

draining it without, in some instances, even attempting to remove the stones, so desperate has been the condition of the patient. On the other hand cholecystectomy has been done in those cases which presented a fair chance for not only immediate relief of the conditions present, but with the knowledge that complete removal allowed also a better final result. Yet even here the 6 deaths which occurred in acute cases as traced out with one exception, were due to gangrene and perforation with peritonitis. The exception was an acute gall bladder and may be put down as an operative death. This case was one of empyema of the gall bladder in a stout woman operated at the Methodist Episcopal Hospital. The operation was rather readily performed, but there was a more than usually intense inflammation about the cystic duct in which a stone was impacted. The duct was isolated and the usual exploration made without difficulty. The cystic artery was isolated and tied without immediate hemorrhage. The gall bladder was removed in the usual manner. This woman had a myocarditis as many cases of gall bladder disease have and which, as I have shown in a previous paper, is due in many instances to the gall bladder disease. The patient took a good anesthetic, did nicely for forty-eight hours at the end of which time there was a small sharp hemorrhage from the wound depths caused, I believe, by the loosening of the ligature of the cystic artery. This hemorrhage would not have been of itself sufficient to have caused death; in amount it was certainly not more than six or eight ounces, probably

less than eight ounces. However, with this patient's weakened myocardium there ensued immediately after the hemorrhage a dilatation of the heart with death.

#### Comparison of the Operative Mortality in Acute Cholecystitis as Compared With Chronic Cholecystitis.

Of these cases of chronic cholecystitis there were 331 cases with one death; of the acute cases there were 230 cases with 24 deaths of which 12 were cases of gangrene and perforation. Again we cannot compare statistics of this kind. The question is one of the underlying pathology for which the operation is done. There are a certain number of cases which have reached the stage which cannot be saved by any method of operating. This is evidenced also by the fact that of the 48 cases (this does not include those cases in which drainage of the common duct was instituted in addition to cholecystostomy and cholecystectomy. There were five deaths.

In addition to the cases in which a cholecystectomy or a cholecystostomy was done there were 13 cases in which there were 17 secondary operations upon the common duct following a cholecystectomy or cholecystostomy, the secondary operation being necessary either through stricture (two cases), recurrent stone (9 cases) or persistent leakage (2 cases). Of these 17 operations three resulted fatally; two of these deaths were in long persistent sinus cases one was in a case in which the original operation had been done for empyema of the gall bladder and in which at the second operation