RETROSPECT OF SURGERY.

Pelvic Abscess With Special Reference to Rectal Drainage.

IN the *Journal of Surgery, Gynecology and Obstetrics, June*, 1908, is an article on this subject by Dr. Archibald MacLaren, of St. Paul, Minnesota.

He considers that the problem of how to deal with pus in the pelvis has been practically solved, in so far as woman is concerned, that all intraperitoneal pelvic collections of pus, with the exception of tubercular cases, whether from cellular tissue, appendages, uterus, or appendix, can be cured in the vast majority of cases by Vaginal Section.

He bases this view upon an experience of 210 pelvic cases treated by Vaginal Section. In his pus tube cases comparatively very few required a later laparotomy and removal of appendages.

This procedure has been followed by many Surgeons with excellent results in suitable cases. There can be no doubt that Vaginal Section and drainage provides a short, safe operation in many cases taxing but slightly the strength of the patient and avoiding a painful prolonged convalescence.

Dr. Archibald MacLaren then takes up the object of pelvic abscesses in the male, here, to reach the pouch of Douglas, the opening must be made through the anterior rectal wall.

He says the fear of increasing the infection or of further contaminating the abscess cavity has held the Surgeon back and prevented the male being offered the same chance of relief as the female. The great majority of pelvic abscesses in man are due to perforative appendicitis. He considers it important to examine every case of acute appendicitis through the rectum before operation, and the pelvic accumulation is drained at the first operation with a supra-pubic drain, rectal drainage is reserved for cases which develop pelvic accumulations or convalesce badly.

He advises rectal puncture and drainage in another class of cases, in diffuse septic peritonitis of some days standing where any operative procedure from above would take away the only chance of recovery that the patient had.

The author does not consider there is danger from rectal drainage. His procedure is to place the patient in the exaggerated lithotomy position (Pryor's position), after dilating the sphincter ani, the anterior wall of the rectum is exposed by the use of a weighted vaginal speculum—a long bladed retractor is used for the anterior wall to hold the bladder, previously catheterized,, out of the way. The rectum is then cleansed, the bulging anterior wall is located and the abscess is opened with long dissecting forceps or pointed scissors, a dilator is passed along the scissors as a guide and then a 1-4 inch rubber winged tube is passed well up into the cavity.

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Restoration of the Perineal Portion of the Urethra After Destruction by Fracture of the Pelvis.

The *Annals of Surgery*, January, 1909, contains a paper on this subject by Dr. Hugh Cabot, of Boston, Mass.

The restoration of considerable gaps in the urethra, he states, resulting from stricture has long been a difficult problem. Grafting by the Thiersch method, interposition of portions of