

## Clinical Department.

### SURGICAL CLINIC AT THE MASSACHUSETTS GENERAL HOSPITAL BEFORE MEMBERS OF THE MASSACHUSETTS MEDICAL SOCIETY.

TUESDAY, JUNE 11, 1895.

REPORTED BY M. H. RICHARDSON, M.D.,  
*One of the Visiting Surgeons.*

#### EXHIBITION OF PATIENTS.

##### CASE 1. Traumatic hydronephrosis. Dr. Porter.

George E., aged twenty-six, on November 1, 1894, ten days before his entrance to the hospital, while lifting a barrel, felt something give way in the right side. He was seized immediately with sharp pain, which soon became localized in the left hypochondrium. This was followed by vomiting and the passage of a bloody stool. The urine contained blood, pus and casts. On examination a dull and elastic tumor was found in the umbilical region extending into the left flank. The tumor at this time was punctured with the aspirating needle without result. He was then discharged, but soon after re-entered the hospital for pain and a sudden increase in the size of the tumor. Examination of the blood showed a leucocytosis of 27,000. The skin was yellowish in color. He was tapped twice, and fifty ounces of fluid containing urea were withdrawn. The sac immediately refilled. On December 6th, five weeks from the receipt of his injury, a median incision revealed a large fluctuating tumor extending from the brim of the pelvis up to the renal region. This sac was opened and drained by a lumbar incision, the anterior cut having been first closed. The lumbar wound healed, except for a fistula which discharged urine equal to the amount discharged *per urethram*. It was decided that there had been a ureteral wound, and an operation for its relief was undertaken. Guided by the fistula, a lumbar incision was made, and finally extended downwards nearly to Poupart's ligament. The adhesions and inflammatory tissue prevented the finding of the ureter. It was thought unwise to prosecute the operation further. The large wound was closed, except in the upper part for drainage. The quantity of urine from the fistula and from the bladder varied from day to day, sometimes the one, sometimes the other discharging in excess. Finally the amount from the fistula diminished, and apparently there was recovery of perfect health. The patient left the hospital, passing a catheter through the fistula every few days, with drawing a varying amount of urine. The man is now at work in the same condition.

CASE 2. Cholecystotomy: removal of stone from the common duct. Dr. Porter.

Mary S., aged thirty-five, entered the hospital in February, 1893. For six months she had had hepatic colic, with nausea and vomiting. Persistent jaundice with clay-colored stools and pigmented urine soon followed. She has had attacks similar to the above every two weeks, and has been obliged to give up work. While in the hospital she had another attack similar to the first. Examination showed an induration in the region of the gall-bladder. On February 25, 1893, a contracted gall-bladder was exposed and a stone detected in the common duct. After the removal of this stone by incision of the duct she made a very good recovery. The pain and jaundice disappeared

entirely, and she was discharged from the hospital on March 30th, at the end of five weeks. She is now in perfect health, and has had a baby since the operation.

CASE 3. Floating cartilage removed from the elbow-joint. Dr. Porter.

Allan McD. entered the hospital October 10, 1894. Two months before entrance, while lifting a plank, he injured the elbow. He continued at his work, but at times the joint would lock at right angles, further extension being impossible. Manipulating around the triceps insertion would apparently displace something, and the joint would recover its normal position. No moving body could be felt. An incision was made at the outer side of the triceps tendon into the joint, from which a loose cartilage was removed. Upon exploring the joint with the finger a second cartilage was found lying in the olecranon fossa, thus explaining the limitation to extension. At the present time the man has perfect use of the elbow-joint.

CASE 4. Ruptured middle meningeal artery: trephining. Dr. Porter.

John A. R. entered the hospital November 3, 1894, having been thrown from a carriage one hour previously. He was so stupid on entrance that he could not be roused. There were three scalp wounds; one over the right frontal bone, one over the right parietal, and a third over the left portion of the occipital. The respiration and pulse were good. There was bleeding from the right nostril; neither paralysis nor spasm were present. A fracture with depression was found at the anterior wound, one inch back of the external angular process, with a crack running anteroposteriorly.

Operation was performed immediately. The dura was found dark, tense, and bulging. There was extradural hemorrhage from the middle meningeal. On opening the dura, blood under great tension spurted out. The dural opening was enlarged, clots and disorganized brain substance were removed, and no source of intradural hemorrhage was found. The bleeding ceased, and the dura and outside wound were closed without drainage. He was delirious and restless for two weeks after the operation. It was nearly six weeks before his mental functions were sufficiently restored for him to appreciate his situation. He was discharged in two months, much improved. Present condition: he has no headaches; he has good physical vigor; there is slight hesitation in speech. He states that he is well enough to return to business, but his friends advise a longer vacation.

CASE 5. Floating cartilage removed from the knee-joint. Dr. Porter.

Julius J. entered the hospital November 30, 1894, having had trouble with his knee for six years. At first, every two or three months, the joint would get caught and fixed so that prolonged manipulations would be necessary before he could flex and extend the leg freely. These symptoms increased in frequency and in severity. On examination an effusion into the knee-joint was found, with a freely movable body. On December 1st the left knee was opened and one floating cartilage was removed. He was discharged December 19th, cured. The knee at present is perfectly good. The patient is able still to catch a floating body in the side of the joint, but it never gets caught between the bones.

CASE 6. Nephrotomy for renal stone. Dr. Warren.

This patient had suffered since early in life with

calculus of the kidney. The principal symptom was intense pain, shooting into the groin from the right kidney. A year ago I performed nephrotomy. The kidney was exposed through an incision made in the lumbar region. On passing my hand into the abdomen I grasped the kidney and brought it up into the wound. While holding the kidney my thumb and finger were deep into its pelvis, and there I felt this calculus. To expose the stone and to deliver it, I made a cut through the dorsum of the kidney in the median line, thinking that I would get less hemorrhage in this way than in any other. I could use only one hand in making this cut, as I was holding the stone with the other. I passed the knife into the kidney until it grated upon the stone. The hemorrhage was really quite appalling; it was more venous than arterial. I plugged the vessels by putting my finger into the hole made by the knife. After taking out the stone a little gauze was passed as far as the pelvis. Since the operation, from which he made a very satisfactory convalescence, he has been in excellent health, and has suffered no pain.

CASE 7. Trephining for epilepsy. Dr. Warren.

Fourteen or fifteen years ago this man received a pistol shot in the head, the missile piercing the orbit and becoming lodged in the base of the brain. Some years afterwards he began to have epileptic seizures, each attack preceded by peculiar symptoms of the right hand. The starting-point of the spasm was localized in the left fissure of Rolando. These epileptic seizures got to be more and more troublesome. In falling he dislocated his humerus in one year no less than seven times. I trephined over the left Rolandic fissure near the occipital protuberance, and from this point cut through the temporal bone with rongeur forceps nearly to the external angular process in front of the zygoma. On exploration a large quantity of serous fluid was evacuated from a cyst that was situated beneath the quadrate lobe in the left anterior fossa of the brain. He recovered from the operation without serious incident. You will see that the fingers of the right hand are kept in a peculiar position of partial extension. His father says he has not been relieved by the operation. He continues to have fits, though less frequently than before. He has dislocated the shoulder five times since the operation. The interesting point is that these very extensive operations for epilepsy do not seem to produce as definite results as we had hoped. You will notice the enormous depression under the scar, and that the brain has not filled up again since the last operation, which took place about six months ago. Surgeons dwell on the importance of the post-operative treatment of epilepsy, for even after operation the habit of epilepsy remains. We ought, therefore, to supplement the operation by a very thorough course of the bromides.

CASE 8. Cancer of the breast. Dr. Warren.

You know how much attention is devoted to the operative treatment of cancer. At the last meeting of the American Surgical Association this was the principal topic of discussion. The latest results following operations for cancer have encouraged the hope that we may be able to cure a certain percentage of cases in localities hitherto regarded as inoperable. In cancer of the breast we have been doing more extensive dissections than ever before. The so-called completed operation having been substituted for the old method, a thorough dissection of the axilla is now the

rule in every case, whether glands can be felt there or not. The breast is now removed with the pectoralis major and the contents of the axilla in a single mass. We are doing bolder and bolder operations. In the case that will be shown presently I have done not only the completed operation, but I have removed both pectorals, have resected the clavicle, and explored the supra-clavicular space.

Mrs. B., aged fifty-two, noticed six months before entrance to the hospital, a small lump in the left upper quadrant of the right breast, about the size of a small orange. The skin was not adherent. Glands could be felt in the axilla. The breast was removed February 5, 1889. Microscopic examination by Dr. Whitney proved the diagnosis scirrhous cancer. I have not seen her for six years. The scar of the incision, as you will see, is smooth, non-adherent, and soft. There is not the slightest evidence of a recurrence locally or remotely. The pectorals were not removed in this case. The incision was carried well over to the upper arm, so that a very thorough dissection of the axilla could be made.

There are quite a number of cases as favorable as this. I have found 27 per cent. of cures in my own practice. Of course there are a good many cases that I have not heard from, but the outlook is certainly very encouraging.

CASE 9. Cancer of breast; completed operation; removal of pectorals; dissection of axilla; resection of clavicle and exploration of supra-clavicular space. Dr. Warren.

This patient, a woman of forty-five, I have asked to call in order that you may see the extent of the incision in the modern operation for cancer of the breast. The cut is carried up here across the axilla to a point well beyond the posterior axillary fold (*latissimus dorsi*). The *mamma* with the pectorals are first cut away; the fat and glands are then dissected from the axillary vessels in one mass with the breast and the pectorals. The clavicular portion of the *pectoralis major* is left intact in most instances. In this case the clavicle was divided so that a clear view could be had of the sub clavian triangle. It was possible to make a most minute and satisfactory dissection of the whole region from the outer fold of the axilla to the bifurcation of the innominate artery; to remove every suspicious gland and to explore all doubtful places. The dissections having been completed the clavicle can be wired, as in the case before you. In a recent dissection I went as high as the seventh cervical vertebra.

CASE 10. Resection of the jaw for ankylosis.

Dr. Cabot showed a boy of thirteen upon whom he had operated three years before for unilateral bony ankylosis of the jaw, which was the result of otitis following scarlet fever. The operation was a cuneiform resection of the neck of the jaw through an incision just beneath the zygoma. The boy can open his mouth one and three-quarters inches, and the jaw has lateral, grinding motion of three-quarters of an inch. The scar is almost invisible and there is no paralysis of the facial nerves.

CASE 11. Jacksonian epilepsy.

Dr. Cabot showed a young man who had been cured by operation of Jacksonian epilepsy, the result of a cyst of the brain. The case will be more fully reported later.

CASE 12. Fractured thigh. Dr. Cabot.

A fractured thigh under treatment in an ambulatory manner on a modified Taylor's hip splint. The modification consists in adjusting to the splint hands which surround and support the thigh within which coaptation splints are applied, so as to give thorough support to the bone. Dr. Cabot said that he had already used this method in three cases with very good satisfaction, one of them being a case in which all other apparatus had been tried and had proved unsatisfactory on account of the restlessness of the patient, and in which this splint, which was first adjusted to that case, had worked admirably, giving extension and coaptation in a thoroughly satisfactory manner. In the case shown to the Society the splint was applied at the end of four weeks, which time the patient spent in bed with a Buck's extension. Dr. Cabot said that he would have preferred to apply the apparatus and get the patient up earlier, but there was delay in having the splint made. He thought that these cases might be got out of bed easily at the end of a fortnight, and after that they might get about on crutches.

CASE 13, shown by Dr. Cabot, was a man who had been operated upon for the radical cure of inguinal hernia by an original modification of the method devised by Halsted, and in a somewhat different form by Bassini. By Halsted's method the cord is transplanted towards the anterior iliac spine and brought directly through the muscular wall and the aponeurosis of the external oblique. Bassini, in the effort to restore the valvular arrangement of the canal, carries the cord downward between the muscles and the fascia of the external oblique, making a slanting canal much like that which nature has provided. Dr. Cabot, in the case shown, had brought the cord through the internal ring, after strengthening the upper borders of that canal by one or two tendon sutures, and had then carried it upward between the muscles and the fascia of the external oblique, to emerge through said fascia at the point where it would emerge by Halsted's operation. The ring and the canal below were then sutured firmly, and closed as in Halsted's method. It seemed to him that if it were found wise to make the emergence of the cord through the wall by a slanting canal, that a canal slanting in this manner upward, was much less likely to be forced open by downward pressure of the bowels than one which imitated the natural canal, as in the method of Bassini.

CASE 14. Resection of four feet of intestine for mesenteric thrombosis.

Dr. Elliot showed a patient in good health, from whom he had resected four feet of small intestine about a year previously. The patient had suffered from very acute abdominal symptoms, and on opening the abdomen a large knuckle of intestine was found dark and gangrenous. After the resection was made the ends of the gut were sewed into the abdominal wound making an artificial anus, which was subsequently closed by another resection. Examination of the part removed showed it to be one of the very rare cases of thrombosis of the mesenteric veins.

CASE 15. Incision of common duct; removal of gall-stone; suture of duct. Dr. Elliot.

The patient was shown in robust health. About a year ago he had had a gall-stone removed from his hepatic duct, on account of the following symptoms: gall-stone colic, severe pain, jaundice, clay-colored stools and vomiting. The stone was located by touch.

The duct was incised over the stone and closed with sutures immediately after the removal of the stone. Recovery was rapid. This is the only case on record in which the hepatic duct has been closed with sutures after extraction of a stone.

CASE 16. Osteoplastic operation for ankylosis of the jaw. Dr. Elliot.

The patient, a boy of twelve, had had complete ankylosis of the jaw since he was ten months old. He was emaciated, with a small, undeveloped jaw. One year ago the ramus of the jaw was divided on both sides. The jaw was constantly moved, and finally good motion was established. The patient can eat well, and has gained in weight.

CASE 17. Removal of the Gasserian ganglion for neuralgia. Dr. Mixer.

Martin Z., aged forty-five, without premonitory symptoms was seized in 1880 with violent jumping pain in the terminals of the right trifacial nerve. During the next six years he had complete remissions of pain for months at a time. At the end of six years the infra-orbital nerve was avulsed without relief. A year later the inferior dental was removed by trephining through the ascending ramus of the jaw. Three years' relief followed this procedure. In 1891 Dr. Mixer operated at the foramina of exit from the skull, avulsing the second and third divisions. One year's relief followed. Since that time the pain has been constant. September 18, 1894, the Gasserian ganglion was removed with a relief which has been thus far complete. The patient shows very little deformity, even after such extensive operations as the two last. There has been no interference with the general health, and the cerebral functions are not impaired.

CASE 18. Nephrotomy followed by nephrectomy. Dr. Mixer.

A woman, aged thirty-three, for one year had had symptoms which resulted in a perinephritic abscess. The right kidney was opened by lumbar incision by Dr. Richardson before this Society a year ago.<sup>1</sup> A counter opening was made in the right groin. From this operation she rallied well, but she continued septic, the temperature fluctuating between extreme limits. In September, Dr. Mixer extirpated the kidney through an incision which extended from the last rib to the anterior superior spine of the ilium. After this operation, which was very successful, she regained her strength and flesh in a remarkable manner, and is now, as you see, in perfect health.

CASE 19. Intra-peritoneal suprapubic cystotomy for stone. Dr. M. H. Richardson.

The patient, aged fifty-one, had suffered from urinary symptoms for four years. Operation April, 1895. The stone proved too large for the lithotrite. The bladder was exposed by the suprapubic cut; but owing to the great thickness of its walls and consequent rigidity, the prevesical space could not be utilized. The intestines were protected with gauze, and the bladder opened. The stone weighed 2,250 grains. The intra-peritoneal route, first deliberately suggested and performed by Dr. Harrington, was taken in this case by necessity. The rapid convalescence, with entire absence of peritonitis after the unavoidable contamination by the foul contents of the bladder, is another proof of the great tolerance of the peritoneum even when infected by fluids extremely septic, if efficient drainage is employed.

<sup>1</sup> *Vide* Boston Medical and Surgical Journal, June 28, 1894, p. 646.

CASE 20. Intra-peritoneal suprapubic cystotomy for stone. Dr. Richardson.

Operation May 27, 1895. This is very similar to the preceding case in history, operation and result. The stone weighed 1,610 grains, and had been fractured transversely in the middle at no very remote date, as was shown by the recent deposition of urinary salts upon the broken section, which was itself marked by concentric layers. The patient is still in bed, but convalescing well.

CASE 21. Recurrent appendicitis; appendix removed through an inch incision. Dr. Richardson.

W. D. R., aged twenty-two, had had six or eight attacks of appendicitis. Was brought to the hospital May 21, 1895, during an appendicitis of moderate severity. The appendix could be felt directly under the abdominal wall in the usual position. He was eased through this attack without operation, and when perfectly well the appendix was delivered through an incision just large enough to admit the index finger. The abdominal muscles were divided in accordance with McBurney's recommendation, a most admirable and efficient procedure. The case is shown on the eighth day entirely healed. The approximation is so effectual by this method that the chief objection to the operation — that of ventral hernia — is fully met. The mortality is very slight, as Bull has shown.

CASES 22 and 23. Intestinal resection for fecal fistula following operations for appendicitis. Dr. Richardson.

These two cases were more or less complete resections with end-to-end suture. The bowel had become necrotic, probably from the pressure of the drainage-tubes used by the surgeons after operations upon the appendix. In both practically the entire contents of the bowel were discharged through the fistula. Following the method first used in such cases by Dr. Porter fifteen years ago, I separated freely the adhesions about the affected coil, so as to deliver it fully through the wound. The general peritoneal cavity was of course opened by this procedure, but it enabled me to bring the opening into full view, to resect carefully the ragged end of gut, and to make a perfect joint. Both cases have recovered entirely. One of them was operated upon a year ago to-day; and you may remember how difficult the operation was on account of hemorrhage.<sup>8</sup> This method in my hands has succeeded in every case in closing permanently the fistula. A complete circular resection is generally necessary on account of the great extent of the opening. In one case the appendix was found close to the opening in the cecum, and removed.

CASE 24. Nephrectomy for tubercular pyo-nephrosis. Dr. Richardson.

Mrs. G., aged thirty, suffered from pain in the left kidney a year and a half ago, accompanied by pus in the urine. A year ago nephrotomy was successfully performed at the Massachusetts Homeopathic Hospital. The discharge from the persisting sinus contained urea. She was much emaciated when I first saw her, with a chronic septicemia. The left renal region was occupied by an immovable tumor. May 25th the kidney was enucleated through an anterior incision (that is, a little in front of a vertical line half-way between the umbilicus and the spines of the lumbar vertebræ).

Though the abdominal cavity was opened in front,

most of the manipulations were retro-peritoneal. The progress has been very satisfactory. The sinus became closed immediately. The other kidney is working well. In the enucleation of the kidney, which was nothing but a bag of pus, no vessels required ligation.

CASE 25. Tumor of brain weighing a pound removed from left hemisphere. Dr. Richardson.

This man, aged thirty-eight, began to show hesitation in speech last October. December 1st he gave up his business. He began soon after to lose power of motion in the right hand. This loss of power soon became complete, and involved also the leg. The paralysis was preceded by twitchings of the hand and foot. The diagnosis by Drs. Putnam and Walton was glioma in the left motor region. The first operation was performed February 14, 1895, and consisted in a superficial exploration about the left fissure of Rolando after a very large osteoplastic resection of the left side of the cranium. No tumor was detected. The flap was replaced and sutured. He recovered well, and seemed somewhat improved by the relief to the intracranial pressure. The flap united, but underneath it a large mass forced itself until three months later it projected under the scar. The second operation, May 25th, revealed at once a lobulated tumor projecting from the wound. This was enucleated with the fingers without difficulty, though the hemorrhage and shock were great. The mass filled almost completely the left half of the cranial cavity, its weight being roughly estimated by Dr. Whitney at one pound, as the fragments saved filled a pint jar. The fingers swept from the *crista galli* to the internal occipital protuberance, the whole length of the *falx cerebri*.

He has recovered practically from the operation. The enormous cavity left in the cranium has become filled with what seems to be normal brain tissue. The aphasia is much improved, while the power of motion is returning with great rapidity.

#### OPERATIONS IN THE BRADLEE WARD.

CASE 1. Abdominal hysterectomy for fibroid of the uterus.

Dr. J. W. Elliot did an abdominal hysterectomy for a fibroid of moderate size, which was accompanied with a large amount of ascitic fluid. The ascites was found to be due to a general tubercular peritonitis. The case thus showed the rare combination of a fibroid of the uterus, with a tubercular salpingitis and tubercular peritonitis.

CASE 2. Cholecystotomy. Dr. Mixer operated upon a woman of fifty-six whose first attack of gall-stones occurred thirty years ago. She entered the hospital April 22d, in the midst of a very severe attack of gall-stone colic. She was discharged April 30th, and re-entered June 4th with another attack.

The abdomen was opened by a cut parallel to the ribs. The gall-bladder was normal in appearance, though its walls were slightly thickened. The fundus was first secured by two stitches, between which an incision was then made. Five stones were removed. The common duct was then explored both inside and out, but nothing abnormal was found. The wound in the gall-bladder was next closed, and finally the external wound without drainage.

CASE 3. Appendicitis in the interval of health.

Dr. Elliot did an operation for appendicitis in the interval between the attacks. The abdomen was

<sup>8</sup> Vide Boston Medical and Surgical Journal, June 28, 1894, p. 645.

opened by the method suggested by Dr. McBurney. The skin and external oblique were incised in the direction of the fibres of that muscle, and the internal oblique and transversalis were incised in the direction of their fibres, so that the lines of incision through the two muscles were at right angles to each other, one overlapping the other. After the chronically inflamed appendix was removed through a one-inch opening, the fibres of the muscles and the fascia fell back into place, leaving no direct opening into the abdomen. A few buried stitches were taken to hold the muscular fibres together. The method seemed to show clearly its value in preventing a hernia of the scar.

#### CASE 4. Ovariectomy. Dr. Harrington.

The patient, aged sixty-five, had had an ovarian cyst weighing ten pounds removed five years ago in Pittsfield by Dr. Paddock. Recently the abdomen had become enormously enlarged, transmitting a thrill, and dull to percussion, except below the umbilicus where a ventral hernia through the old scar existed.

The bowels were found firmly adherent to the skin. The surface of the tumor was extremely tense, and the intestines were adherent to it in all directions. The adhesions were so strong that the tumor could not be enucleated without injury to the gut. The tumor was finally opened, and more than fourteen pounds of fluid evacuated from different sacs. Glass and gauze drains were left in, one drain going into interior of cyst.

#### OPERATION IN THE BIGELOW AMPHITHEATRE.

CASE 1. Nephrotomy. Dr. Harrington. The patient, a man of twenty-nine, had had fever, chills, and night-sweats accompanied by pain in the left kidney and left groin. There was frequent painful micturition, and the urine contained pus. No tubercle bacilli could be detected. Under ether the bladder was sounded, but no stone could be found. Great temporary improvement followed rest and nursing, but there was no decisive tendency towards cure. There was a tense and painful tumor in the left renal region. By a lumbar incision two sacs of pus were evacuated. Several stones were found, weighing all together sixty-eight grains. The policy of temporary drainage was adopted, with a view towards ultimate nephrectomy.

#### CASE 2. Retro-esophageal tumor. Dr. Mixer.

William D., aged thirty, single, shoemaker, had been well till six weeks before operation, though he had met with some injuries, and had had a venereal sore. His first complaint was difficulty in deglutition. Three weeks later he noticed a bunch in the throat which was slow in growth and painless. Respiration was very difficult and somewhat noisy. No definite outlines to the growth could be made out, but it evidently was flattening the trachea against the thyroid isthmus from behind. The mass was supposed to be situated between the trachea and the esophagus, and to extend into the mediastinum. After consultation it was decided to perform tracheotomy under cocaine anesthesia, and then to explore thoroughly the precervical region. The trachea was opened immediately and found to be so flattened antero-posteriorly that no tube could be introduced. In trying to adjust a canula inspiration became almost completely blocked. Immediate death was prevented finally by means of a gum-elastic catheter, for which later a large laryngeal tube was substituted. Through this the patient was

anesthetized by chloroform, which worked most satisfactorily. The tracheal cut was carried well down towards the aorta until space was found for the introduction of the largest sized canula. The subsequent manipulations, by which an extensive encapsulated myxo-sarcoma was removed from the depths of the precervical space and the posterior mediastinum, were comparatively easy. The relief to breathing was marked. The patient recovered from the operation remarkably well.

#### CASE 3. Intestinal resection and suture for cancer. Dr. Mixer.

Mrs. H., fifty-seven years old and a patient of Dr. Fraser of East Boston, had had for two years symptoms upon which the diagnosis of cancer of the ascending colon was based. There was loss of flesh, impaired digestion, with pain in the right of the abdomen with gurgling and squeaking, and a tumor which was tender, somewhat movable, and irregular. Exploratory laparotomy was advised, after consultation, with the chances against any radical improvement. The mass was found to be a tumor of the hepatic flexure of the colon that had sagged down towards the ileo-cecal valve. The disease was so distinctly localized that extirpation seemed justifiable. The whole ileo-cecal coil was removed after securing in sections the meso-colon. The beginning of the transverse colon was then united to the small intestine, which had been cut near the ileo-cecal valve, by means of a lateral anastomosis with the Murphy button. The cut ends were closed by continuous suture. After most careful irrigation the abdominal wound was tightly closed. The specimen proved to be an extensive ulcerated carcinoma of the large intestine.

#### CASE 4. Nephrectomy for calcareous pyelitis. Dr. Richardson.

Mrs. X., aged forty-seven, a patient of Dr. J. A. Steadman, of Canton, had noticed a tumor in the left renal region for some six months. Her general health had become seriously impaired without visible cause. The tumor filled the left renal region, bulging posteriorly, and extending in front nearly to the median line. It was hard, and in places irregular and nodular. Posteriorly there was distinct fluctuation. The temperature indicated a mild sepsis. Aspiration showed pus. Nephrotomy was advised unless total extirpation should prove easy after exploration. A curved anterior incision was selected for the purpose of ascertaining the condition of the other kidney, and to control hemorrhage if necessary. A transverse cut was carried towards the spine, and abundant room was thus gained. The right kidney was found of normal size, shape and feel. The left was enucleated from its capsule without great difficulty though the wall was sessile to the abdominal aorta. The bleeding, which was insignificant, was from three or four very small arteries in the thickened pelvis. There was abundant foul pus and numerous fragments of a friable calculus. The whole calcareous mass weighed about 1,500 grains. The peritoneum, which was opened in places during the separation from the descending colon, was efficiently protected by means of gauze. After thorough flushing with warm water the external wound was closed, a small gauze drain being left in the lower angle of the transverse cut.

A MEDICAL MAYOR. — Dr. A. W. Fly has been re-elected Mayor of Galveston, Tex.