CANADA

MEDICAL JOURNAL.

ORIGINAL COMMUNICATIONS.

Gastrotomy for the removal of Ovarian and other Tumors from the Abdominal Cavity. By ROBERT NELSON, M.D., New York.

Continued from page 270.

SPONGE.—There is not the slightest need of a sponge during the cutting part of the operation, nor in the interior of the abdomen in cases of non-adherent tumors. When there are adhesions a sponge may (rarely) be needed to dip away the little blood that sometimes obscures the orifice of a divided arteriole, in order to secure it by torsion or ligature. The sponge ought never to be *rubbed* on the part, for, by doing so, the part becomes irritated, the innervation exalted, and the little plug that had closed the vessel drawn out; these effects create active bleeding after it has ceased. A good operator rarely employs a sponge, and when he does he is careful to make use of a new one, and not one that has been contaminated by use.

THE LONG AND SHORT INCISIONS CONSIDERED.—Early operators employed the "*long incision*;" that is, long enough to admit of the escape of the tumor, and to afford an insight to what they were about, a cut from fifteen to twenty-six inches long. Recent operators, anxious both for improvement and perhaps novelty, deprecate the long incision as being dangerous from its great extent, and advocate a short cut, since, by puncturing one or more cysts, the contents can be evacuated and so much reduced in size, that the sacks may be drawn through a cut of only a few inches long, and then severed outside of the abdomen, without exposing the viscera to the air. This notion has been largely put in practice of late years with results far from favorable.

A short cut is less painful than a long one. This is its only merit,