

In a lecture reported in the *Lancet*†, Hare, now Professor of Surgery in Owens' College, Manchester, gives concise rules for mapping out the fissure of Rolando along which most of the motor centres are localized. He measures the total distance from the glabella, or space between the eyebrows, to the occipital protuberance. Measuring on this line from before backward, a segment equal to 55.7 of the entire distance gives a point which marks the upper end of the fissure. From this point downwards and forwards, at an angle of 67° to the sagittal line and extending for 3½ inches a line may be traced on the scalp corresponding to the direction and extent of the fissure of Rolando. Professor Hare points out that in most instances the upper end of the fissure may be determined by a point half an inch behind the centre of the first mentioned line.

As to the details of the operation itself we are indebted more to the published writings of Victor Horsley than to any other source.‡ He discards the old-fashioned crucial incision for a large flap, which, of course, must be formed carefully with reference to arterial distribution. He adopts Macewen's plan of replacing the trephine "buttons" and any other portions of bone removed. His experience is against the use of drainage for it appears that the arachnoid like the peritoneum has great absorptive powers. He invariably uses chloroform as the anæsthetic, and expresses the opinion that when the dura mater has been opened an unusually small quantity of chloroform suffices to keep up anæsthesia. He gives a hypodermic injection of morphine before administering the chloroform, first, because a smaller quantity of chloroform is required, and second, on account of the action of morphine in producing anæmia of the brain, an action first observed by himself and Ferrier in experiments on monkeys, and which he considers to be of some importance in dealing with a tissue in which the control of hæmorrhage is unusually difficult.

ABDOMINAL SURGERY.

The peritoneum has been in recent years the happy hunting ground of the surgeon. Long a *terra incognita* regarded with timorous and mistrustful eye by the surgeon who for any reason may have had to venture into its labyrinthine expanse, this dark continent has now been thoroughly explored, and we are familiar with its natural history. Need it be said that much of the mystery which once enshrouded this region has been swept away, and that many of the views once held regarding it have proved visionary.

Nothing has been more startling in this revolution of surgical opinion than the demonstration of the remarkable power of self-protection against septic influences possessed by the peritoneum. It was at one time considered one of the most noteworthy achievements of antiseptic surgery that, under it, operations involving the peritoneum healed so well. In his

lectures on Suppuration and Septic Diseases,§ by far the most valuable contribution of the year to this department of knowledge, Watson Cheyne has shown that the peritoneum possesses in a marked degree that power upon which Lister in his clinical lectures is wont to lay so much stress, the power of the healthy living tissues to destroy septic organisms, provided these are not in excess.

It is the appreciation of this fact which has led surgeons to deal so boldly with wounds of the intestine and abdominal viscera. Compare the practice in the day of that Master of Surgery, Syme, or even the practice of ten years ago, as for example in the pages of Erichsen, (7th edition,) with the procedure in any first-class Hospital to-day. Syme said, "in respect to the treatment of wounded intestine, it is evident, that, unless the injured part presents itself to view no local treatment can be employed to remedy the injury."* The surgeon of to-day says, if the injured part do not present itself to view it must be brought into view, and dealt with as required. In the face of recent results the surgeon who allows a patient with a penetrating stab or bullet wound of the abdomen or a ruptured bladder, to die, without making an effort to get at the visceral lesion by aid of abdominal section is guilty of a fatal faint heartedness. Apart from the danger of fecal or urinary extravasation is the risk of hæmorrhage and a wound in an abdominal viscus is no exception to the golden rule of surgery, "tie the bleeding point."

During the past year there have been many reports of cases treated on these lines with perfect success; indeed, in no department of surgery has there been greater activity or more thoroughly justifiable work.

H. C. Dalton, of St. Louis records a case† in which bullet wounds of the stomach and liver were sutured, the patient making an excellent and speedy recovery, and appends a valuable table of statistics embodying the results of 69 reported cases. Five-sixths of these have been reported since 1886, and 19 since the date of Sir Wm. MacCormac's lecture in May, 1887.‡ These statistics give a recovery in nearly 40 *per cent.* of the patients operated upon, while under the old expectant treatment recovery in such cases did not occur in 8 *per cent.*

While the indications for operative interference in penetrating wounds of the abdomen are unmistakeable, they are scarcely less so in acute intestinal obstruction. In fact, the cardinal rule for herniotomy, "when in doubt, operate" may be applied to those cases in which the hernia is concealed, or in which there is acute intestinal obstruction due to bands, intussusception, mesenteric fenestræ, etc. In a paper read before the Brooklyn Pathological Society,|| Rockwell gives a table of statistics of laparotomy in acute intestinal obstruction, the number of cases being, curiously enough, the same as in Dalton's statis-

§ *British Medical Journal*, 1888, Vol. I., pp. 404, 452, 524, et seq.

* *Prin. of Surgery*, 3rd Edition, p. 302.

† *Annals of Surgery*, Vol. II, p. 81.

‡ *British Medical Journal*, 1887, I, 975, 1001.

|| *Annals of Surgery*, Vol. I., p. 81.

† *Lancet*, 1888, I., 407.

‡ See for example *British Medical Journal*, '86, II., 670.