

match to the end of tube, it will ignite. Nothing short of complete strangulation will prevent the passage of the gas. Thus in cases of fecal impaction, the symptoms of which so often resemble obstructions of graver character, the gas could be forced by and around the impaction, affording unmistakable evidence that strangulation did not exist. If the gas could not be made to traverse the entire intestinal tract, distention of the abdomen, with exaggerated tympanites, over a given space would, as undoubtedly, show that obstruction did exist.

A CASE OF SPLENECTOMY FOR LEUCÆMIC ENLARGEMENT.

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MICHAEL Hamerlein, æt. 47 years, was sent to me by Dr. Pettit in September, 1886, was born in Germany, and does not remember anything about his parents, but is sure they did not die of tumors, nor of any malignant disease. He had typhoid fever when 16 years of age; served three years during our war. In 1865 was wounded in the right leg, but made complete recovery. While in the service was sick for some time with chronic diarrhœa, and was "moonblind" for two weeks at one time. During May and June, of 1886, he had chills and fever; during July was in a hospital at Erie, Pa., where his enlarged spleen was for the first time detected. He says he has been sickly for six years, but complained of nothing definite. Present condition, anemic and cachetic, has a sallow appearance, complains only of slight headache, extreme weakness, shortness of breath and of the swelling of his feet and legs when he walks much; says that six months ago he had intense abdominal pain which soon subsided. His pulse is fair in volume but slightly irregular; on palpation,

he presents a large tumor in the left side of the abdomen, which reaches to the height of the sixth rib in the axillary line and to the crest of the ileum below, at a level of three inches above the navel it extends an inch and a half to the right of the middle line; opposite the navel is quite a notch and then two inches below, it again extends an inch and a half over to the right of the middle line, thence downward to within two inches of the pubes. Posteriorly, it can be traced to within three inches of the spine; its free border can be plainly felt through the abdominal walls. The glands in both groins are slightly enlarged, but neither the thyroid, cervical nor axillary. The bowels move daily, his appetite is poor. His general condition led me to make careful estimate of the relative number of white corpuscles in his blood; the proportion was found to be one 1 to 50 or 60. Estimation of urea gave a total excretion of 20 to 21 grams in 24 hours.

The patient was in a pitiable condition, and while there was no doubt as to the diagnosis of leucocythæmia with the most pronounced lesion of the spleen, still the proportion of white corpuscles to the red did not seem to be so overwhelming as in a large majority of case where the spleen is so prominently affected. The man suffered constantly, realizing his impending fate, and implored me to take any measure that offered the slightest prospect of relief. The question of extirpation of the spleen, thus brought up by his own request, I canvassed carefully in my own mind, well aware of the fatality attending its removal under such conditions. I yet felt that the predominance of white corpuscles was not so conspicuous as to make the operation necessarily and absolutely unjustifiable. I, accordingly, discussed it with him at some length, and told him I thought he had about one chance of life out of five. This chance he gladly accepted, and on this distinct understanding, he was prepared for operation.

The operation was made Sept. 29, in my clinic at the Buffalo General Hospital, in the presence of the hospital staff, numerous invited spectators and the clinical class. Prof. Mann kindly assisted me. Chloroform with nitrite of amyl was the anæsthetic, which he took kindly. The incision was made in Langenbuch's line, along the outer margin of the left rectus.

It was some eight inches in length and gave ready access to the spleen. The splenic capsule was found very adherent to the parietal peritoneum; these adhesions I severed as rapidly as I could, and with but little loss of blood. Then slipping the free or hepatic end of the tumor out of the incision, I tried to lift it out. The mass was so soft that it threatened to part under this strain. Accordingly, I had to pass my hand up under it toward the diaphragm, where I found its suspensory ligament both strong and inaccessible; finally, by trying to clamp its apparent pedicle at the hilum, I by force lifted it out of the abdomen. Instantly after its removal, it was found that nearly all of its vessels were ruptured, and its site filled with blood, mainly venous; it took considerable time to sponge it out fast enough so that I could see the source of the hæmorrhage. Most of this was found to come from the diaphragm, and it was very hard work to seize with long forceps the bleeding vessels and secure them. Several times I had to resort to the ligature *en masse*: even then there was a great deal of venous oozing which I finally stopped with Monsell's salt. The other sources of hemorrhage gave very much less trouble. Finally, everything was made apparently secure, and I closed the opening with sixteen silver sutures. Hypodermics of brandy were freely given, although at no time was the patient completely collapsed before he rallied from the anæsthetic. The total time occupied was just one hour; he rallied pretty well and conversed with me, complaining of severe pain; his pulse improved up to the time when I left the building. A few hours after the operation he went into a sudden collapse and died.

An autopsy was made on the following day, which was not complete, but was directed especially to ascertaining the results of the operation. I was pleased to find that the oozing had been insignificant, that no ligature had given way and that the hemorrhage seemed to have been mastered. There were none of the ordinary glandular evidences of leucocythæmia. Aside from this, no further examination was made. The spleen weighed, after removal and emptying of considerable of its blood, just nine pounds.

I was prepared for a difficult and trying operative ordeal,

fearing hemorrhage more than anything else, and expecting to find the largest vessels to be enlargement of the normal vessels supplying the region. I was surprised, therefore, when I found the large number of adventitious vessels entering through the suspensory ligament. Opportunity was not offered for discovering exactly what the vascular arrangement was, but the normal vessels entering from the diaphragm through this peritoneal fold must have been enormously dilated. I had but little expectation of success, and should not have consented to operate except at the earnest solicitation of the patient, as mentioned.

I submit the report of the case without further remark, simply as a contribution to the statistics of splenectomy.

NOTE ON ELECTROLYSIS OF UTERINE FIBROMA.

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THE prominence given lately to the opinions and methods of Dr. Apostoli in his revival of this operation, long ago practiced both in America and England, stimulates me to put on record a single case never before reported, treated some years since in the city of Chicago.

The patient, then about 38 years of age, consulted me for menorrhagia which had existed about a year, and which had depleted her excessively at each menstrual period. The diagnosis of fibroma had not previously been made, but the uterine cavity was found $6\frac{1}{2}$ inches in depth, and with quite uniform and symmetrical enlargement of the anterior wall. Intra-mural fibroid seemed to be present, probably in places also sub-mucous, accounting for the alarming hemorrhages.

Electrolysis was done Feb. 6, 1875, with the assistance of Prof. John E. Owens, in the following manner:

A Schlotterbeck's speculum was introduced edgewise, handles down, and the vagina distended as widely as practicable