

TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting held October 1, 1906.

The Vice-President, ROBERT G. LE CONTE, M.D., in the Chair.

LYMPHANGEIOMA OF THE CHEEK

DR. FRANCIS T. STEWART reported the case of an infant, who was seen by him with Dr. Robert Pitfield soon after birth. The whole right side of the face was occupied by a soft semifluctuating mass which extended from the mid-line of the upper lip back over the parotid, and from the orbit down over the lower jaw (Fig. 1), and which bulged into the mouth. The right eye was closed, the nose displaced to the left, and the mouth distorted. A hollow needle passed into the cheek withdraw a small quantity of straw-colored fluid. The skin was exceedingly thin and contained a few dilated veins but was not adherent. It was thought advisable to postpone operation as long as possible in order to give the infant a firmer hold on life. At the end of four months, however, the swelling had distinctly increased in size and there was evidence of pressure effects on the upper jaw. Immediate operation was therefore advised. The skin was reflected by an incision similar to that employed by Weber for resection of the upper jaw, and the growth, which had also extended backwards along the floor of the orbit for about one-half inch, enucleated with but little loss of blood. There were apparently no muscle fibres in the cheek and at the completion of operation nothing remained but bone and very thin skin. After resecting the redundant portion of the flap, the mucous membrane was sutured to the jaw with catgut and the cutaneous incision closed with horse-hair. Just as the operation was completed the baby ceased to breathe (ether had been employed) and artificial respiration was

needed for some minutes. Primary union was secured except at a point corresponding to the inner canthus, which healed by



FIG. 1.—Lymphangeloma of cheek.

granulation. The right face, of course, is sunken, the nose is still displaced to the left, and the lower lid and upper lip are slightly out of alignment.

SARCOMA OF PUBES.

DR. FRANCIS T. STEWART described the case of a woman aged 38 years, a multipara, who had never had any serious illness until the present time. The family history presents nothing relevant. About one year ago she fell against the corner of a table, striking the pubes. The blow was sharp enough to make a distinct impression on her memory, but did not incapacitate her and the soreness passed away in a short time. Four months ago pain appeared rather suddenly in the region of the injury and has since caused considerable discomfort, although it was never deemed serious enough to demand the services of a physician. Quite recently a swelling was noticed in the lower abdomen, and it was for such that the patient sought advice. There had been but little loss in weight, and the anæmia which was noted was said to have been present for many years. The tumor

extended from the right anterior superior spine of the ilium to the left for $7\frac{1}{2}$ inches, and rose about $2\frac{1}{2}$ above the pubes, to the posterior surface of which it was firmly attached. The lateral extension on the right was moderately movable. The skin was at no place adherent. The growth was smooth, slightly lobulated, a little tender, and as hard as cartilage. The superficial veins were distended but no other pressure symptoms were in evidence. The growth could be felt by vaginal examination but did not invade the uterus or appendages.

Operation was performed September 15, 1906, in the Pennsylvania Hospital. A long curved incision was made from the right anterior superior spine downwards and inwards across the

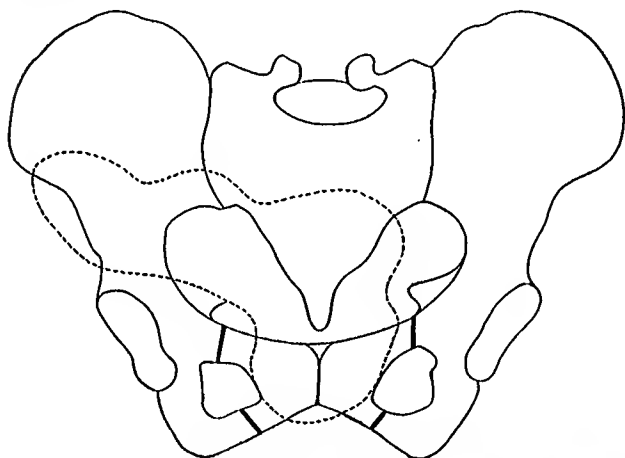


FIG. 2.—Sarcoma of pubes. Dotted line showing limits of tumor. Dark lines showing points at which bone was cut.

abdomen to the extreme limit of the growth on the left. As the abdominal muscles were invaded, they were severed above the growth, thus exposing the peritoneum which was peeled from the mass except at three points where it was so firmly adherent that it tore, necessitating the use of catgut sutures. The bladder was not involved but the growth had displaced the right external iliac vessels outwards and appropriated about two inches of the vein, which was therefore tied and severed above and below. Both round ligaments were cut and the remaining superficial

soft structures separated or divided. The lower margin of the wound was then reflected downward, and both pubic bones separated from their fellows by the chisel, the amount of bone removed measuring four inches transversely (Fig. 2). The obturator vessels on the left were preserved, those on the right were sacrificed. Beginning on the left, the bone was elevated after some difficulty and forcibly turned to the right as the muscular and ligamentous attachments were severed. It was possible to suture a portion of the lateral muscles on the right to Poupart's ligament, but the recti had retracted to the umbilicus and, as the operation had already consumed about two hours, no plastic work was attempted. The skin-wound was simply sutured except at the middle and the right end, where gauze drains were placed. Intravenous infusion was necessary towards the close of the operation but subsequently reaction progressed unaided. The following day the right leg was somewhat bluish in color and was evidently larger than the left but there was no œdema; there was, however, a sensation of "pins and needles" in the foot and the whole limb was moved with difficulty. On the second day the drains were removed but had to be replaced because of the large amount of lymph which was discharged. Œdema did not appear until the third day and has never been excessive. On the fifth day pus appeared in the wound but the infection has been comparatively benign and will probably not mar the result. It should also be noted that there has never been any difficulty with the bladder or bowels, despite the absence of muscles over the lower abdomen.

Examination of the specimen showed that the growth evidently sprung from the periosteum covering the posterior surface of the pubes. Microscopic investigation revealed a typical spindle-celled sarcoma.

STAB WOUND OF THE INTERNAL MAMMARY ARTERY.

DR. JOHN H. JOPSON reported this case mainly because of the comparative rarity of the lesion and because it is the only instance he has encountered. The important vessels of the chest-wall that are liable to injury are the intercostals and the internal mammary. Only 15 cases of wound of the intercostals were recorded during the Civil War. In 1892 Schwartz collected 52 cases of injury of the internal mammary artery which had been

reported during the past century. Among these were seven in which the artery had been opened during operation and these he excluded, leaving 45 cases of wounds proper. Surgically the internal mammary are more important than are the intercostal arteries.

Dr. Jopson's case was that of a man of 50 years who was brought to the hospital at 10 A.M. with a history of having been stabbed a short time before. The man's clothing was saturated with blood and he was in a state of collapse, being practically exsanguinated. He was also under the influence of liquor. The wound was an inch in length, two and one-half inches to the right of the sternum in the second interspace, passing obliquely upward and inward; it was not bleeding. The resident physician applied a dressing and administered stimulants. At 1 P.M. Dr. Jopson saw the man. The wound was not bleeding, but though the man had reacted to stimulation the pulse was still of poor quality. At 4 P.M. the wound was examined and was not bleeding, but in a few minutes Dr. Jopson was called from the operating-room and found that severe hæmorrhage had begun. Compression was applied and the patient was at once prepared for operation. At this time he was not certain that the heart was not wounded. An anæsthetic was given and the wound enlarged. The internal mammary was found divided in the second interspace and both ends were bleeding. Both were tied with catgut sutures which included the surrounding muscle. Salt solution was infused, an iodoform gauze drain inserted into the pleura, and a dressing applied and the patient sent to the ward. The pulse reacted but soon went down and the man died that night. Autopsy by the coroner's physician showed atheromatous vessels. The pleura was full of blood but there had been no leakage from the ligated vessel. No other organs were injured.

Dr. Jopson said that the subject of wounds of the internal mammary artery had been specially investigated by Schwartz in his Königsburg dissertation, in which he analyzes 45 cases, as previously mentioned. Of the 45, nine died of acute hæmorrhage, which in four came from a wounded lung, heart or other neighboring structure, in 4 from the artery itself, and in 1 from an undetermined source. Of the 36 who survived the immediate effects, the wound became infected in 24, of whom 18 died and six recovered. Of the 12 with uninfected wounds, 8 recovered and 4 died.

There were 21 cases of secondary hæmorrhage, 16 in the infected group, 5 in the uninfected group. In Dr. Jopson's case the consecutive hæmorrhage was brought about by strain during vomiting. In the reported cases, secondary hæmorrhage was due in some to vomiting, in others to straining at stool, or other muscular exertion. Schwartz concluded that ligature of the vessel is not an infallible means of preventing secondary hæmorrhage. He believes that immediate ligature is not necessary, it being better to seal the wound primarily and raise the intrathoracic tension. The pleura is wounded in a large number of cases and this favors the continuation of hæmorrhage. Dr. Jopson believes that primary ligature is advisable. He also believes it would be better if we were more radical in our treatment of all penetrating wounds of the chest. Often we are too conservative in the presence of hæmorrhage, and even in the case of penetrating wounds of the chest in general. A year ago he reported a successful case of suture of the lung for hæmorrhage, and discussed the question of inserting a drainage-tube and controlling bleeding by establishing a pneumothorax as recommended by Le Conte. It is better to resort to a ligature of the bleeding vessel if it can be applied; if this cannot be done, then the establishment of a pneumothorax may be tried in hæmorrhage from the lung. In any case, even if the bleeding has ceased, infection is apt to occur. Two cases of chest wound he has had to treat in the past twelve months as empyema because of the consequent infection.

DR. EDWARD MARTIN, speaking on the general subject of penetrating wounds of the chest, put on record a case bearing on the question of hæmorrhage. A negro climbing into a window was shot in the third interspace one-half inch to the right of the sternum. When seen later he exhibited the symptoms of hæmopneumothorax and progressive bleeding. An osteoplastic flap was turned back, revealing a cut internal mammary artery which was not bleeding. The man was turned on his side and three pints of blood poured out of the pleura. A bullet-wound of the lung, though not bleeding, was sutured and the lung sutured to the parietes. Though there was evidence of use of the lung afterward, the man died in ten hours from progressive bleeding. Autopsy showed that the internal mammary had not bled but that hæmorrhage had occurred from an intercostal artery which had been cut one and one-half inches from its origin by the bullet

which had broken a rib close to the vertebral articulation. Had the X-rays been in use at that time the man might possibly have been saved. The case is recorded as an instance of a wounded internal mammary artery not bleeding and an intercostal bleeding which caused death.

DR. GEORGE G. ROSS cited a case in which he is not able to say whether or not the internal mammary artery was wounded. The subject was an obese colored woman who was shot in the right side, the bullet going across into the left side also. The patient was in shock and there were indications of hæmorrhage. She reacted, however, and as there was no external hæmorrhage operation was not performed. Ten days later Dr. Ross evacuated two quarts of foul pus from the left pleura. As the woman recovered he does not know what internal organ was injured.

DR. ROBERT G. LE CONTE said that he had carried out experiments on the cadaver to determine the frequency of injury to intercostal vessels in wounds of the chest. His results appeared to demonstrate that the intercostal artery at the lower border of a rib would not be injured unless the rib showed marks of violence. The internal mammary artery is half an inch from the border of the sternum, and in case of a wound in this locality there is always the probability of injury of that vessel, and exploration should be made. If the artery is wounded as low as the fourth or fifth interspace it is questionable if the hæmorrhage will be severe enough to cause death, while if the wound is in the second interspace the resulting hæmorrhage will be fatal unless controlled. Should the vessel be injured below the third interspace—that is, below the origin of the triangularis sterni muscle—hæmorrhage may be controlled by packing against the muscle. Dr. Le Conte has seen this done in one case. Above this point the pleura alone is beneath the vessel, and packing cannot be employed, hence resection of a costal cartilage or enlarging the wound sufficiently to expose the artery must be done. The greatest danger of hæmorrhage is of course from a vessel that has not been completely severed.

Dr. Le Conte's experience with hæmorrhage from the lung is limited, but in his few cases of severe hæmorrhage he has simply made an opening in the pleura and allowed air to be drawn in. The rapidity of the formation of complete pneumothorax can be graded as desired. If alarming symptoms super-

vene the opening can be temporarily closed, followed later by the insertion of a smaller tube. He has seen no instance of this expedient failing to control hæmorrhage, and consequently has never had to seek a bleeding vessel in the lung. It is the ideal treatment, but where the patient fails to improve resection of one or more ribs becomes necessary, with a search for and direct control of the bleeding point.

DR. JORSON, in closing, said that Schwartz's experiments on animals had shown the rapidity of bleeding from the internal mammary. A small vessel cut a short distance from the large one of which it is a branch will bleed almost as profusely as will a similar opening in the trunk itself. When the internal mammary is cut in the second interspace it is practically equivalent to making an opening the size of that vessel in the subclavian.

SURGICAL TREATMENT OF PERFORATING ULCER OF THE STOMACH.

DR. ROBERT G. LE CONTE read a paper with the above title (for which see page 907).

PERITONITIS WITHOUT VISCERAL LESION.

DR. EDWARD MARTIN reported several cases of this condition (for which see page 917).

DR. JOHN H. GIBBON regards Dr. Le Conte's first two cases as teaching the lesson that gastric ulcer is probably much more common than we think. Surgeons do not get more cases because the diagnosis is not more frequently made. In the series reported by Dr. Le Conte were two cases which gave no symptoms and in three of his own seven there was no history to lead to suspicion of ulcer. Since he reported four cases a few years ago he has met with three more as follows:

CASE I was in a man of 50 with the typical history and symptoms of a gastric ulcer for a number of years. When seen by Dr. Gibbon he had been sick 36 hours and had all the evidence of general peritonitis. Operation revealed peritonitis and also a gastric ulcer but without perforation. Drainage was established but the man died next morning. At autopsy the entire alimentary tract was removed but showed no lesion except the gastric ulcer. There was a diffuse peritonitis and no adhesions to the ulcer. Dr. Gibbon believes it is possible to get infection of the peritoneum

from a non-perforated gastric ulcer, just as this condition arises from the appendix, without macroscopic perforation.

CASE II was a man, a typical alcoholic, who had a lead-pencil-sized perforation in the anterior wall of the stomach. The patient died five days later from delirium tremens.

CASE III was the one referred to by Dr. Le Conte. There was the typical history of perforating ulcer, three-fourths grain of morphin having afforded no relief from the pain. The perforation was in the anterior wall toward the lesser curvature. It was patched up by means of omentum and the patient recovered.

Of the seven cases seen by Dr. Gibbon three recovered. In two, death was due to lateness of operation, in one to delirium tremens, and in one to faulty technic. The last mentioned died on the twenty-fourth day from obstruction of the bowel and abscess of the pelvis. The insertion of a drain is the safest procedure for the majority of surgeons. He always feels more secure when a drain extends down to the point of perforation. The question of suprapubic drainage should be decided by the length of time that has elapsed after perforation and by the quantity and character of the fluid in the peritoneal cavity. Dr. Gibbon has always used suprapubic drainage. As to gastro-enterostomy when one is in doubt as to whether the pylorus has been closed in repairing the perforation, one point is to be remembered. Experience in closing typhoid and gunshot perforations of the intestine when the surgeon believes the gut is almost closed but finds later that the lumen is sufficiently open, makes one think that the pylorus will likewise stand a great deal of narrowing. Regarding secondary gastro-enterostomy Dr. Gibbon did one 18 months after operation for perforation. He agrees with Dr. Le Conte that it is a mistake to do a gastro-enterostomy when perforation is present. It opens a new field for infection and is bad technic.

Regarding Dr. Martin's paper on peritonitis without visceral lesion, the surgeon not infrequently finds no cause to account for peritoneal infection and feels that possibly he has overlooked a lesion. It is comforting to hear that postmortem in the reported cases revealed no discoverable source of the peritonitis. Many such cases are probably due to the pneumococcus.

Dr. Gibbon is partial to local anesthesia, but this is not satisfactory for exploring the abdomen, hence ethyl chlorid is used

for this purpose. Four thousand cases of ethyl chlorid anæsthesia are now on record at the Pennsylvania Hospital. This anæsthetic is very satisfactory, especially if it is preceded by a small dose of morphin. He did a colostomy by its aid and the man was talking to him while the dressings were being applied. It is the ideal agent for short operations.

DR. WILLIAM L. RODMAN is satisfied that the literature on the subject of gastric ulcer, in so far as perforation is concerned, has to be rewritten, as perforation is far more frequent than has hitherto been dreamed. During last May he spent a fortnight with Dr. Mayo, and during that time saw him operate on 12 cases of gastric and duodenal ulcer, and of these three had previously perforated; in all three the evidence was conclusive. Dr. Rodman has operated on three cases of perforated gastric ulcer which were latent, and previous to perforation presented not the slightest symptom suggestive of ulcer. In one instance one of the best medical men in the city had been in attendance and had not suspected the presence of ulcer.

As to the wisdom of drainage he agrees with Dr. Le Conte. It is not absolutely necessary in all cases but is very generally advisable. Suprapubic drainage is not necessary in the majority of instances but the necessity for such drainage must depend upon whether or not there has been gross soiling of the peritoneum and whether the extravasated material has wandered far from the site of perforation. If perforation occurs shortly after a meal, then suprapubic drainage would be indicated; if when the stomach is empty, it usually will not be needed. It must be remembered also that in a large percentage of cases of perforation, as shown especially by Cripps and English, the stomach contents are sterile, and far different from the intestinal contents.

As to performing gastro-enterostomy after dealing with a perforation, Dr. Rodman agrees with Drs. Le Conte and Gibbon that it is wholly unnecessary unless there be stenosis of the pylorus. Dr. Gibbon raised the question as to whether it is better to excise the ulcer than to do gastro-enterostomy. Both are in most instances unwise, but if the ulcer is accessible and the surrounding tissue not too necrotic, then excision is preferable to gastro-enterostomy. In regard to Dr. Martin's paper, he also has failed to find perforation in some cases and yet peritonitis was present. However, there is no reason why we may not find

peritonitis without macroscopic lesion of the viscera. Infection of intra-abdominal tumors may occur because of their prolonged contact with hollow viscera; and without apparent lesion uterine fibroids have become infected through the intestine or the bladder. If then infection of tumors may occur in this way why should not peritonitis be caused in the same manner? Dr. Rodman agrees in the wisdom of using local anæsthesia, but it is unwise to attempt it in the case of children. He has several times performed laparotomy under local anæsthesia, using a weak solution of cocaine. In one case he used only carbolic acid. There was no pain except when the parietal peritoneum was cut. The patient was dull and in a semi-stupor and perhaps not so appreciative of pain as the average case.

DR. JOHN H. JORSON said that Dr. Martin mentioned finding the streptococcus in one of his cases of peritonitis without evident visceral lesion. In pediatric literature a constantly increasing number of cases of pneumococcus infection of the peritoneum are being reported. Clinically these cases are difficult to distinguish from those of streptococcus or other infection, and unless cultures are made a pneumococcus infection could not be excluded in the class of cases under discussion.

DR. FRANCIS T. STEWART has operated on seven cases of perforated gastric ulcer and in six he used drainage. Five recovered. In one he closed a perforation, did a gastro-enterostomy, and employed no drain; the patient recovered. He also omitted drainage in a case of typhoid perforation and the patient recovered. He cleans the peritoneum by irrigation with salt solution after thoroughly packing off the surrounding structures. Dr. Stewart assisted at one operation for perforated gastric ulcer in which the operator placed a drain at the site of the perforation. Leakage occurred with a resulting gastric fistula and death of the patient from inanition. Given a recent perforation, should the patient be placed in the Fowler position? If the peritonitis is generalized, suprapubic drainage should be established and the head of the bed elevated. If, however, the soiling is confined to the upper abdomen, the foot of the bed should be raised in order to prevent dissemination of the infection. Gastro-enterostomy is in a transition stage at present and its indications and contraindications are not fixed. It should rarely be performed at the time

a perforation is closed. An alarming number of cases of peptic ulcer of the jejunum have been reported as a sequel of gastro-enterostomy, a number of which have perforated. Several have been operated upon and some of these have recovered. All were foreign cases.

As to peritonitis without visceral lesion, Dr. Stewart has seen several instances in which the diagnosis was confirmed post mortem. In one case which survived, the gonococcus was found. A second case was that of a woman with a diagnosis of typhoid fever and a supposed perforation. Operation revealed peritonitis but no indication of typhoid fever and no visceral lesion. Cultures showed the pneumococcus. A third case was one of typhoid fever operated on for perforation; no perforation was found and the patient recovered. If the causative lesion be not found at once it is best to make a further careful search, as the lesion will almost always be finally located. Dr. Stewart assisted at one operation for supposed appendicitis in which suppurative peritonitis was found. Air came out of the abdomen but the operator simply removed the appendix, although that organ did not appear to be much diseased. Autopsy showed a leaking gastric ulcer which a more careful search would have located.

Local anæsthesia is often useful for exploratory purposes, but its use in these cases should be limited to the diagnosis of peritonitis. If this condition be found, general anæsthesia should be employed, as washing out of the abdomen or searching for a perforation cannot well be performed even in the adult by the use of a local anæsthetic.

DR. JOHN B. ROBERTS cited a case of traumatic ulcer of the stomach which was mistaken for a peptic ulcer. When the abdomen was opened for repeated vomiting of blood there was found a thickening of the posterior wall of the stomach near the pylorus. Dr. Roberts did a posterior gastro-enterostomy which was followed by the vicious circle. Dr. Stewart operated later for this condition, and found two sewing needles, one in the liver and one behind the stomach, which Dr. Roberts had not left in the abdomen. The woman afterward gave a clear history of having eaten pie, some months previously, in which there was some foreign body which gave intense pain at the time of swallowing. Soon after this she had profuse vomiting of blood and applied to a dispensary for treatment. The swallowed needles

were evidently the cause of the bleeding and probably caused a chronic ulcer where the thickening in the stomach-wall was felt at the time of the first operation. The case is a warning against being in too great a hurry to make the diagnosis of peptic ulcer before getting as full a history as is possible.

DR. CHARLES H. FRAZIER alluded to a case at the University Hospital operated on by Dr. Norris for strangulated hernia. The following morning the patient showed evidence of collapse and it was thought that a ligature had slipped, giving rise to internal hæmorrhage. An exploratory laparotomy revealed a perforated gastric ulcer and the abdomen filled with blood. The perforation was closed but the patient did not react from the shock of operation and soon died.

DR. JOHN B. ROBERTS said he had lost two patients from perforation of gastric ulcer a considerable time after operation in the pelvis. One was a man upon whom he had performed suprapubic lithotomy; the other was a case of extraperitoneal rupture of the bladder, doing well after incision and drainage, in which death suddenly occurred. The abdomen was found at autopsy to be full of blood from sudden perforation of an ulcer of the stomach. There may be some definite connection between septic processes in the pelvis (one of his cases had suppurated) and duodenal or gastric ulcer, just as in the case of similar ulcers developing after severe burns of the skin.

DR. LE CONTE, in closing, made clear his position regarding drainage in cases of perforated gastric ulcer. In the majority of cases seen by the surgeon the abdomen is not opened within an hour or two after perforation has occurred. When the extent of the soiling is as far as one can see or feel, then the case should be treated as one of general peritonitis, the patient placed in the exaggerated Fowler position, with suprapubic drainage and employment of the other measures advised by Murphy. If one can use this procedure with success in the presence of an extensive peritonitis, why should it do harm where the peritoneal inflammation is more limited? This method of treatment does no harm and can do good.

As to peritonitis without visceral lesion, the condition is not common, yet most surgeons have seen one or more cases. In one case seen in the Childrens Hospital, the attending physician and Dr. Le Conte had a long dispute, the former believing it to be

one of peritonitis, the latter considering it pneumonia. After a delay of 48 hours Dr. Le Conte operated and found a diffuse peritonitis but no visceral lesion to account for it. The pneumococcus was isolated from the peritoneal contents and the autopsy showed that the infection had passed through the diaphragm from a pneumonic lung. He made this error because pain is often referred to the abdomen instead of to the chest in beginning pneumonia.

DR. MARTIN, in closing, said he did not wish to be understood as advising against thorough search for a possible visceral lesion. He meant to say that in the absence of local symptoms and previous history exploratory opening may be sufficient. The Germans are the only people who can stand abdominal operations under local anæsthesia. In answer to a question by Dr. Ross, Dr. Martin said that peritonitis in the cases reported was not due to an intussusception which had been self-reduced.

STRANGULATED HERNIA OF THE OVARY IN A TWO MONTHS OLD INFANT.

DR. EDWARD B. HODGE reported this case, which occurred in an Italian child. There had been a small umbilical hernia following infection of the cord at birth, but otherwise the child was healthy. Two weeks before admission a lump appeared in the right groin and four days later the child became fretful. On a Saturday the child vomited but had a stool as the result of an enema. On Sunday it vomited a number of times and on Monday was sent to the hospital. It had been in shock but condition on admission was good. It apparently had a hard strangulated hernia. Operation under chloroform showed a thick hernial sac which contained a swollen and discolored ovary, almost black, three and one-half by one and three-fourths centimeters in size. There was no intestine in the sac. The ovary and tube were tied off and the parts repaired as well as possible. The child had good convalescence except occasional vomiting, and now appears to be well. It is a question if the condition of the ovary was not due to torsion or injury, as he is not satisfied there was constriction sufficient to cause the lesion present. To decide if there was a uterus bicornis it would have been necessary to enlarge the internal ring, and this was not considered justifiable. Hernia of

the ovary is not extremely rare but appears uncommon enough to warrant the report of a case occurring at this age.

DR. JOHN H. JOPSON believes this patient is one of the youngest subjects of operation for hernia of the ovary on record. A case of hernia of the uterus and ovary operated upon in a child of seven months has been reported by Defontaine. In cases of hernia of these organs there is frequently some congenital abnormality, as bicornate uterus, imperforate vagina, or pseudohermaphroditism. A case such as that reported by Dr. Hodge might lead to hernia of the uterus if adhesions of the ovary to the sac were present. In such cases the round ligament not infrequently is short and this aids in the production of the hernia of the uterus.

DR. GEORGE ERETY SHOEMAKER said he saw the patient referred to by Dr. Hodge three days before it was operated on. The mass in the groin was at first a small, painless swelling which he thought was infiltrated omentum. He advised temporizing on account of the baby's age, but at the end of three days the mass was four or five times as large as it was before and there was vomiting and subnormal temperature. He then sent the child to the hospital. The condition was no doubt congenital.

LARGE CYSTIC KIDNEY.

DR. JOHN H. GIBBON showed a specimen of cystic kidney in which the renal tissue had been entirely obliterated, none being demonstrable by the microscope. The question of diagnosis was interesting, the case being sent in as an ovarian cyst. In many respects it resembled that condition, but the diagnosis of cystic kidney was confirmed when the patient was put upon the operating-table. The tumor extended from the pelvis to the costal border and it would evidently have been foolish to attempt its removal posteriorly, hence it was taken out through the abdomen. It was tapped before removal and eleven pints and four ounces of fluid withdrawn. This was accomplished as easily as any nephrectomy he has ever performed. The incision was made through the sheath of the right rectus muscle, the muscle pulled aside and the sheath opened beneath it. Five or six inches of the ureter, which was as large as the thumb, were removed, with the kidney. The remainder of the ureter was not explored, though this should have been done. This point was not considered until the ureter had been ligated, and then, as the patient

was old and not in good condition, it was allowed to remain. Vaginal examination before operation revealed no stone in the lower part of the ureter. As high as 60 ounces of urine a day has been secreted by the patient since the operation. The vessels in the pelvis of the kidney were so distinct at the time of operation there was no trouble in their ligation. The vena cava was exposed for a length of six inches. Dr. Gibbon believes it is better in the case of a large growth of the kidney to go in anteriorly. Opening through the peritoneal cavity does not interfere with drainage.

DR. ROBERT G. LE CONTE stated that tumors of the right kidney are easy to remove under the circumstances narrated by Dr. Gibbon, the colon usually being internal to the mass. In the left kidney, however, the descending colon is often to the outer side and the tumor presents under the mesocolon. Consequently, the mesentery must be incised, and if the tumor is a large one the left colic artery must be divided before the removal can be effected. Ligature of this vessel endangers the life of the descending colon and is not infrequently followed by gangrene.