

## CASE OF RESECTION OF INTESTINE, WITH APPROXIMATION OF THE DIVIDED ENDS BY MEANS OF MURPHY'S BUTTON.

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I THINK this case may be of interest, as I believe it was the first occasion on which the Murphy button was used successfully in this district.

The patient, aged fifty-five, though a much older man for his age, and who had suffered all his life from a marked angular curvature of the spine and chronic bronchitis, came under my care for a strangulated inguinal hernia on Nov. 27th, 1894. He had had a reducible hernia for twenty years and had always worn a truss. Three days before his admission the hernia came down, and all the symptoms of an acutely strangulated hernia followed; he was treated, before seeing me, with an ice-bag and a turpentine enema, and taxis was tried, but without any reduction of the strangulated intestine. On his admission the patient was collapsed, there was stercoraceous vomiting, and all the physical signs and symptoms of a strangulated hernia were present; there was some fulness in the right iliac fossa with pain on pressure. Herniotomy was at once performed. On laying open the sac the smallest possible quantity of fluid was let out, and about four inches of small intestine were found to be so tightly strangulated that the hernia director could not be inserted until the constriction had been partly divided. The ring was then very freely divided and a small portion of the gut both above and below the constricted area was brought down for inspection. The strangulated portion was quite black, the surface glistening only in places; the upper end of the gangrenous portion appeared to be united to the non-strangulated portion of intestine by only the serous coat. A fresh incision about three inches long was made in the middle line of the abdomen midway between the umbilicus and pubes, and the strangulated portion of the gut was brought from the scrotal incision to the opening in the middle line. Swain's intestinal clamps were placed on the healthy intestine about ten inches apart, with the portion to be resected lying between; the gangrenous intestine was then resected with the scissors, about half an inch of non-strangulated gut on either side being removed with it. Some vessels in the mesentery were ligatured; no wedge-shaped portion of the mesentery was removed. The male and female portions of the button were fixed in the cut ends of the intestine by means of a purse-string of silk and the two parts of the button were fitted together; the largest size button that is made for the small intestine was used. No sutures were used to unite the divided intestine or mesentery. On removing the clamps the upper and distended intestine was observed to be emptying its contents through the button into the lower portion without a sign of any leakage; the gut was then dropped into the peritoneal cavity and the wound closed. As the patient was considerably collapsed before the operation commenced it was deemed advisable not to prolong the administration of the chloroform by performing an operation for the radical cure, so the scrotal sac was drained only, and the wound sutured. A little weak milk-and-brandy was given by the mouth during the night. On Nov. 28th the vomiting had ceased and the abdomen was somewhat distended. On the 29th the patient passed flatus frequently. On Dec. 1st there was considerable pain in the right iliac region and some distension. On the 2nd there was a slight action of the bowels. There was nothing special to record till the 4th, when there was a rigor, distension, and severe pain in the abdomen. The passage of flatus had almost ceased. There were dyspnoea and cough. The pulse was very weak and intermittent. Dr. Shaw kindly saw the man with me in the evening, and we decided that the grave condition of the patient was due to double pneumonia, and not to any complication of the intestinal lesion. Stimulants were freely given by the mouth, and a turpentine enema greatly relieved the distended abdomen. The patient from this time gradually improved. The bowels were opened twice on the 8th and 9th, and between the 10th and the 16th there was some diarrhoea. On the 14th a small quantity of blood was passed; no button could be felt in the rectum. On the 26th the patient was sitting up, and no button could be felt. On Jan. 4th, 1895,

Murphy's button was passed without pain. On April 2nd it was over four months since the operation; the man had been under close observation throughout, and there were no signs of any obstruction.

*Remarks.*—There are one or two special points I should like to notice. The advantages of the button are undoubted to my mind, as it certainly takes a very much shorter time to perform resection with the button than any suturing operation I know of, and this question of time is a most important one in intestinal surgery. It may be said that in dealing with small intestine cases, as the button must be small enough to pass through the ileo-cæcal valve, the opening in the united ends of the intestine must be small also, and that the size of the ring tends to diminish. All I can say is that so far this case shows nothing of the kind. I have wondered whether a button could not be made with the expanded portions consisting of some such substance as decalcified bone, but retaining the ingenious ideas of Dr. Murphy in the spring screw arrangement of the male and female portions. If this could be done we should then be able to increase the size of the opening in the intestine very considerably for the small intestine cases. I think the making of a second incision in the middle line useful, as it is a much more convenient place to carry out the operation on the intestine, and it is a much less serious incision than that of opening up the inguinal canal for, say, three or four inches. Five weeks is a long time for the button to be retained, but then it must be remembered that its expulsion was not hastened in any way by aperients, as none were ordered till the morning of Jan. 4th. The patient, hearing the order given for a good dose of "house medicine," promptly got rid of the button before the dose could be administered.

Clifton, Bristol.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### THE RADICAL TREATMENT OF LUPUS.

By RICHARD T. CÆSAR, M.R.C.S. ENG.

IN THE LANCET of July 21st, 1894, Mr. Bidwell published particulars of six cases of lupus treated by free excision and skin grafting, and in his paper he stated that he believed Mr. Watson Cheyne was the first to perform such an operation in this country, his cases being exhibited at the Medical Society of London in March, 1893. When Mr. Watson Cheyne performed his operations I do not know, but I should like to mention two cases in which I performed the very same operation, with the exception that I did not do the skin grafting. The first I performed nearly twenty years ago and the second about ten; in both cases I simply made a free deep incision all round the edges of the ulcer and raised the floor entire. I used no sutures nor in any way attempted to bring the edges of the wound together; I simply dressed it as an ordinary granulating surface, and both cases turned out all that could be desired without any return in either, and the resulting scar was trifling.

CASE 1. — A man aged sixty-two years consulted me in March, 1876, for an ulcer on the left side of his face, which he said had existed for some years, but of late was spreading very fast. He stated he had been under various treatment by different medical men, and had, as usual in such cases, tried all sorts of "certain cures" and quack remedies without the slightest good resulting. It was then so large and unsightly that he was compelled to give up his situation as coachman. On removing the dressing I found a patch of lupus much larger than a half-crown piece, situate on the left cheek and spreading towards the outer angle of the eye. I first tried the application of the usual remedies, but without benefit, and the man becoming impatient for some more active treatment, I suggested the complete removal of the diseased structure, hoping thus to make a permanent cure, and to this proposal he readily consented. With the kind assistance of my friend and former pupil, Dr. H. Payne, I made a deep incision all round the edges,

keeping well away from the diseased structures; I then dissected off the entire floor of the ulcer, keeping my knife well under the disease, so as to make sure of removing all the diseased tissues. Having applied pressure forceps to a few bleeding points, I dressed the wound with dry antiseptic dressing without strapping or sutures, allowing it to granulate; this it did most satisfactorily, and in a little time was well and the scar not particularly noticeable, so that he was able to resume his occupation. I had the advantage of constantly seeing this man for some years after, and there was no sign of the disease returning.

CASE 2.—A boy aged eight years was admitted into the Shirley Children's Hospital in December, 1884, with a large patch of lupus on the left cheek  $2\frac{1}{2}$  in. by  $1\frac{1}{2}$  in. He had been under treatment for some time, both private and hospital, before applying to me. I first tried local and general treatment, but as this failed to afford any prospect of cure, and the disease continued to spread, I decided to treat it after the same manner as the first case, and with the kind assistance of my colleagues, Dr. C. G. Beaumont and Mr. Chamberlain, I made a deep incision round the ulcer, keeping well away from all traces of the disease. This done, I dissected off the floor, as in the previous case, and treated it in every way the same, and the result was entirely satisfactory; the wound healed, and the resulting scar was not very perceptible. So far as I could afterwards learn, there was no return of the disease.

I do not publish these cases with any wish or intention of claiming priority for the operation, but to confirm Mr. Bidwell in the good results which he claims for the proceeding. No doubt the skin grafting may be of some advantage; but I do not think it is essential to the success of the operation, which I consider far preferable to the old plan of scraping, as there is more control over the diseased structures and a better chance of thoroughly removing them. Of course, the great point is to get well beyond the disease and not be afraid of removing too much; and, like all operations of the kind, the sooner it is done the better for the patient. Had I noticed the papers to which Mr. Bidwell refers I should have mentioned these cases before; but they must have escaped my attention, as I have no recollection of having seen them.

Wellington, Salop.

#### EPITHELIOMA OF THE TONGUE IN WOMEN.

BY CHAUNCEY PUZEY, F.R.C.S. ENG.,  
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As a contribution to the statistics of epithelioma of the tongue attacking women<sup>1</sup> I send a short note of two cases upon which I operated in the summer of 1892. Curiously, both patients were admitted within a few weeks of each other, and they are the only cases occurring in women which have come under my care during twenty years of hospital work.

CASE 1.—The patient, a woman aged fifty-three years, had the left side of the tongue (posterior position) extensively affected with epithelioma, and several of the submaxillary glands of the same side were enlarged. She was in a very feeble condition from pain and starvation, but urgent in requesting operation. On June 20th, 1892, I removed the left lateral half of the tongue close to the hyoid bone. Very little blood was lost, but the patient was so weak that removal of the glands was deferred. For some hours after operation it seemed doubtful if she would rally; but after that she made a rapid recovery. A few weeks later the submaxillary region was thoroughly cleared out. For two or three months she improved remarkably, but then disease recurred in the glands at the back of the neck and the case soon ended fatally.

CASE 2.—The patient, a stout, ruddy, healthy-looking woman aged fifty-nine years, was admitted a few weeks later. She had a large epithelioma involving the middle portion of the right lateral half of the tongue and slightly invading the floor of the mouth, but without glandular enlargement. On July 29th, 1892, I removed the right lateral half of the tongue, close to the hyoid bone. She made a rapid recovery. Twelve months later I heard that everything was perfectly satisfactory, and so it continued until the end of last autumn, when disease recurred somewhere in the submaxillary region (I did not see her) and she died last Christmas. The operation had given her two years of comfort.

<sup>1</sup> Vide THE LANCET, March 2nd, 1895.

The operation in both cases was that generally known as Marrant Baker's, and the only other point to which I wish to refer is that there was throughout the whole period of the healing of the wound in both cases complete absence of fetor, which I attribute to the hourly painting of the whole wound with glycerine of borax.

Liverpool.

#### FAT EMBOLISM FOLLOWING FREE INCISION OF THE FEMALE BREAST FOR DIFFUSE SUPPURATION.

BY SURGEON-MAJOR A. F. FERGUSON,  
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THE patient, a healthy female twenty-two years of age, came to the Civil Hospital, Shikarpur, on April 7th, 1894, in great pain and looking very much worn out by intense suffering. The left breast was enormously swollen, red, and exquisitely tender, with a doughy elastic semi-fluctuant feeling uniformly throughout. The tenderness was so great that chloroform was necessary for examination. A free incision was made in what appeared to be the most likely situation. There was great hæmorrhage, but only a small quantity of pus. The excision was extended, but still no collection of pus was reached; the finger was introduced and passed through the gland, which was spleen-like in consistence, and the fingers could easily be pushed through it; but still only a small quantity of pus escaped, and it seemed to be equally distributed throughout the gland. A drainage-tube was inserted and a suitable dressing applied. The pain continued and the suffering seemed great. Morphine was given pretty freely, but she was very restless nevertheless. On the next day she looked extremely anxious and worn out, and the breathing was oppressed. The drainage-tube was removed, and some milky, oily-looking fluid escaped with it. There had been a good deal of bleeding, but only slight purulent discharge. The dyspnoea rapidly increased, and at 5 P.M. the following note was made: "The breathing is very much oppressed and 30 per minute, the face cyanosed, the pulse running, and patient unconscious." She died at 11 P.M. A post-mortem examination was obtained with great difficulty, and during its performance the relatives were outside clamouring for the body, so it was necessarily very superficial. The lungs were much congested, a great portion of the left approaching red hepatisation. Portions were kept and hardened. The kidneys could not be obtained, nor could the other organs be carefully examined under the circumstances. Sections of the lungs, stained with perosmic acid and mounted in Farrant's solution, were shown at the Indian Medical Congress at Calcutta. They show the capillaries and smaller vessels blocked with fat, and globules of fat in the blood in the larger vessels.

Mhow, Central India.

A Mirror  
OF

#### HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

#### UNIVERSITY COLLEGE HOSPITAL.

A CASE OF TUMOUR OF THE LUNG; REMARKS.

(Under the care of Dr. G. V. POORE.)

PULMONARY growths of a malignant character are usually secondary to disease in other parts. Probably in the large hospitals sarcoma of the lung secondary to bone disease of similar nature is most frequent, whilst in the infirmaries the disease is usually secondary to a scirrhus growth which first showed itself in the breast. This case is a most instructive one of primary sarcoma of the lung—a condition which, as this case demonstrates, is extremely difficult of diagnosis until evidence of compression of intra-thoracic veins or the appearance of tumours elsewhere affords additional aid.