

preferable to a primary nephrotomy and drainage, because in spite of the utmost care they were apt to become more or less septic before the second operation was done.

DR. LILIENTHAL, in closing, said that during the past two and a half years he had done at least sixteen cases of prostatectomy in two stages, and all of those cases had recovered. Many of these patients were of advanced age, and some of them were extremely feeble, with cardiac and other lesions. This method had also been practised with success by Drs. Goldenberg, Cabot and Ware.

Dr. Lilienthal said that Dr. Johnson had evidently misunderstood him in regard to his method of treating pus kidneys. In his paper he had made no reference to hydronephrosis, and he would not treat such a condition of the kidney in two stages without a particular reason. The method he had advocated related to the treatment of pus kidney. First, an incision should be made into the kidney; then, when the patient had recovered from the effects of that incision, in four or five days, certainly less than ten days, before dense adhesions had formed, it would be found that the kidney had shrunk away from its bed, and could be removed in less than one-quarter of the time it would have taken at the primary operation. It was not a secondary nephrectomy that he was urging, but a *two-stage* nephrectomy, which was quite a different thing. There was practically no mortality when the operation was done by this method.

Stated Meeting, October 27, 1909.

The Vice-President, DR. ELLSWORTH ELIOT, JR., in the Chair.

EPIDIDYMECTOMY FOR TUBERCULOSIS.

DR. FRANK S. MATHEWS presented a man 39 years old who gave a history of having had tuberculous glands removed from both sides of his neck by Dr. Murphy of Chicago, 13 years ago. About five years ago he suffered from frequent urination and pain for a few months. These symptoms then disappeared, but a year before operation he developed a swelling on the left side of the scrotum. He consulted a physician, who regarded it as

a hydrocele and aspirated it several times. It always recurred, however, and subsequently a similar swelling developed on the opposite side.

When Dr. Mathews first saw the patient, two and a half years ago, both sides of the scrotum were occupied by a tumor about double the size of an adult fist. There were no evidences of tuberculosis elsewhere in the body. The patient's temperature, during the twenty-four hours, ranged from normal to 101. The case was regarded as one of tuberculous epididymitis, and a double epididymectomy was done. Through incisions on the outer sides of the scrotum the epididymis and vas of either side were removed without injuring the spermatic vessels. The operation, which proved somewhat difficult, occupied an hour and a half. There was fluid in both tunica. Both wounds were closed with the exception of an opening for a small piece of rubber tissue. Both testes were hard at the time of the operation, but gradually became normal to the feel. The patient has gained about 20 pounds since the operation, and is now enjoying excellent health. There is nothing abnormal in his urine at present. His sexual power, which was in abeyance at time of operation, has returned to the extent that he has sexual desire and orgasm but no emission. The prostate feels slightly nodular. His wife became pregnant between the times of involvement of the left and right testicle.

SARCOMA OF THE INTESTINES AND STOMACH.

DR. JOHN F. ERDMANN presented a man 57 years old who came under his care in June, 1909, with the history that about one year ago he began belching and vomiting bile, and had attacks of pain encircling his abdomen, particularly marked in the lateral regions. These pains would subside on expelling flatus. Three months before coming under observation he had acute pains in the pit of the stomach, and vomited some food, but the vomitus contained no retention evidences. He had lost considerable weight during the preceding six months. He was constipated. He had never vomited blood. Lately, he had had some food intake pains. He complained of a painful tumor in the lower abdomen, which he said was fixed.

Upon examination, a tumor the size of a cocoanut was found fixed to the abdominal wall between the umbilicus and the pubis.

There was a certain amount of mobility, deep-seated, as though the tumor was pedunculated. Palpation was extremely painful. By rectum, the patient was very sensitive, the examining finger just reaching the mass.

On June 5, 1909, upon exposure, a tumor was found invading the jejunum and ileum, firmly adherent to the parietal peritoneum in the median line. This was released without any difficulty by excising the peritoneal invasion. The tumor was found to consist of large sections of jejunum and ileum. The coils were doubled upon themselves, with a large central coil invaded by the tumor occupying the lumen and walls of the gut. At the proximal end, well up in the jejunum, two other masses were found invading the lumen to such a degree as to produce stenosis. The balance of the intestines, both proximal and distal, were found negative.

Forty-eight inches of jejunum and ileum were excised, and a side-to-side anastomosis made by means of the Roosevelt clamp. Previous to completing the peritoneal toilet, a complete examination of the abdominal contents was made, and upon palpating the stomach a mass about the diameter of a silver dollar was found in its greater curvature. No other metastases presenting, this was excised, the opening sutured and the abdomen closed.

After a rather stormy postoperative convalescence in the first week, the subsequent period was uneventful. Six weeks after the operation the patient weighed 129 pounds. His present weight was 157 pounds, a gain of thirty pounds in three months.

Pathologically, the growth was reported as a small round-celled sarcoma.

OPEN ULCER OF STOMACH CLOSED BY ADHERENT GALL-BLADDER: GASTRO-ENTEROSTOMY.

DR. WILLIAM A. DOWNES presented a man of 42 who gave a history of stomach trouble extending back for many years. In July, 1908, this condition began to be accompanied by pain and periodical vomiting—about twice weekly. The following December the vomiting became almost continuous and the pain more severe. He was unable to retain scarcely any food and his weight fell from 150 to 115 pounds. His condition was such that he was practically bed-ridden.

At the time of the operation, on April 12, 1909, a small

tumor could be felt in the epigastric region, just in the median line. Upon opening the abdomen and exposing the pyloric end of the stomach by raising the liver, an ulcer of the stomach about the size of a silver 25-cent piece presented. This was an open ulcer, with its edges firmly agglutinated to the overlying gall-bladder, and this had prevented any escape of the gastric contents. Actual peritoneal adhesions between the gall-bladder and stomach existed only along the posterior margin of the ulcer. There was extensive induration involving the entire pylorus and the mass was firmly fixed posteriorly—in fact the condition was thought most likely to be malignant, but the extent and location made any attempt at removal out of the question.

As the patient was in very poor condition, the opening in the stomach was sealed by replacing the gall-bladder over it, suturing it with catgut, and covering it with omentum. A posterior gastro-enterostomy was then done.

The patient made a rapid recovery, and had had no gastric pain or vomiting since the operation. He had gained about 30 pounds in weight.

In reply to a question as to why he had not closed the opening in the stomach in the usual way, and had used the gall-bladder instead, Dr. Downes said that aside from the patient's poor condition, the depth of the ulcer was such that it was almost impossible to get at it. No attempt was made to remove the mass which involved the pylorus, as it would have occasioned too much shock. The condition at the time was regarded as unquestionably malignant, and it was thought that the quickest and most expedient way to meet the requirements was to take advantage of the position of the gall-bladder.

In view of the subsequent history of the case, and the marked improvement in the man's condition, the mass which was seen at the time and which had since disappeared, was probably composed of inflammatory exudate.

DR. ELLSWORTH ELIOT, JR., said the method described by Dr. Downes had been utilized by an English surgeon, who had used the gall-bladder successfully in one or two instances in sealing a gastric perforation. The danger of a possible twist in the gall-bladder in manipulating it for this purpose should not be lost sight of.

Dr. Eliot said that in case of gastro-enterostomy for supposed

pyloric cancer upon which he operated about nine years ago, the anastomosis was completed by means of a Murphy button. The operation disclosed a hard circumferential nodular growth in the pylorus that appeared unquestionably to be carcinoma. Three months after the anastomosis, when the abdomen was again opened to radically excise the growth, the tumor had completely disappeared. It was doubtless inflammatory in nature.

For seven or eight years after these operations, the patient complained of intermittent attacks of abdominal pain. At the end of that time the Murphy button was passed per rectum and her attacks of pain were relieved.

INTESTINAL ANASTOMOSIS BY INVAGINATION: UNION OF COLON WITH RECTUM.

DR. WALTON MARTIN presented a girl who had been operated on by Dr. Chas. L. Gibson for the removal of an intraligamentous cyst, with adhesions. In the course of its removal, the sigmoid was denuded, necessitating the resection of a portion of it. An anastomosis was then done by invaginating the lower end of the colon into the upper end of the rectum, and inserting a row of catgut sutures. A subsequent examination with the sigmoidoscope failed to show any constriction in the lumen of the bowel.

NEPHRECTOMY FOR HYDRONEPHROSIS.

DR. ALEXANDER B. JOHNSON present a man 41 years old, a driver by occupation, who was admitted to the New York Hospital on June 26, 1909. The history obtained from him was that a tumor was first noticed in the right hypochondrium seven years ago. It had slowly but steadily increased in size and recently had become painful. The pain was referred to the loin, radiating downward and inward to the groin. The urine was clear, amber in color, acid, with a specific gravity of 1031; it contained calcium oxalate crystals, but neither albumin nor sugar.

The man was operated on by Dr. F. W. Murray on July 3, 1909. Through a right rectus incision, six inches long, a very large hydronephrotic kidney was exposed. On account of its great size, its removal was deemed impracticable, and the sac was thereupon incised anteriorly, giving vent to two quarts or more of a reddish-brown fluid. After the insertion of a drainage tube, the wound was closed. The tube continued to give exit

to urinous fluid in large amounts. After a time, ammoniacal infection and decomposition of the urine occurred, and the escaping urine became distinctly purulent. The cavity of the sac was irrigated with various antiseptic solutions in the hope of clearing it, but without much success.

On August 23, 1909, Dr. Johnson excised the sinus and a portion of the former scar, and through an eight-inch incision made below and parallel with the costal border he exposed a large hydronephrotic kidney. It was moderately adherent, and required somewhat prolonged dissection with the hand and fingers before it could be enucleated. The pedicle was clamped and tied *en masse* with ligatures of strong plain gut, and the wound closed by suture. The patient made an uneventful recovery.

In connection with this case, Dr. Johnson showed the specimen, which consisted of a large, hydronephrotic kidney with dilated pelvis and calices. The sac was quite thick and tough, and the kidney structure had, for the most part, disappeared, so far as could be seen with the naked eye. The cyst-like cavity contained numerous spherical and ovoid calculi, 109 in number.

Dr. Johnson, in reply to a question, said the calculi were scattered about in several of the calices, and some were found in the pelvis. He recalled an almost identical case which was operated on by Dr. McBurney. In that case, the kidney had not been previously opened and drained, and the formation of the stones could not be attributed to ammoniacal infection of the urine, as no infection had occurred. In his own case he did not think the entire kidney was infected; probably only some of the dilated calices.

CARCINOMA OF BLADDER AND UTERUS: HYSTERECTOMY, CYSTECTOMY, AND DOUBLE LUMBAR URETEROSTOMY.

DR. WALTON MARTIN presented a negro woman, 43 years old, who was admitted to St. Luke's Hospital on September 3, 1909. Her chief complaints were bleeding from the uterus, and vesical tenesmus. For the previous fifteen months she had had constant bleeding from the vagina, so that she had been unable to determine the menstrual period. The amount of hemorrhage varied from time to time, but was never very profuse. Three months ago the patient began to have bilateral pain in the

lower pelvis, radiating to the back, and vesical tenesmus. There had been no hæmaturia and no increased frequency of urination. She had lost about 25 pounds in weight in the last year.

The previous history obtained from the patient was that she had had eight full-term children and one miscarriage. Menstruation began at fourteen and lasted usually four days. Before the onset of her present illness she had always been in good health. Her family history was negative.

On vaginal examination, the cervix of the uterus was found to be enlarged and hard, and there was an irregular ulcer extending from the cervix to the anterior vaginal wall. Between the cervix and the bladder there was a firm mass apparently involving the bladder wall. Abdominal examination was negative. The woman was poorly nourished and looked ill. Temperature, 100; pulse, 100; respirations, 26. The urine was acid, with a faint trace of albumin. The microscope showed a few red blood cells and leucocytes. The clinical diagnosis was carcinoma of the uterus. On September 6, 1909, under ether anæsthesia, with the patient in the lithotomy position, the ulcerated area on the cervix was cauterized, and an incision made through the anterior vaginal wall, about one-quarter of an inch below the ulcerated surface. An attempt was made to dissect the vaginal wall with the growth away from the bladder, but it was soon seen that the indurated tissue extended into the wall of the bladder in this situation. The vagina was accordingly packed with gauze, and the patient placed in the Trendelenburg position. The abdomen was opened in the midline from one inch above the navel to the symphysis pubis. The body of the uterus, the tubes and the ovaries appeared normal. The cervical portion was enlarged and indurated, and this induration extended into the base of the bladder and the tissue about the right ureter. No enlarged lymph-glands were observed.

The ovarian arteries and the round ligaments were ligated and divided on each side. The uterine arteries were ligated close to their origin. The ureters were exposed for about four inches, then divided three inches above their insertion in the bladder, and through one-inch stab-wounds in the lumbar region they were drawn out by artery forceps. About one inch of the ureter was allowed to hang free from the skin of the loin, and a small catheter was inserted into each ureter. The bladder and uterus

were dissected out, the vagina being divided about one inch below the ulcerated surface of the cervix. There was profuse hemorrhage from the vaginal vessels. The vagina was closed with catgut stitches.

On removal of the bladder and uterus it was evident that too much peritoneum had been taken away to make it possible to cover the denuded surfaces. A gauze drain was introduced in the lower angle of the wound, and the abdomen was closed.

After the operation, the patient was in moderate shock for a few hours. The pulse was 100, regular, but weak. On the following day the pulse was of good force, temperature, 102; respirations, 24. On the third day the temperature was normal, the pulse 100.

On the second day, the drainage from the ureters being unsatisfactory, the catheters were removed, the ureter ends split and turned back and sutured into the lumbar wounds. From this time on the right ureter drained normally, drop by drop. The skin about the orifices of the ureters was kept scrupulously clean, and the urine allowed to escape into sterilized gauze pads. The patient seemed to be comfortable. The left ureter, however, did not drain properly, only a few drops of urine escaping from time to time.

On the eighth day the skin stitches were removed from the abdominal wound, which had healed by primary union except for the drainage tract. This was closed at the end of the second week. On the eighth day a ureteral catheter was passed into the pelvis of the left kidney. The urine escaped drop by drop. On the following day the patient had a chill, and the temperature rose from normal to 104. Two days later the left ureter was washed out with normal salt solution. After that there was no further interference with the ureters. For about ten days there was an afternoon rise of temperature; then it gradually fell to normal. The patient gained strength and flesh, and left the hospital 35 days after admission in good condition. She returned to her home, and now did her usual housework—washing, ironing, and cooking. She wore about her loins a sterilized gauze pad, which she herself changed every four hours.

Histological examinations made from sections taken from the cervix and wall of the bladder showed carcinoma of those organs.

HYDRONEPHROSIS, CONGENITAL, RELIEVED BY
NEPHRECTOMY.

DR. SAMUEL ALEXANDER presented a man, 22 years old, who was operated on in Christ Hospital, Jersey City, in June, 1908, for the relief of intermittent attacks of pain in the right hypochondrium, associated with enlargement of the kidney on that side. At that time, two incisions were made, one abdominal, apparently for exploratory purposes, and another in the right lumbar region, through which the kidney was opened and drained. The patient made a good recovery from this operation, and went home. Ten days later he had a sudden elevation of temperature. The lumbar wound re-opened, and there was a profuse secondary hemorrhage. A tube was inserted into the kidney, and this tube was worn continuously for eighteen months. The tube was attached to a rubber glove which was worn next to the patient's body, and into this about 16 ounces of urine was excreted daily. The urine was of a very low specific gravity and contained but a trace of urea. The opposite kidney secreted about 30 ounces of normal urine daily through the urethra.

When Dr. Alexander first saw this patient at Bellevue Hospital on February 1, 1909, his condition had become so uncomfortable from the long-continued drainage of the urine through the loin that an operation for his relief was deemed imperative. The right kidney was exposed through a lateral incision, and it was found to be in a condition of apparently congenital hydronephrosis, which was probably the result of its anomalous blood supply, the renal vein and artery overlapping and compressing the ureter, causing at times complete occlusion of the latter. The kidney was made up of three or four large cysts, containing cloudy fluid. An intracapsular enucleation of the organ was done, and the patient made a good recovery.

Dr. Alexander said that the chief reason for showing this case was to bring up for discussion the question of the post-operative treatment of these patients, as well as cases of inoperable tumor of the bladder, where double nephrostomy was imperative. In the case he had shown, the patient was rendered uncomfortable for many months by wearing a drainage tube which made it impossible for him to rest on his back.

By doing a ureterostomy, as in the case shown by Dr. Martin,

we certainly increased the comfort of those patients with inoperable cases of tumor of the bladder. In such cases he was in favor of doing the operation in two stages,—first doing a double ureterostomy and subsequently extirpating the bladder. The postoperative treatment of these patients was of the utmost importance to the patient's comfort.

DR. CLARENCE A. MCWILLIAMS said he had seen the late Dr. McCosh perform three such operations on the uterus and bladder where the ureters were cut and allowed to remain *in situ* in the pelvis. The urine was passed per vagina—the patients wearing rubber urinals. One of these patients was alive a year after the operation, the second died of recurrence within a few months, while the third was lost sight of subsequently.

DR. ERDMANN said he had seen paroxysmal anuria occur after unilateral ureterostomy. In that case it was demonstrated that there was no blocking of the opposite ureter, and the temporary anuria was apparently due to irritation of the ureter.

DR. MARTIN, in closing the discussion, said he preferred to do an implantation of the ureters in the loins rather than to let them dangle free in the laparotomy wound; he regarded the former as a cleaner and safer procedure. In reviewing the literature of the subject he had found the report of one case of exstrophy of the bladder where a double ureterostomy had been done with loin implantation by Dr. John T. Bottomley and the patient was alive and fairly comfortable fifteen months after the operation. In another case done for carcinoma of the bladder, reported by Rovsing, the patient wore a rubber apparatus which kept her dry and comfortable, and she was in good condition one year after the operation. In his own case, Dr. Martin said, the patient kept herself fairly comfortable by the use of layers of gauze. He regarded the two-stage operation of distinct advantage in dealing with inoperable tumors of the bladder. In reply to a question, he said that he had feared that the ureter would become kinked in the course of his implantation, but the introduction of a catheter had shown that none had occurred.

AN OPERATION FOR PARALYTIC SHOULDER JOINT DUE TO INFANTILE PARALYSIS.

A paper with the above title by Dr. O. Kiliani, was presented and, in the absence of the author, was read by the secretary, for which see page 79.