James Luke was born at Exeter on December 12, 1799, the third son of a merchant and banker. At the age of 17, and upon the death of his father, he became attached to John Andrews of the London Hospital. He attended the lectures and three years later was appointed Demonstrator of Anatomy. In 1827 he was elected Assistant Surgeon and ultimately achieved the position of Consulting Surgeon in 1861.

At the Royal College of Surgeons, Luke was a member of the Council for 20 years, and was President in 1853 and again in 1862. He was a Hunterian Orator in 1852.

Luke was a tall man and was said to harbor an irascible temper. He was scrupulously careful about the cleanliness of his instruments, a peculiarity which was rather unique during his day. A rapid surgeon, he once amputated at the hip and removed the limb in 27 seconds. He was particularly interested in the treatment of cleft palate, fractures, and the repair of groin hernias. In this Classic article, Luke describes his approach to the management of colonic obstruction. He is believed to have been the first surgeon to perform a pararectus incision, bringing the bowel out in the neighborhood of the rectus muscle. He mentions in the article that this appears to be the preferred approach when the site of the obstruction is not clearly delineated. This is in contrast to the operation advocated by Amussat (Dis Colon Rectum 1983; 26: 483-487).

Luke retired to Buckinghamshire, where he lived as a country gentleman and employed himself in woodcarving until his death on August 15, 1881.


The interest attached usually to cases of Intestinal Obstruction arising out of the obscurities by which they are attended, and the treatment of them by operation, induces me to believe, that the following may not be unacceptable to the Society. Under that impression, and with the intention of placing it in connection with those

A CASE OF
OBSTRUCTION OF THE COLON,
RELIEVED BY AN OPERATION PERFORMED AT THE GROIN.

BY
JAMES LUKE,
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LECTURER ON SURGERY, AND
MEMBER OF THE COUNCIL OF THE
ROYAL COLLEGE OF SURGERY OF ENGLAND
ETC., ETC.

COMMUNICATED BY
JAMES MONCRIEFF ARNOTT, F.R.S.

Received April 25th.—Read June 24th, 1851.
other cases of intestinal obstruction, of which its members are already cognisant, I have prepared a report for the Society's consideration.

The subject of my report is a man 60 years of age, by profession a wine cooper; thin, and of temperate habits. He applied at my residence Dec. 16th, 1850, complaining of being generally unwell. He attributed his ailment to a cold, which he thought he had taken about five weeks previously, by remaining for a considerable time in a damp cellar. He did not complain of any pain, but his countenance was depressed; his eyes sallow, and his tongue coated. There was not any increased frequency of pulse, nor increased heat of skin. Upon inquiry, he stated that his bowels were confined, and that lately he had some difficulty in getting medicine to act upon them. His complaints were considered to be the result of ordinary constipation, and two pills containing grs. x of Pil. Rhei Comp. were ordered to be taken immediately.

17th. After the pills were taken, there was one small evacuation of lumpy faeces, but from this he did not experience any feeling of relief. He was ordered to take 3 of Castor Oil, which he was to repeat provided the bowels should not be opened before the evening.

18th. By the continued mastication of bread (as instructed), the Castor Oil remained on the stomach four hours and was then rejected. In the evening he took 3 ss of Castor Oil, which was also rejected. This morning he feels worse, his bowels have not been relieved, and he vomits everything taken into the stomach. He complains of pain at the praecordia, and also in the neighborhood of the the cæcum, in which latter situation the abdomen is somewhat tumid, but in neither situation is the pain increased by the pressure of the hand. The skin is hot, the pulse quick, and the tongue thickly coated. The urine is scanty, and on cooling is very turbid from the deposit of lithates. He feels so unwell that he is not enabled to go to business, which he has done up to yesterday.

Ordered a blister, to be applied to the pit of the stomach, the surface of which is to be dressed with lint dipped in R. Opii. He is to take one grain of Calomel with a quarter of a grain of the Extract of Colocynth with two grains of Calomel.

21st. I requested Dr. Munk to meet me in consultation. The injection had brought away a small quantity of hardened faeces, but the medicine had not produced any evacuation from the bowels. The abdomen has become more tumid and tympanitic, and the sensation of air passing from one part of the abdomen to another, has frequently been experienced by the patient. There is little or no pain, but there is a feeling of distension. He feels weaker, and is evidently more prostrate, and the hiccough is occasionally, but not constantly, very troublesome. Both Dr. Munk and myself think there are strong grounds for supposing that obstruction exists in the bowels, but that at present it is premature to adopt that opinion definitively until further trial has been given to medicine. By way of exploration, the oesophagus tube was passed into the rectum. When introduced to the extent of twelve inches, its further progress was obstructed, and it could not be passed beyond that limit. Warm water injected through the tube, returned immediately without bringing away any faeces.

Ordered one grain of Aloes, and half a grain of Calomel, every hour. Two drops of Croton Oil on bread to be used as a suppository.

22d. There has not been any relief from the bowels, and the patient is evidently worse. The abdomen is more distended, and the pulse has become irregular and weak.

Ordered to continue the pills.

23d. Symptoms are still worse than yesterday, and the patient has passed a very bad night. There have not been any evacuations from the bowels, and the distension of the abdomen has much increased. The hiccough continues, but the sickness has been stayed; the pulse is very irregular and weak; the countenance is pinched. With symptoms progressively becoming more severe, without reasonable grounds for hope of relief from the further administration of medicine, Dr. Munk and myself thought that the time had arrived when it was our duty to propose operative interference, under the idea that the obstruction of the bowel which, on the 21st, we strongly suspected, did really exist, and was irremediable by other means.

Before adopting that conclusion, we were fully aware of the uncertainties generally attendant upon abdominal section in such cases, and of the undesirableness of such a proceeding, except with the presence of some pretty clear indication of the seat of obstruction, by which our endeav-