

THE SUTURING OF ARTERIAL WOUNDS.

In July, 1895, Gluck reported to the Berlin Medical Society the suturing of an arterial wall in an arteriovenous aneurism. HEIDENHAIN (*Centralblatt für Chirurgie*, 1895, No. 49) reports a case in which, during the removal of a carcinoma of the breast, the axillary artery was wounded. The edges of the wound were caught with hæmostatic forceps and a continuous suture of catgut introduced with needles, such as are used in inserting intestinal sutures. The wound was packed and not closed until the end of forty-eight hours, when all danger of secondary hemorrhage seemed to be passed. The case recovered completely, and there was no evidence of a traumatic aneurism when the author examined the patient six months later. The author advises the use of catgut, such as is used for ligatures, and the union of endothelium to endothelium; sometimes there is a slight oozing through the stitch-wounds after the suture is completed, but packing for a few minutes will stop it. He does not believe it is necessary to heal the wound by secondary suture, as the healing of the tissues about the artery tends to support it.

THE TREATMENT OF ARTIFICIAL ANUS BY PRIMARY INCISION INTO THE PERITONEAL CAVITY.

In the treatment of the artificial anus by operative procedure great difficulty is encountered in preserving aseptic conditions in the peritoneal cavity and gaining a knowledge of the exact position and the amount of adhesions which bind the intestines together.

To overcome these difficulties GÄNGOLPHE (*Revue de Chirurgie*, April, 1896) advises the following method of operating: the abdominal parietes surrounding the artificial anus are incised down to the peritoneum, isolating the anus and surrounding area. The incision embraces the skin and subcutaneous tissues solely. At the upper angle of the incision the cut is deepened so that it includes the peritoneum and admits the passage of the exploratory finger within the abdominal cavity. After a careful examination of the conditions present, curved scissors are passed along the finger and the entire incision is completed. The anus thus freed is drawn outside, surrounded by aseptic pads, and the intestine united by the most suitable method of enterorrhaphy. The intestine is then returned to the abdominal cavity and the parietes closed by a suitable method of suture, as in laparotomy.

The author claims the following advantages for this method:

1. It is rapid. The surgeon is in no danger of wounding any portion of the intestines, and can go immediately into the peritoneal cavity.
2. It is sure. The finger introduced in the cavity explores beforehand, and then guides the scissors, which cut free the artificial anus without endangering the remaining intestines.
3. It permits of the drawing out of the entire mass upon sterilized compresses, where the principal part of the operation can be done leisurely and with easy access. This insures asepsis and diminishes the chance of infection.
4. It is applicable in all cases, and produces success in cases that were formerly unsuccessful.