SURGERY

UNDER THE CHARGE OF

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A New Method of Gastrostomy and Esophagoplasty.—ROPKKE (*Zentralbl. f. Chir.*, 1912, xxxix, 1569) says that the oblique or tortuous canal provided by the usual methods of performing a gastrostomy, sooner or later changes under tension and becomes a more or less direct fistula leading into the stomach. The feeding tube passes in and out loosely, the stomach contents escape alongside, and the surrounding skin becomes sore and inflamed. Ropke reports a case of cancer of the lower end of the esophagus in which he performed an operation devised by Janu, who had performed it experimentally on dogs and on the human cadaver. In Ropke's case there was found a nodular tumor the size of the fist, which was inoperable. The abdomen is opened by an incision in the median line above the umbilicus. The omentum is separated along the greater curvature, the gastric arteries and veins being carefully avoided to the neighborhood of the pylorus, where they are double ligatured and divided. From the pylorus a quilted suture is introduced through both walls of the stomach up to the fundus. The suture ends just above where the left gastric artery reaches the stomach and includes between it and the greater curvature, a narrow strip of stomach about $2\frac{1}{2}$ fingers' breadths wide. This strip is left to communicate with the rest of the stomach at the cardiac end, but is cut off from the stomach in the rest of its extent by the suture. Beginning at the pyloric end this narrow strip of stomach is divided from the rest from the pyloric end up to its cardiac end, where it remains attached and is turned outward and wrapped in gauze. The quilted suture is then turned in and covered by a sero-muscular suture in its whole extent and the latter suture is continued to the cut edges of the separated flap, so that from it is made a tube leading into the stomach. The peritoaeal cavity is then closed around the attachment of the new tube to the stomach where the stomach is fixed in the abdominal wound without disturbing the sutures of the new tube. The latter is now completed, a small tampon is inserted into its end and fixed by a suture, and the end of the canal is turned in over the tampon by a suture. According to the length of the new canal—in Ropke's case 22 cm.—a tunnel is made of varying length upward, under or through the pectoral muscle from the abdominal wound toward the left clavicle. With a long forceps the new stomach canal

is drawn through this tunnel. The abdominal wound is then closed completely. The upper end of the gastric canal is sutured closely to the edges of the upper end of the tunnel, its closing suture is removed, the small tampon in its end is taken out, and the edges of its mucous membrane are sutured to the skin edges of the surrounding wound. Good healing occurred. After eight days fluid and pulpy food were passed through the new canal into the stomach, and this was kept up afterward. No backflow of stomach contents occurred.

The Necessity of Suturing Incisions of the Pelvis and Ureter.—BAZY and BAZY (*Jour. d'Urolog.*, 1912, ii, 645) consider that one should not follow a uniform course in the matter of suturing the pelvis and ureter after incision into them. They do not agree with those who say that the suture ought always to be employed, any more than with those who believe that it ought never to be used. They believe that its use should depend upon the possibility or facility with which it can be employed. They are convinced that it is an excellent practice and that the results which it gives are constantly good. But as it is not absolutely necessary, it should not be attempted at the risk of compromising the success of the operation. One should avoid with care denuding the urinary ducts and separating them from the cellulo-adipose tissue surrounding them, which fortify and carry nourishing vessels to them. It is upon these tissues, rendered resistant by the irritation from the presence of the calculi, and upon them alone that one will depend to hold the suture. Under these circumstances it can be introduced easily, rapidly, and efficaciously, and it will not be followed by contractures. When the pelvis and ureter have been denuded, suture is often impossible and in such cases it will be well to cover the opening and protect the duct by a plastic flap made from the surrounding tissues. Suture should not be employed when it appears to be difficult and in consequence gives little chance of a satisfactory result, nor when it appears to be dangerous from the standpoint of the ulterior integrity of the calibre of the urinary tract. It should not be done in patients with a precarious general condition, or when after a laborious operation it seems especially important to shorten the duration of the operation. A septic condition of the urine is not a contraindication to the suture. Nevertheless, when the infection appears to be serious and a ureterotomy has been done, it will be best, in place of attempting removal of the margins, to provide drainage of the ureter, which seems to have very desirable advantages.

Cutaneous Autoplasty in the Cure of Grave Urethro-rectal Fistulæ.—MICHON (*Jour. d'Urolog.*, 1912, ii, 681) says that some urethro-rectal fistulæ are particularly grave because of the extent of the destruction of the posterior urethra and the cicatricial induration of the perineal tissues, and demand other than the ordinary procedures for their cure. Michon obtained a good result in such a case with the following operation: A small cutaneous flap is cut from the posterior median part of the scrotum, rectangular in shape, 3 cm. long, and wide enough so that with its anterior end attached to the scrotum, it can be drawn without difficulty into the perineum. It is at first left attached by its two small ends, the one anterior and the other posterior,