quarter of an inch from the divided ends. The suture is caught up by forceps, divided in the middle, and tied at once on either side, thus avoiding the confusion that would result if all the sutures were passed before any of them were tied. This process is repeated nine times more, or until

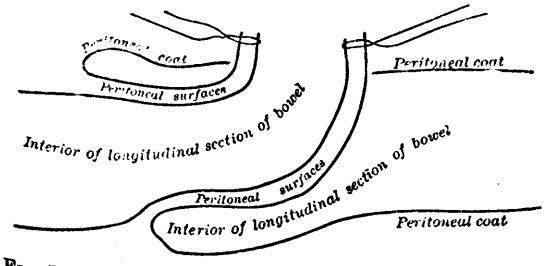

FIG. 7.—Longitudinal section of intestine, showing the relative position of the peritoneal coats of bowel invaginated at the longitudinal opening.

twenty sutures are placed and tied. The temporary sutures, having served their purpose, are cut off short. The cut ends of the bowel are dusted over with either iodoform or acetanilide, and the invagination is reduced by means of gentle manipulation accompanied by slight traction. The edges of the longitudinal opening are turned in, and it is closed by Lembert sutures passed through the peritoneal, muscular, and submucous coats.

Anastomsis of segments of ileum and colon may be effected by this method in the following manner:

A temporary suture is passed through all the coats of the greater and lesser intestinal segments at their mesenteric border, care being taken to adapt this border of either segment to the corresponding border of the other. This suture is tied and the ends left long. A second temporary suture is passed through the side of the larger segment at the point where the superior border

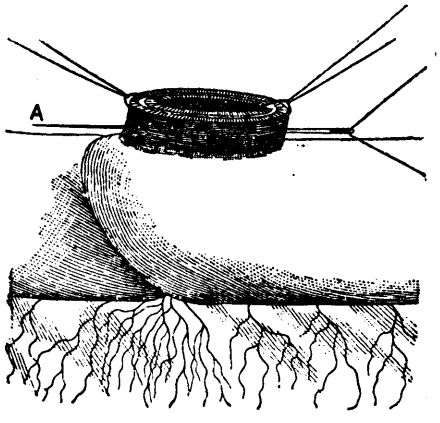

FIG. 8—A shows the needle passed through both sides of the bowel and through all the intestinal coats, and shows that one passage of the needle places two sutures.

of the smaller segment touches it, and through which the suture is also passed through all the coats of the highest free end of the larger segment. The location of these sutures and the accurate adaption of the mesenteric borders of the segments is shown in Fig. 5.

A longitudinal incision is made in the superior borders of the larger segment two inches from the divided gut. The ends of the temporary suture are now drawn through this opening, traction is made, and the free edges of the large segment is inverted and invaginated, and the free edges of the intestine now appear in the longitudinal opening as concentric rings. If the difference of calibre between the two segments is great, a V-shaped portion of the convexity of the larger segment may be removed. This and the method of suturing are shown in Fig. 8.

The intussusception is reduced and the longitudinal slit is closed, as previously described.

Gastro duodenostomy or Gastro-enterostomy.—Prior to the performance of operations on the stomach, the patient is deprived of food for two days and the stomach is cleansed by several

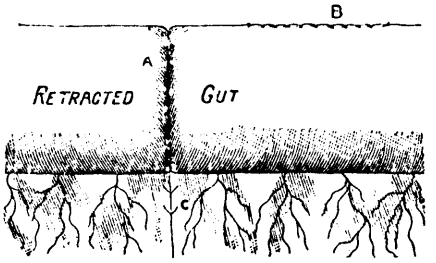

FIG. 9—This figure shows the intestine after the completion of the anastomosis and the reduction of the invagination. A, line marking the point of union between the ends of the bowel, showing that the peritoneal coat is well turned in, and that the sutures and knots are all inside the gut; B, longitudinal slit in the bowel closed by Lembert sutures.

irrigations with an antiseptic solution during this interval. The patient having been anæsthetized and the abdomen opened by means of either a transverse or a longitudinal incision, after pylorectomy, the duodenum, may be united to the stomach by means of this method.

Owing, however, to the partial fixation of the duodneum, this method is only applicable to cases in which the growth is confined to the pylorus. When the disease is extensive, it is better to anastomose the jejunum to the stomach at a point on its greater curvature. Gastro-enterostomy is performed as follows:

A portion of the jejunum, as close to the duodenum as possible, is drawn out of the abdominal cavity, emptied of its contents, and clamped. A portion of the greater curvature of the stomach is also drawn into the wound, and the jejunum is