PARTIAL GASTRECTOMY.

If the growth be limited to the body of the stomach, partial gastrectomy may be done by a free circular or elliptical incision, the opening being closed by a continuous chromicised gut suture to the mucous margin and interrupted Lembert sutures to the peritoneal coat, all bleeding points being previously caught up and ligatured.

In many cases, both of sarcoma and cancer, the disease has advanced well into the body of the stomach, and to get it away an extensive partial gastrectomy has to be performed. In Langenbuch's case in 1894 he excised seven-eighths of the stomach, and sutured the pylorus to the small cardiac portion of stomach remaining, the patient making a good recovery. This operation has been repeated a number of times by others, and with considerable success. A list of collected cases of almost complete gastrectomy, in which at least three-fourths of the stomach has been removed for cancer, contains 14 cases with 4 deaths, equal 28.5 per cent. mortality. My colleague Mr. Ward has done three partial gastrectomies; two cases succumbed to the operation, but the first patient doubled her weight in three months.

It seems advisable in these cases to close the gastric openings, and establish a gastro-enterostomy with the remaining portion of the stomach, but the technique will depend on the amount of stomach removed and the state of the parts left.

In concluding my appointed task as Hunterian Professor, I venture to hope that I have succeeded in demonstrating what an important relation surgery bears to diseases of the stomach, both simple and malignant. I have tried to prove my points not only by the relation of some of my own cases, but by statistical evidence gathered from all sources, and, in the latter, my work has been lightened by the kind assistance of Mr. Willmott Evans. I know how wearisome to the average reader is the study of tables of statistics, but I venture to think that they will show not only the actual risk of any special operation, but also how great is the improvement that is taking place in the results of stomach operations generally.

I am proud to be able to say that my last 32 operations on the stomach in my private practice have all recovered, and I can see no reason why the success in this branch of surgery should not be as great as in gall-bladder surgery, which now holds a very different position to what it did when I gave my first paper on the subject before the Clinical Society in 1885, nay, even to what it did when I lectured from this chair on Diseases of the Gall Bladder and Bile Ducts in 1897. In order, however, that surgery may attain its maximum amount of success, we must ask our medical colleagues for earlier diagnoses and earlier surgical consultations, so that if the case is one that can be only cured or relieved by an operation, it may be performed before the recuperative powers have been lost. Then, and only then, shall we attain the ideal.

REFERENCE.

1 *Arch. f. klin. Chir*, 1896, vol. li, p. 484.

CORRECTION.

TREATMENT OF GASTRIC ULCER.

Mr. Mayo Robson points out that in the synopsis of his first lecture, published in the BRITISH MEDICAL JOURNAL for March 10th, 1900, p. 564, there is a printer's error, which, if allowed to pass, would give a wrong impression of the mortality in operations on intractable ulcers of the stomach. The sentence with regard to the mortality in his experience should read. "I find that I have operated on 34 cases of intractable gastric ulcer, with various complications, which in every case must have caused permanent disability, or would have ended fatally, but excluding perforation, hæmorrhage, and cancer, all of which I am considering separately. Of these, 18 operations were done in private with *one* death, giving a mortality of 5.5 per cent., and 16 in hospital with 5 deaths, giving a mortality of 31.2 per cent.; or, if both private and hospital cases be taken together, the mortality is 17.6 per cent."

MEDICAL GRADUATES IN GERMANY.—The total number of degrees in medicine conferred by the German universities in the academic year 1898-99 was 1,050. Of these, Berlin gave 87, Bonn 22, Breslau 30, Erlangen 47, Freiburg-in-Baden 60, Giessen 32, Göttingen 31, Greifswald 10, Halle 23, Heidelberg 32, Jena 34, Kiel 86, Königsberg 24, Leipzig 55, Marburg 28, Munich 134, Rostock 14, Strassburg 43, Tübingen 46, and Würburg 147. The number of degrees awarded by these universities in the previous academic year was 1,208, while the corresponding figure for 1896-97 was 1,268, showing a progressive diminution.

A NEW METHOD OF PERFORMING PERINEAL PROSTATECTOMY.

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THE vast majority of cases of senile enlargement of the prostate are, in my opinion, best treated by careful, cleanly, and judicious catheterism. There is, however, a minority in which a surgical operation of some kind is advisable, and a still smaller proportion in which an operation is imperative to save the patient's life or ameliorate his sufferings. I propose this evening introducing to your notice, by means of an illustrative case from practice, a new method of removing certain forms of enlarged prostate through the perineum. In order to clear the way for your appreciation of this procedure, I shall classify briefly the various recognised surgical operations for the disease under consideration as follows:

1. *Palliative operations*, undertaken when there is cystitis or some other complication present, rendering catheterism impossible or extremely difficult.

(1) Suprapubic cystotomy, with temporary or permanent drainage through a retained tube.

(2) Perineal urethrotomy, with temporary or permanent drainage.

2. *Operations undertaken for the purpose of inducing permament atrophy or shrinkage of the prostate.*

(1) Castration.

(2) Vasectomy.

3. *Radical operations*, which aim at removing a part or the whole of the obstructing portion of the gland:

(1) Division of a median obstruction by means of the galvano-cautery introduced through the urethra (Bottini) or through a perineal urethrotomy (Wishard).

(2) Removal of a median growth through a perineal opening in the urethra by cutting forceps or other instrument.

(3) Suprapubic prostatectomy (McGill), suitable only for enlarged middle lobe, ring of hypertrophied tissue round the orifice of the urethra, or enlargements of the lateral lobes projecting into the bladder.

(4) Perineal prostatectomy by Dittel's method, which consists in removing a wedge-shaped portion from the under surface of one or both lateral lobes, through an incision extending from the median raphe round the sphincter ani to the tip of the coccyx, the urethra and bladder being left intact.

(5) Nicoll's operation, which is similar to this last, only that a preliminary suprapubic cystotomy is performed, for the purpose of introducing a finger into the bladder, with a view to pushing the prostatic tumour into the perineal wound, thus facilitating its removal.

In the operation that I am about to describe advantage is taken of the perineal incision recommended by Dittel, but Nicoll's object is attained by a much less heroic and dangerous proceeding than suprapubic cystotomy—namely, by a preliminary perineal opening into the urethra.

A gentleman, aged 59, sent by Dr. Richard Heath, of St. Leonards-on-Sea, consulted me on October 11th, 1889, suffering from the following symptoms: Increased frequency of micturition, averaging about ten or eleven times by day and seven or eight times by night; difficulty in starting the stream, necessitating much straining to effect this; he finds that when he places his hand on the hypogastric region and pushes the abdomen upwards the stream starts more readily. Diminished force of the stream. Dribbling at the end of micturition. Sometimes the stream is intermittent. The urine is clear, as a rule; some eight months ago it was very dark in colour, but patient cannot say if it contained blood. Pain and discomfort behind the glans during micturition, and discomfort above the pubes before the act. The symptoms have existed three years, and have been gradually growing worse. At first they were more troublesome at night, but latterly they have been as bad in the daytime. They are increased by exercise, particularly in walking.

I sounded the patient, but could find no stone. There was some difficulty in passing the instrument over the enlarged prostate. Residual urine, 4½ ounces; trace of albumen. *Per rectum* there was a tumour felt in the right side of the prostate, twice the size of a walnut, very dense throughout, with a nodule of intense hardness, which was very painful on pressure. This nodule felt like a stone embedded in the prostate. The left lobe of the prostate was scarcely enlarged, and quite soft.

On the 17th I made a cystoscopic examination, the patient being anæsthetised by Dr. Dudley Buxton, and Mr. Victor Horsley being present in consultation. The right lobe of the prostate was seen to be enlarged and projecting into the bladder, the size of a walnut, irregularly nodulated, and of a dark brown colour. The left lobe was not visible in the bladder, which, generally, presented a healthy appearance, except that the mucous membrane was trabeculated, the result of constant straining and back-