A SERIES OF INTESTINAL ANASTOMOSES.

BY THOMAS S. CULLEN, M.B. (TOR.).
Associate Professor of Gynecology, Johns Hopkins University.

In going over my cases of the last few years I thought it might be advisable to describe in detail those in which it was necessary to remove portions of the bowel. The number is somewhat limited, but each case offers several points of interest:

Secondary carcinoma of the small bowel, 1 case.

Primary carcinoma of the cecum, 2 cases.

Tuberculosis of the cecum with perforation, 1 case.

Carcinoma of the sigmoid flexure, 1 case.

Carcinoma of the sigmoid flexure, complicated by a large uterine myoma, 1 case.

Carcinoma of the rectum secondary to a primary growth in the right Fallopian tube, 1 case.

Rectal diverticula, with perforation and abscess, 1 case.

Secondary Carcinoma of the Small Bowel.

In the following case a loop of the small bowel had become adherent to a friable carcinoma of the ovary. The growth had invaded the intestinal wall and the slightest traction was sufficient to rupture it. The Connell interrupted suture was employed except for the last few sutures, where we used mattress sutures penetrating the peritoneal and muscular coats but not piercing the mucosa. To make doubly sure we reinforced with a running suture entirely around the bowel. As it was impossible to completely remove the carcinoma of the ovary, a large gangrenous area being left behind and requiring drainage, we found it necessary to push the loop containing the anastomoses far over to the left among healthy loops; otherwise it would certainly have been infected by the necrotic and gangrenous tissue. As noted in the history the bowel gave no further trouble.

*Tentative diagnosis: Subperitoneal and intraligamentary myomata. Actual condition: Hydrosalpinx, adeno-carcinoma of the right ovary, involvement of the small bowel and marked extension to the bladder. Hysterectomy, partial removal of the cancerous growth, resection of a portion of the small bowel; temporary recovery.**

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