvarium removed with difficulty because of numerous Pacchionian granulations which extend unusually far posteriorly. Dura and longitudinal sinus not remarkable. Pia-arachnoid over hemispheres negative. In the pia-arachnoid covering the right half of the spinal cord there is a blood clot which starts about 2 cm. below the olive and extends upward over the lateral aspect of the right halves of the medulla oblongata and pons as far as the point of exit of the trigeminal nerve; this clot measures 3-4 mm. in its thickest portion. The left lateral ventricle contains dark red fluid and the right contains dark red blood clot, approximately a cast of the ventricle. This blood clot connects with a clot filling the third ventricle, and this in turn connects through the aqueduct of Sylvius to a clot filling the fourth ventricle. The clot in the pia-arachnoid covering the

spinal cord, medulla and pons is apparently a continuation of the bleeding from the fourth ventricle. The veins of Galen are thrombosed and this thrombus extends out and down into, and completely filling, the straight sinus as far as the latter's junction with the lateral sinus. The basal nuclei and fiber tracts, which form the floor of the right lateral ventricle, consist of a mass of gelatinous, almost fluid, light red-brown tissue. On sectioning the basal ganglia on the

left, numerous pin-head, bright red, irregular areas appear, probably due to diffusion of blood from cut vessels. Cortex, cerebellum and spinal cord negative. Middle Ears—Negative.

Anatomical Diagnoses: Cerebral softening (right basal ganglia) with hemorrhage into ventricles and pia-arachnoid of cord and with thrombosis of Galen's veins and the straight sinus. Pulmonary congestion, slight (right lower lobe). Subinvolution of uterus. Lactating breasts. Post-operative abdominal wound. Post-operative uterine wound. Fatty changes in aorta—slight.

Microscopical Examination: Basal Ganglia (left)—Definite thrombosis of one of the larger blood vessels. All the other larger blood vessels are surrounded by small or larger areas of ex-

travasated red blood corpuscles. Many of the smaller blood vessels are similarly surrounded by small foci of extravasated blood. In many of these the vessels cannot be made out, suggesting softening. At the peripheries of all these areas of hemorrhage are found moderate numbers of neutrophilic polymorphonuclear leukocytes. No organisms are seen. Galen's Veins—Section through both shows completely obliterating thrombi. No organisms seen. Pons—All the larger blood vessels in the peduncles are surrounded by areas of extravasated blood. There are no obvious thrombi. Some of medium sized blood vessels appear to have walls of unusual thickness. Cerebellum—Negative. Spinal Cord—Massive hemorrhage in the meninges.

A TRIBUTE TO A PIONEER IN MODERN PATHOLOGY.

BY J. C. WARREN, M.D., BOSTON, AND S. J. MIXTER, M.D., BOSTON.

THE death of Dr. William Fiske Whitney on March 4, 1921, was an event which brings home to the memory of his contemporaries a long career of useful service.

Entering on his professional work at a time when the microscope had just begun to be a prominent feature in medical teaching and in the practice of medicine, he was appointed Curator of the Anatomical Museum of the Harvard Medical School in 1879. He brought with him to this office as thorough a training in the laboratory branch of medical education as prevailed at that time in the prominent medical centers of Europe.

He came into his new position at a transition period when scientific medicine was beginning to assume a prominent place in the medical curriculum. The old anatomical collection, like that of the Musée Dupuytren in Paris, and many others, represented the labors of an earlier generation. The field was an open one for the new-comer, and Dr. Whitney promptly took advantage of the situation and became a pioneer in modern museum work, which, under the fostering influence of the Association of International Museums, has of late years become so prominent a feature of the modern medical plant.

During his long and devoted term of service as Curator, the Museum has twice found a new home, and a comparison of the present quarters with those in the old building on North Grove Street, of which Dr. Holmes said: "Oh, star-eyed Science, hast thou wandered there!" is a sufficient indication of the amount of work Dr. Whitney has been able to accomplish. The character of his work in this field is best enumerated by one who has rendered him faithful and efficient service during many years.*

* Miss E. Harriet Piper.

"Dr. Whitney was especially fitted to fill the position of Curator, on account of his wide range of knowledge on all subjects, and his familiarity with more than half a dozen different languages.

"He spent much time and thought on the present home of the Collection, visiting many museums in various parts of the country, which enabled him to eliminate impractical features. When the time came for moving the thousands of specimens, the picture of every detail was so clearly in his mind, and they were packed in such a manner that he was able to put them at once in their proper places, and not one specimen was injured.

"He succeeded so well in the accomplishment of his purpose that during the Medical and Surgical Congress in June, 1921, strangers from various countries expressed their admiration of what they considered 'one of the finest museums they had ever had the good fortune to visit.'

"Dr. Whitney aimed to have the museum simple, quiet and dignified, as it represented human suffering, and he hoped in the study of the specimens, alleviation of pain might be found. It was to him a sacred trust, in the fulfilling of which he never spared himself in any way. He felt that the value of the Museum was in its use, and extended the resources as far as it was consistent with the safety of the specimens, and a request was never refused under these conditions. As a result, many valuable contributions were secured because the donor felt 'they would be carefully preserved.'"

But it is in another field that Dr. Whitney will probably be best remembered by his contemporaries. Dr. Whitney was preëminently a clinical pathologist and his intimate association with many medical and surgical colleagues at a time when the field of medical practice was greatly expanding, enabled him to be of great service to them in their practice. The pathological reports which he sent to his medical colleagues at a time when the practising physician was becoming more and more dependent upon pathological findings, were models of their kind.

It was, however, in the domain of surgery that he was able to figure as a pioneer in a special line of work. The surgeon of today has little conception of the difficulty of obtaining reports upon examination of tumors and other morbid specimens, which prevailed at that time. The specimen was often lost or rendered unfit for microscopical examination. This was true of hospital as well as of private clinical work. The Cabot endowment for a laboratory for such a purpose at the Massachusetts