

was explored with the Nelaton bullet-probe, which passed outward and somewhat downward and entered the peritoneal cavity about two inches from the surface wound in the direction of the caecum. The bullet itself could be felt externally, beneath the skin and fascia, an inch above and back of the line of the great trochanter of the femur on that side. It had evidently pursued a straight course from the point of entrance, through the abdominal wall, peritoneal cavity, and bony pelvis. Considering the limitation of the injuries to the lateral portion of the abdominal cavity, and the possibility of injury to the caecum, a lateral incision seemed clearly indicated. This was made over the point where the probe was felt to enter the peritoneal cavity, in an oblique direction, very much like the oblique incision in appendicitis, and was extended until about four and a half inches in length. On retracting the wound a rosette-shaped mass was exposed to one and one-half inches in diameter, surrounded by small clots, with a small amount of dark, liquid, fecal matter filling the irregularities of its surface. This mass was the everted mucous membrane of a loop of small intestine, the wall of which had been torn across fully half its circumference, the tear extending slightly up on to the mesentery. The omentum near by had been perforated by the bullet. The main portion of the abdominal cavity was found on inspection to be uncontaminated, and was then packed off on all sides from the injured area with a barrier of laparotomy sponges. The loop of intestine was then raised out of the abdomen, exposed on hot towels, and a clean-cut bullet hole discovered a half-inch away from the main transverse tear, on the same side of the bowel-cylinder, not opposite to it. Evidently the bullet had entered the bowel through the clean-cut hole and made its exit through the large rent, everting the mucous membrane in its passage.

The mucous membrane turned in readily, and the large rent was closed with a continuous Lembert suture of fine silk,

sewed over twice. The perforation near by was closed transversely to the axis of the bowel with the same suture. The stitching brought the two suture lines so closely together that the operator depressed them both, and buried them with a running suture on the serous surface of the bowel at the further sides of the two wounds. This gave additional security to the bowel wall and produced no real tendency to strangulation, although it probably temporarily reduced the caliber of the bowel somewhat. There was little risk of the latter doing harm at a portion of the bowel where the contents are fluid.

The bullet-hole of exit in the parietal peritoneum was found and sutured, and bleeding points in the omental perforation ligated. The upper surface of the caecum showed a contusion only. The loop of intestine and the area of peritoneum which had been exposed to infection were thoroughly sponged off with hot bichloride solution, and the intestine returned to the abdomen. No irrigation was used. The suture lines were painted over with Woelfler's mixture of iodoform and compound tincture benzoin, the protective sponges withdrawn, and the wound closed with the crossed silk-worm gut suture, a single drain of wicking being brought through its lower angle. The bullet was then removed from the buttock through an incision in the skin and fascia.

The patient's recovery was uneventful. For twenty-four hours he was allowed no fluids at all, and for three days received no food. One or two hypodermic injections of morphine on the first day and a morning and evening suppository of two grains of opium for several succeeding days kept him quiet and relieved his hunger. On the fourth day he was given peptonized milk in increasing quantities, and was kept on fluid diet until the tenth day. He never complained of any pain in the abdomen; had no tympanites, and has had no bowel trouble whatever to the present time. The wicking drain was removed on the sixth day, and the bowels were then moved by enema on the