

ascending gut into the field of operation if a median incision was made, I made my incision to the left of the rectus. By so locating the opening I reduced the dangers of infection of the peritoneum from the old fistula. I introduced a catheter into the fistula as a guide to the coil of bowel leading into the mass, plainly to be felt in the cecal region. In this I was not successful. Fluids injected into the rectum failed to reach the fistula, thus showing that there existed an obstruction somewhere in the large bowel.

The fistula was sealed with a large layer of absorbent cotton and colloidion before making the left side incision. The mass was examined intraperitoneally and found to be quite extensive. A coil of ileum was selected and traced to the mass; this coil was marked by passing a piece of sterilized gauze through the mesentery. The descending colon was now looked for, but much difficulty experienced in locating it, owing to its contracted condition, and even when found the gut could not be brought up into the field of operation. The sigmoid was now located and by careful work raised so that I thought it safe to begin the anastomotic part of the operation. This was done by first pulling up, by means of the gauze landmarks, the coil of small bowel. The opening in this was made, having put in the usual purse string suture, then one-half of the button was introduced. The opening in this button was filled with vaselin to prevent escape of gases, while the sigmoid was opened in a like manner and the other half of the button introduced. The two halves of the button were now pressed together and a few Lembert sutures, as extra safeguards, applied around the button. The incision was closed in the usual way.

The bowels continued to discharge through a fistula all its gases and feces for nearly a week; this I think must have been due to the button getting blocked with some of the hardened feces or else the colon end of the button fitted the lumen of the contracted bowel so snugly that nothing could get through. At the end of a week the bowels began moving naturally and the fecal fistula diminished. Without the button no one could have completed this operation, owing to the contracted condition of the sigmoid in its almost inaccessible position. This man returned to his home and lived several months, the fistula remaining closed up to the time of his death.

RESPIRATORY PARALYSIS.

REPORT OF A CASE RESULTING FROM ADMINISTRATION OF CHLOROFORM—RECOVERY.

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The patient, a doctor's wife, 43 years of age, was taken with a severe pain in the abdomen November 17, but as she had been subject to such attacks at intervals for several years, it was not thought serious. Her condition, however, continued to grow worse until on November 27 her husband became alarmed and sent for me to operate upon her, if an operation was thought advisable. Another twenty-four hours elapsed before I saw her. At that time her face was drawn, eyes sunken, temperature 102, pulse 120, tongue dry, brown and heavily furred. She had been vomiting bile; the abdomen was slightly distended, the walls tense and too tender to admit of any but the gentlest manipulation. Pain was referred to the right side, and as it was thought we had to deal with an abscess, it was considered safer to open the abdomen than to try to make a diagnosis by palpation. It was decided to operate at once, and all preparations were made before the anesthetic was begun, as we anticipated trouble from the latter. The patient was put on the operating-table and the administration of the anesthetic was begun by Dr. Rohlf. The chloroform was administered on a piece of gauze stretched over a wire frame, and from a dropper bottle. The patient did well until partly unconscious, when she seemed to voluntarily hold her breath. I made rhythmic pressure on her chest and in a short time she seemed nearly ready for the operation. At this point it was noticed that her face was getting cyanotic, the chloroform was instantly withdrawn, the head lowered, and the jaw held up, but the cyanosis increased at a rapid rate and became alarmingly great, the lips getting nearly black. Respiration had ceased entirely, but the pulse was fairly good and about 140. Artificial respiration was instituted, and in two or three minutes the face assumed a healthy color and the pulse became as strong as it had been before we began. We

stopped the artificial respiration, but there was not the slightest effort at spontaneous respiration, cyanosis rapidly returned, the heart began to perceptibly fail, and artificial respiration was quickly renewed, $\frac{1}{40}$ of a grain of strychnia sulphate and $\frac{1}{100}$ of nitroglycerin, which had been previously prepared, was administered hypodermically and ammonia vapor applied to the nostrils. In a few minutes the blood seemed to be perfectly aerated, the pulse was good, and we again desisted. Again there was no effort at respiration on the part of the patient and cyanosis rapidly returned. We waited a few seconds, but there was no respiration and the heart began to fail. We resumed our efforts with the result that in a few minutes cheeks, ears and lips were a healthy pink and heart beating as strongly as before. Again and again we repeated the above procedure—except the hypodermics—and always with the same results, stopping for a few seconds every few minutes, but quickly resuming when the color of the face began to change. After twenty or thirty minutes there was a feeble respiratory effort, when we stopped and the patient was put in the horizontal position. Respiration slowly became stronger and the patient showed signs of returning consciousness. We then held a consultation as to whether the operation should be abandoned. The unanimous opinion of four physicians was that the patient would die unless she was relieved in some way, and we decided to proceed. Ether was substituted for chloroform, but the respirations did not rise above 10 per minute. The abdomen was opened as for appendectomy, and a large mass of intestines was found adherent together and to the pelvic wall. On cautiously loosening the colon from the wall, I opened a small abscess containing ten or twelve cubic centimeters of pus. The pus was carefully removed with strips of dry gauze, and the appendix found, with the end sloughed away. After making the cavity perfectly dry, we packed it with iodoform gauze and walled off the general peritoneal cavity with the same material. We partly closed the external wound, put on a dressing, and put the patient to bed. When we finished, her respirations were 6 or 7 to the minute and the pulse 160. The patient was covered with hot blankets and surrounded with hot water bags and her body and limbs rubbed vigorously with dry towels, as she was in a profuse cold perspiration. In an hour her pulse was 130, respirations 14, and she was conscious.

A few years ago this patient was prepared for laparotomy on account of pus in the pelvis, but was affected so badly by the ether which was administered that the operation was abandoned and a quart or more of pus was evacuated by the vagina. The pus cavity closed up, but the patient has always remained more or less of an invalid with frequent exacerbations of the abdominal symptoms.

This was an object-lesson in the value of artificial respiration promptly begun and persistently carried out; without it this patient would surely have died. In every case of this kind which has come under my observation, the chloroform has paralyzed the respiration and not the heart.

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SYPHILIS.

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Remembering the old maxim, that "art is long, experience deceptive, and judgment difficult." I herewith offer some questions which are not clear to my mind in the light of my present knowledge:

1. Is syphilis a curable disease, or is it possible to eradicate all the syphilitic germs from a syphilitic?
2. Is not a person once a syphilitic always a syphilitic?
3. Is the germ of tertiary syphilis the same as the germ of secondary syphilis, and also the same germ that causes the chancre? or is their virulency modified by removal from the chancre?
4. Is it possible to inoculate a non-syphilitic by semen, or secretions from a tertiary syphilitic, and produce a syphilitic chancre?
5. Should syphilitics marry? and when?

In the light of my present knowledge, I believe