

pendent on infection spreading from the common bile duct or duodenum. It may be asked, if common duct cholelithiasis and pancreatitis are so often associated, why should some cases of common duct obstruction go on for months or years without the pancreas participating?

As I shall hope to show by lantern slides and by clinical evidence, the explanation of the presence or absence of pancreatitis as a complication of cholelithiasis is an anatomical one, though the degree of inflammation when infection does occur, is in a great measure a vital process, dependent on the powers of resistance of the individual.

I must ask you to excuse me for taking you back to the dissecting room for a few minutes, as though doubtless you are well acquainted with the normal anatomy of the pancreas, there may be some who are unacquainted with the great number of variations that may be encountered; which varieties may save a patient from or may commit him to pancreatitis should he be unfortunate enough to suffer from common duct cholelithiasis.

The common bile duct starting by the junction of the cystic and hepatic duct courses along the free border of the lesser omentum associated with the portal vein and hepatic artery, it then passes behind the first portion of the duodenum and soon comes into relation with the pancreas, which it either grooves deeply or passes through or behind, before it pierces the wall of the second part of the duodenum, where it empties into the diverticulum of Vater along with the duct of Wirsung. It may be divided into four portions—

- (a) The supra-duodenal portion.
- (b) The retro-duodenal portion.
- (c) The pancreatic portion.
- (d) The intra-parietal portion.

The latter two only are important for our present purpose.

If the choledochus passes behind and not through the head of the pancreas the duct may escape pressure when the pancreas is congested or otherwise swollen; whereas if it pass through the gland, any congestion or swelling of the pancreas will, by pressing on the common bile duct, bring on jaundice with its various sequelae. Thus is explained to my mind many of the cases of so-called catarrhal jaundice, which may come on as an extension from gastro-duodenal catarrh, or in the course of a pneumonia, or during typhoid fever, influenza and other ailments, and which I believe to be often dependent on catarrhal inflammation of the pancreas leading to pressure on the bile ducts. In some cases I have proved this hypothesis to be correct at operations undertaken for chronic jaundice.