VIII. Laparotomy for Removal of a Fork Swallowed Fifteen Years Previously. By Drs. ROSATI and CATANI (Florence, Italy). Dr. Walter J. Freeman reports the following remarkable case occurring in the hospital of St. Giovanni di Dio, of Florence, Egisto Cipriani, an Italian juggler, æt. 38, in 1872, accidentally swallowed a fork with which he was performing. Various attempts to extract it *per vias naturales* proving unavailing, he resorted to the occupation of type-setting until fifteen years later, when an attack of pleurisy was accompanied by obstinate but not stercoraceous vomiting, which continued after the cure of the pleural complaint. A tumor was found in the median line of the abdomen below the umbilicus, and as the fork had not been known to pass per anum, it was decided to perform laparotomy to examine the tumor and search for the foreign body. Accordingly, under full antiseptic precautions, an incision was first made in the gauze over the spot chosen for operating, the rest of the abdomen being covered with the gauze, which was renewed several times during the operation. The operator then made an incision in the median line four inches in length downward from a point an inch and a half below the umbilicus. A tenaculum was used in every instance to pick up the fascia before inserting the grooved director. Nearly an hour was expended in opening the cavity by reason of the strong adhesions due between the tumor and the parietes. A few bubbles of inodorous gas was the first sign that a cavity had been opened; the opening was enlarged sufficiently to admit an exploring finger, when the fork was immediately felt. With a pair of strong forceps the fork was drawn to the opening, where but a few strokes of the knife were necessary to free it, without having to enlarge the opening into the sac more than an inch. It was then found that the fork had passed through the whole length of the small intestine, and had lodged in the cæcum, where it had set up inflammation and had nearly ulcerated its way through the bowel. It was almost encysted, and by its weight had swung the cæcum around to the median line, where it adhered. No fecal matter nor pus was present, and during the operation the peritoneal cavity was not opened. Without meddling further with the tumor, its opening was closed with catgut sutures, the wound in the

abdominal wall thoroughly cleansed and the edges brought together by five deep stitches. A short (2 inch) drainage tube was laid between the two surfaces of the wound, which was then closed by a continuous suture and iodoform dressing applied. Aside from a chill with some slight elevation of temperature, attributed to catheterization, immediately following the operation, the patient made a rapid and complete recovery. The fork, a solid one, was eight inches in length and the base of the tines, of which there were four, were encrusted with calcareous and fecal matter only one-third the distance up, leaving the points uncovered and very sharp from corrosion.—*Polyclinic*, June, 1887.

IX. Laparotomy with Resection and Suture of the Intestine for Gangrenous Strangulated Hernia. By JOHN A. WYETH, M.D. (New York). In a case of strangulated femoral hernia with gangrene of the gut in a woman, æt. 56, the strangulation having existed about ten days, two and a half inches of the small intestine with a triangular bit of the adjoining mesentery were removed by abdominal section along the outer side of the rectus muscle of the side affected, and the two ends of the gut sutured. The femoral canal was closed and a radical cure of the hernia secured. The writer specially emphasizes his method of joining the ends of the divided gut, a combination of Czerny's sutures through the mucous membrane alone, Lembert's suture and an intermediate suture, piercing the peritoneal coat, passing along with the muscular layer, and coming out on the free border of the gut. The Lembert and intermediate sutures alternate throughout the entire circumference and should be one-eighth inch apart; the Czerny sutures should be from one-fourth to three-eighths inch apart. The patient rallied well from the operation and ultimately made a good recovery. The author divides the treatment of strangulated hernia with gangrene of the intestine into three methods: (1) Establishing a permanent fecal fistula at the seat of the hernia. (2) Immediate excision of the gangrenous portion of the gut through the hernial opening, reunion of the ends by suture and return of the loop. (3) Temporary fistula followed, after an interval of some days, by laparotomy,