

abdominal wall the prevesical space is more or less shut off by the union of the two surfaces and a filling in by new tissue. The new scar tissue which develops is the best support for the sutures. Hofmann's attempts along this line have been successful to the present time. If in an occasional case the urine leaks through the bladder wound, the first drops will give acute pain, which would be an indication for opening the wound and placing a gauze drain in the prevesical space. He considers the situation still a safer one than if a primary tampon had been used.

He recommends very highly the use of vesipyrin as a urinary antiseptic in the effort to obtain a clean and healthy bladder for the operation. After the operation the patient must be catheterized at least twice daily at first, even if the urine is passed spontaneously, since the fixation of the bladder to the abdominal wall gives rise to a certain amount of residual urine. The presence of a permanent catheter in an already irritable bladder cannot add to the safety of the sutures.

**Abdominoperineal Amputation of the Cancerous Rectum.**—GOUILLIOD and FAYSSE (*Revue de chirurgie*, June and July, 1905) report 8 cases in which they performed this operation, 7 in females, which were successful, and 1 in a male, which was fatal.

They divide the operation into four stages: The first includes a median incision below the umbilicus, through which the cancerous rectum is removed, and a left iliac incision for the artificial anus. The sigmoid flexure is brought through the median incision and divided between two Kocher forceps. The upper cut end covered by a compress is left in the superior angle of the wound. The lower end is closed hermetically in two or three layers with fine and very strong silk.

The second stage includes the separation of the rectum from its mesentery, and, if desired, the ligation of the internal iliac arteries. The small intestines are held up toward the diaphragm by compresses. The mesorectum is then divided between forceps until the superior hemorrhoidal arteries are exposed and ligated. The internal iliacs may be tied at this point in the operation, or it may be deferred until the rectum has been freely liberated. When the rectum has been freed from its mesentery to the bottom of the pelvis, the peritoneum is cut through in the circumference of the bowel, and the mass is covered by a compress and abandoned for the time being. The divided edges of the peritoneum are sutured together, covering in the denuded area and the compress.

The third stage consists in the establishment of the artificial anus in the iliac incision, although this may be postponed to the latter part of the operation, to better avoid contact with the intestinal contents. The bowel may be left closed and the artificial anus made on the following day, as advised by Quenu.

The fourth stage includes the removal of the rectum and growth by the perineum. An elliptical incision is made in the perineum around the anus, which is then closed by a Kocher forceps. The rectum is then separated gradually from the surrounding structures and, by pulling downward the portion detached through the abdomen, is reached and removed through the perineal wound. One can work freely through the cellular tissue on the sacral side of the rectum, but must be careful, anteriorly, lest he open the rectum. When the separated bowel and growth are removed, the compress which covered it is drawn down

through the perineal wound and left in position to act as a drain. The gaping wound is then packed with more gauze, and may be reduced in size by a few sutures. The writers placed a permanent catheter in the bladder, but think it would perhaps be better to avoid its use, since the bladder rarely escapes infection from it in spite of all precautions.

In conclusion, the writers consider that, if the sacrifice of the sphincter be admitted to be advisable, the abdominoperineal operation offers a free and safe removal of the cancer in the early stages, and permits the removal of some that are inoperable by other methods. It marks a notable progress in the treatment of cancers of the rectum.

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**Report of the Results of Non-traumatic Surgery of the Brain and Spinal Cord at the Massachusetts General Hospital.**—CODMAN (*Boston Medical and Surgical Journal*, July 20, 1905) says that of the 36 operations performed, in 28 an attempt at a radical removal of the tumor was made, but that none was successful. In those who lived after the operation, relief of pressure was followed by improvement in a considerable number. The failures were probably due to strangulation of the motor cortex through the trephine opening, or to damage to the brain tissue. Therefore, in the hands of most surgeons, a simple, palliative operation for relief of pressure will be the best in the long run. In but three cases was a radical removal of a tumor actually done. Two of these died almost at once and the third recurred later.

Putnam says that the cleaning up of the results of old injuries to the cerebral membranes and skull undoubtedly results favorably in a fair number of cases, although they are strangely variable. The most important point, as regards the treatment of epilepsy by operation, is as to the value of excision of the motor areas of the cortex in cases with localized aura. Although there is much to say of a practical character in its favor, it is still in doubt.

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**A Case of Sacculated Aneurysm of the Abdominal Aorta Treated by the Introduction of Silver Wire and the Passage of a Continuous Current.**—GRIFFITHS (*Lancet*, August 12, 1905) reports an interesting case, in which the illness had its origin about three months before the operation. He experienced a strain in lifting a rather heavy camera and other impedimenta, and swinging them over his shoulder. There was no history of syphilis or rheumatism. He had gonorrhœa about twenty years before. The tumor in the abdomen occupied mainly the epigastrium, and was entirely on the left side of the median line. It was about the size of a cocoanut, and was distinctly pulsating, with a well-marked systolic bruit. The patient said that there had been no increase in the size of the tumor lately, but he thought it had become harder, and although at one time he was able to "squeeze it away," he was now unable to do so.

An incision a little to the left of the median line was made over the tumor, opening the abdomen. The placing of a temporary ligature around the aorta above the tumor was not practicable, on account of insufficient room. A spot devoid of vessels was selected on the surface of the tumor, and a small circle was enclosed in a purse-string suture, through the centre of which a fine, long, metal trocar and cannula were thrust well into the sac. Through the cannula a vulcanite cannula