be an occurrence of great rarity, and the varieties assumed are very considerable. Thus the great trochanter may be broken across, or both trochanters, and the fracture itself may be partly without the capsule. When great deformity exists, however, the existence of extra-capsular fracture may be suspected, and on grasping both hips if there is found greater thickness on the injured side it may be taken as certain that the fracture is at any rate not entirely in the capsule. In all cases of this class of fracture, whether so called extra or intra-capsular, union by bone should be the surgeon's principal aim; and such a result may, in Mr. Hutchinson's opinion, be expected.

GASTROSTOMY FOR CARCINOMATOUS STRICTURE OF THE ŒSOPHAGUS.

BY PROF. S. W. GROSS, PHILADELPHIA.

The first case is a woman, fifty-one years of age, with stricture of the œsophagus, depending on carcinoma, whom you saw five weeks ago. As I found it impossible to pass a bougie, or a soft tube for the purpose of alimentation, and as the trouble in swallowing grew worse and worse, I was finally compelled to open the stomach. Four weeks ago I made an incision parallel with and three-fourths of an inch below the eighth and ninth costal cartilages, down to the peritoneum. The bleeding having been arrested, I then opened the abdominal cavity, and attached the parietal peritoneum to the wall of the stomach with a continued suture of fine black silk, and I also stitched the wall of the stomach to the wall of the abdomen with an outer row of interrupted sutures, so as to afford as much surface as possible for adhesion between the two surfaces of the peritoneum. In this connection, I must say to you that when you insert sutures in the stomach or intestines, you should be careful that they do not penetrate the entire thickness of the viscera. The serous and muscular coats alone should be included, so that the little openings will not admit of the escape of the contents of the organ, through which peritonitis will ensue.

For a few days after the operation the patient was fed by the rectum. Afterward, when the spasm of the œsophagus did not prevent it, she received by the mouth dry champagne, milk, eggs, and chicken soup. At times the spasm was so great that for eighteen or twenty hours she was unable to swallow anything, when we had to return to rectal alimentation. To every three ounces of food given by enema, we added a teaspoonful of the liquor pancreaticus, one-fourth of a grain of carbolic acid and four grains of bicarbonate of sodium. In this way we not only promoted rectal digestion, which is an alkaline digestion, but also prevented the occurrence of tympanites, which was a troublesome symptom for a few days.

Last Thursday, or three weeks after the operation, I made a very small puncture into the stomach and inserted an elastic tube. I bring the patient before you to-day to show you a successful issue after the operation of gastrostomy, which means making a mouth or opening in the stomach for the purpose of nutrition. The incision in the stomach should be small, since with a large opening not only would there be a tendency for the contents of the stomach to escape, making the condition of the patient a dirty one, but the gastric juice would produce troublesome and painful inflammation around the margin of the wound.

I will now show you how the patient receives her food. This gum tube, which is cut off at the point, like the point of a pen, in order to facilitate its introduction, and which equals No. 15 of the French catheter scale, or has a diameter of about three-sixteenths of an inch, is passed into the stomach. To the proximate end of the tube a small glass funnel is attached, into which the warm nourishment is poured. In this way we have provided against death from starvation. There is no necessity for leaving the tube in the stomach, as it can be introduced whenever we desire to feed the patient although for the first few days it was retained, to prevent the closure of the opening.

There are probably a good many persons—we cannot account for tastes—who would rather die than submit to an operation of this description. On the other hand, there are others who prefer to live as long as they possibly can, so that in cases where death is threatened by starvation, gastrostomy may be performed if the patient desires it. The risks of the operation are almost nothing. We have thrown off the old superstitions in regard to the peritoneum. At the present day, after operations involving this membrane, we do not expect the patient to die from peritonisis. The trouble with gastrostomy is, that in the majority of cases the operation has been postponed too long; the patients are run down and unable to rally.

In cases of cicatricial stricture of the œsophagus, resulting from swallowing irritating fluids, as solutions of lye, or strong acids, it is found that the œsophagus becomes very much dilated above the point of stricture, so that we may speak of a complementary stomach in that situation. In cases of this kind, as well as in cases of the one before you, the patient can really enjoy food, which, after having been chewed and swallowed, may be retained in this receptacle for a little while, when it can be regurgitated into a tube, one end of which is in the stomach and the other in the mouth. Dr. Herff, of San Antonio, Texas, informs me that he has under his care a child which has been nourished in this way for four years and a half.

HYDROCECLE, RADICAL CURE.

I propose, to-day, to show you the treatment by