Adeno-carcinoma of the cecum with extensive involvement of the lymph glands; resection of the diseased bowel. Patient apparently well.

Gyn. No. 12016. Mrs. F. H., admitted to the Johns Hopkins Hospital, April 2, 1905. Discharged, June 1. The patient is a widow 55 years of age, white. Her family and previous histories are not important. She has had two children. Her present trouble began about three years ago with an attack of diarrhœa, loss of weight, and general ill health. During the past two years she has had several attacks of colitis. Repeated examinations of the stools have been negative. Abdominal palpation from time to time did not reveal anything. She has lost about 30 pounds in weight during the last year, but recently has gained some. She is quite anemic; red corpuscles 2,700,000, leucocytes 7,000, hemoglobin 40 per cent. She has had little or no pain but a general sense of soreness at short intervals. In the right iliac fossa Dr. Nathan R. Gorter noticed a slight thickening about three weeks ago. This has been growing since that time. Appetite poor, bowels regular, no bleeding from the bowel at any time. On careful palpation I was able to detect a distinct area of induration in the region of the cecum. This appeared to be 4 cm. in diameter, but was no index to the actual size of the growth.

April 3.—A long incision was made through the right rectus. A carcinoma was found involving the cecum and a small portion of the ileum and about half of the ascending colon. The bowel was freed and clamped above and below. A lateral anastomosis was then done by means of the Moynihan forceps. The free end of the ascending colon was closed, the end of the ileum brought out through the lower angle of the abdominal incision and the abdomen closed.

April 6.—The patient has been unable to retain any nourishment. The nausea continues. The bowels have moved, per rectum, several times. The free end of the ileum that was brought out through the lower angle of the wound is sloughing off to some extent. There is no escape of fecal matter through it.

Nausea and vomiting continued at intervals for a week and there was at times free fecal discharge from the enterostomy wound. The patient gradually improved, and several attempts were made to close the fistulous opening, but the bowel was so much indurated as a result of fecal matter coming over it, that the sutures did not hold. The patient made a very satisfactory recovery and was discharged from the hospital on June 1. There was, however, a slight fecal fistula.

Feb. 28, 1906.—The fistulous tract closed fully three months ago. The patient is in excellent condition and is able to go everywhere. She is in better health than for years. Of course,