

were numerous vascular adhesions between the parietes of the abdomen and the viscera—notably the liver, spleen, and more especially the omentum. To the communication between the portal and systemic circulations thus established it seemed fair to ascribe the absence of ascites, and it is the *imitation* of this condition that the surgeon attempts by the operative procedures which

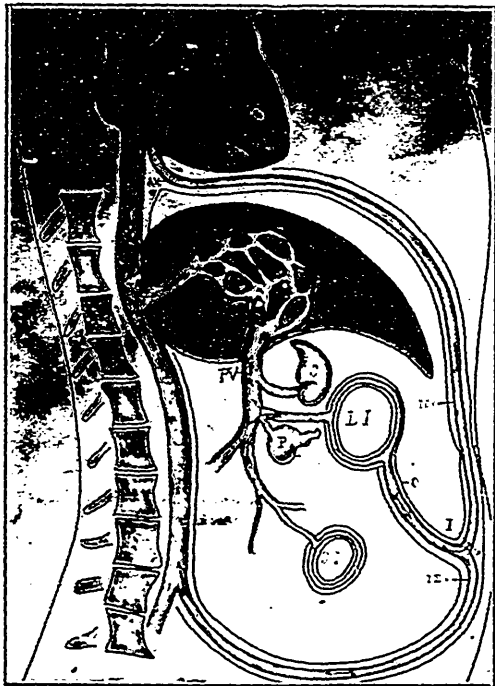


FIG. 1.

Diagrammatic scheme to show the collateral circulation the operation seeks to establish. The arrows show the direction of the current. The viscera drained by the portal vein are sufficiently indicated by the letters on the diagram. *I*, the point of implantation of the omentum into the abdominal wall. (This should have been shown above the umbilicus.) The veins from the omentum (*O*) empty (1) into the intercostal veins (*I.C.V.*), which reach the superior vena cava through the azygos veins (*A.Z.V.*), and (2) into the deep epigastric and lumbar veins (*D.E.V.*), which empty into the inferior vena cava through the lumbar, ilio-lumbar, and common iliac veins, thus avoiding the obstructed passage through the liver.

have been practised. It will of course be observed that such operations are based solely upon the theory that the occurrence of ascites in cirrhosis is due to a purely mechanical cause, viz., the obstruction offered by the diseased liver to the flow through the portal vein. This theory appears to be extremely well founded, and is, I believe, universally accepted to the pointed exclusion