

the lymph of the kidney substance and then to the glands in the vascular pedicle of the kidney. Possibly in these cases of chronic nephritis the lymphatics become blocked either by excess of lymph or by fibrinous deposit and the nephritic poison cannot be drained away from the kidney substance. The author has noted that clear lymph seems to flow from the kidney sponge almost immediately after decapsulation.

Chronic Duodenal Obstruction.—KELLOGG AND KELLOGG (*Ann. Surg.* 1921, lxxiii, 578) say that chronic duodenal obstruction occurs more commonly than is realized and can often be diagnosed from the history and physical signs. The obstruction may involve the first or second portions of the duodenum only, due to ulcer, or gastropexia or adhesions, or the entire duodenum, most frequently caused by compression between the vertebral column behind and the superior mesenteric artery in front, especially when there is traction in the direction of the pelvis from the drag of a distended and ptosed cecum and colon. The physical signs of obstruction in the first portion are those of pyloric obstruction. When the second and third portions are involved it can often be made out by percussion and succussion. The symptoms are those of epigastric discomfort and toxic manifestations. With a competent pylorus, cramp-like pains predominate. When incompetent, regurgitation of bile is frequent. Symptoms are often suggestive of ulcer, gall-bladder or appendicular trouble; in operating for these conditions with negative findings, the duodenum should be carefully examined. Medical treatment, consisting of abdominal support, nutritious diet and anti-constipation measures is beneficial in the majority of cases. Surgical treatment in obstruction of the first and second portions consists of freeing of adhesions, gastropexy or duodenoduodenostomy. In the third portion, the procedure of choice is duodeno-jejunostomy. Duodeno-jejunostomy is indicated in vicious circle after gastro-enterostomy, accompanying gastro-enterostomy when the duodenum is obstructed, in obstruction of the third portion not responding to medical treatment. The author describes the technic and cites cases with a general summary of symptoms and results. Total number of reported cases is 58, with no mortality. In the author's series of 41 cases, only 1 was unimproved.

Enterostomy in the Treatment of Acute Intestinal Obstruction.—SUMMERS (*Surg., Gynec. and Obst.*, 1921, xxxii, 412) says in serious cases surgeons make a primary enterostomy as a life-saving measure or do a combined operation, making an enterostomy in the distended coils after successfully removing the cause of obstruction. The field has been still further broadened by including peritonitis ileus in the indications for operation. Formerly, Nealon's injunction to open the first coil of distended intestine for enterostomy procedure had been regularly followed. In 1910 Bonney advised opening the jejunum for this purpose, for it is the segment of toxicity when the vomitus becomes feculent. The positive proof of the value of this procedure in the circumstances is that drainage of the jejunum causes immediate cessation of vomiting. MacKinnon, in 1917, recommended strongly the simple modern drainage of the intestine by introducing a large-sized catheter and fastening it into position by a double purse-string suture. The catheter comes away in a few days with quick subsequent closure

of the abdominal wall. The author advocates jejunostomy when the vomitus is frankly feculent.

Injury to the Bile Ducts and Methods of Repair.—SWEETSER (*Ann. Surg.*, 1921, lxxiii, 629) says that interference with the normal flow of bile is due to a stenosis of the ducts following deep ulceration, pressure by adhesions and division of the common duct (intentional or accidental) during operation of cholecystectomy. The anatomical abnormalities and the presence of abnormal adhesions, congenital and acquired, must be carefully noted and guarded against in right upper abdominal surgery. The methods devised for restoring the bile stream to the intestine have been varied in order to meet the conditions encountered. In most cases the ends of the ducts are widely separated and the intervening space filled with dense scar-tissue. Simple approximation is no longer possible. Therefore, other means must be employed to bridge the hiatus. The tissues which lend themselves best to a successful and permanent anastomosis are those which normally are bathed in bile and consequently are immune to its irritation. When the mucous membrane of the bile duct, stomach or duodenum can be brought and held successfully to the proximal end of the duct, the result has been permanent in the majority of cases. Splinting with a soft rubber tube aids the process of repair. Failures have been due to stenosis or ascending cholangitis with abscesses in the liver. Attempts to bridge the gap with autogenous grafts have all failed in experimental animals. No human cases are recorded. An attempt was made by Murphy to utilize the biliary fistulous tract, but the patient died in eight months.

The Wassermann Reaction.—RAY (*Amer. Jour. Syphilis*, 1921, v, 320) says that in spite of the multitude of modifications and newer methods for the serodiagnosis of syphilis, the classical Wassermann reaction or a technic which departs from it only in minor details stands today as the only reliable laboratory test for syphilis. A series of 580 reactions, performed with crude and cholesterinized extract each with 2 methods of fixation namely, the one-hour incubator and the four-hour ice-box methods is analyzed with the following conclusions: A positive reaction with cholesterinized antigen alone should be given no specific significance in untreated cases presenting no clinical manifestations of lues and giving a negative history. The four-hour ice-box method of fixation, while increasing the sensitivity of the cholesterine antigen as compared with the one-hour fixation in the water-bath magnifies the non-specificity except in treated cases, congenital syphilis and in some cases of neurosyphilis, where it has a decided advantage. On the other hand, with the crude extract, the four-hour ice-box method of fixation, while increasing the sensitivity does not impair but rather augments the specificity. The cholesterinized antigens possess a specific sensitivity exceeding that of crude in all cases of syphilis under treatment, congenital syphilis and in some cases of neurosyphilis. The great value and importance of lumbar puncture in all cases of syphilis is emphasized. A spinal fluid examination including cell count, globulin estimation, colloidal gold and Wassermann reaction is imperative before prognosis can be given in spite of the fact that treatment has produced a Wassermann negative of the blood.