

is the loose areolar tissue; this forms the highway of dissemination much oftener than the veins or lymphatics. This is particularly true of phlegmasia alba dolens, and to appreciate fully the pathology we must take in the entire field of pathological invasion.

The starting point or nidus of this affection corresponds with the organ or tissue primarily affected, and this I wish to emphasize, for it will be the means of clearing up the vast amount of speculative literature on this subject, and reconcile the different anatomical reports which have been recorded in good faith by a host of honest investigators. In the great majority of cases of phlegmasia dolens the nidus cannot be detected, but a cellulitis in the pelvic realm, partial or circumscribed, can always be detected; this is either perivaginal or peri-uterine, and then branching out along the course of the vessels and between the folds of the broad ligament towards the latter aspect of the pelvis.

The course of the pathological process is manifestly different in these instances, where the disease originates from cellulitis, than when it is traced to an endometritis, a metritis, or a uterine phlebitis. Early in the disease there is a rise of temperature ushered in by a pronounced chill. The most prominent symptom is pain referable to the iliac region running down the thigh along the course of the great vessels and nerves, sometimes increasing in the popliteal space, and then again being felt more in the calf of the affected limb; this is due to pressure on the nerves from the inflammatory induration in the areolar tissue, and an irritation of the neurolemma. The veins are as yet not compromised, hence in the early stages of the disease there is no oedematous infiltration, but an unusual hardness can be distinctly felt along the course of the large veins, and sometimes a redness which is due to the inflammatory process in the cellular tissue around the trunks of the large vessels and nerves. In patients where the disease runs a short

abortive course, the swelling or cedema of the limb will show itself after all acute symptoms have subsided, perhaps a week or two after apparent recovery; this is due to cicatrization of the inflammatory products around the veins, which comprises the lumen and interferes with the flow of blood within them. In a large proportion of cases, the inflammation continues and increases in extent, the subcutaneous cellular tissue may become first involved, but sooner or later the inflammation may spread between all the muscles of the leg; a periphlebitis is also added to the process—by this I mean an inflammation of the connective tissue around or about the vein including the sheath of the vessels. These structures are frequently inflamed without the walls of the vein being in the least affected; this, however, does not apply to the smaller veins which are entirely composed of connective tissue and epithelium and are much sooner complicated.

The cedema of the limb at this stage develops gradually, although sometimes quite suddenly; the smaller veins now become either compressed from inflammatory exudation, or participate in the inflammation, which coagulates the blood in them; it is the function of the intima to preserve the fluidity of the fibrin, but as soon as the internal coat of the vessel becomes altered by inflammation this physiological property is destroyed and the clotting of the blood (thrombosis) will occur; it is only necessary for the inflammation to continue unchecked for the larger veins to become similarly diseased with results much more dangerous and far-reaching.

It becomes absolutely necessary to locate at the earliest opportunity the starting point of the infection as between the uterine cavity or the vaginal canal, for this will give us positive information as to the *modus operandi* of local disinfection; in other words, whether the irritation shall be uterine or vaginal or neither. The steps to assure the differentiation must be divided into two separate stages for the obvious