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HIGH TEMPERATURE AND GLYCOSURIA IN THE
PUERPERAL STATE, THE RESULT OF
NERVOUS INFLUENCES.

BY J. C. CAMERON, M.D.,
Professor of Obstetrics, McGill University.

It has long been claimed by obstetricians that nervous influences alone are sufficient at times to cause elevation of temperature in puerperal women. This claim has been stoutly denied by others, who insist that careful search would reveal some other cause underlying the nervous disturbance, which should be properly credited with the rise of temperature. In spite of such objections, it seems now pretty well determined that nervous high temperatures may and do occur. I am not aware, however, that glycosuria traceable directly to nervous excitement has ever been observed in the puerperal state. The following cases are unique, as far as I can ascertain, and suggest many interesting questions physiological as well as pathological:—

CASE I.—A. D., aged 22, II para, was admitted into the Montreal Maternity on 10th October, 1888, in active labor. Her family history is very indefinite. She lost her father and mother in early childhood, was brought up in an English institution for training servants, and sent out to this country. She first menstruated at the age of 15; the flow recurred regularly every three weeks, was painless, and lasted usually seven or eight days. Her first child was born in May, 1886: there was

considerable post-partum hemorrhage. Shortly afterwards she had an attack of typhoid fever. The history of the present pregnancy is uneventful, except that she suffered a good deal from morning sickness during the first five months, and had gushes of blood every week or two. Her matrimonial relations have not been happy; she was deserted by her husband and had to seek refuge in the Sheltering Home some time before confinement. The authorities of that institution report her as being capricious and violent-tempered, subject to outbreaks of ungovernable passion on slight provocation.

On admission into the Maternity there was no œdema of feet or ankles; the bowels were regular, but micturition was frequent and painful. The urine contained neither albumen nor sugar, and showed a specific gravity of 1012. Labor was short and uneventful, lasting altogether six and one-half hours. There was slight post-partem hemorrhage; a few calcareous plates were found on the maternal face of the placenta. Convalescence went on normally for the first week; but about the seventh day she was noticed to be fretting about something, which turned out subsequently to be an expected letter that failed to arrive. On the morning of the eighth day (Oct. 17th) the temperature was 99.4°; it rose in the evening to 100.6°, and next morning to 102.2°. The urine was examined and showed a trace of sugar. Lactation had then been well established for several days, the tongue was clean, the lochia normal, the urine not increased in amount, and no marked thirst. The diet had been chiefly milk, gruel, broth, and light farinaceous puddings. The temperature rose during waking hours and fell to the normal during sleep, while the pulse did not show any corresponding change. The sugar increased to five per cent. and the specific gravity to 1028. As the temperature subsided the sugar slowly diminished, and by the eighteenth day (Oct. 27) had entirely disappeared. She was then preparing to leave hospital; but on making my daily visit I requested her to remain a few days longer. She thereupon began again to cry and fret, and although her temperature did not rise, sugar reappeared in the urine and persisted for a week. On 2nd November more fretting ran up

the temperature for a couple of days, but sugar did not return, and a few days later she was discharged in fairly good condition. When the temperature ran up and sugar appeared, the flow of milk decreased to return again after the temperature became normal.

In this case we can quite exclude the causes which ordinarily produce rise of temperature in the puerperal state, such as septic trouble, local mischief, disordered lactation, sore nipples, constipation and digestive disorders. The range of temperature was quite remarkable, rising during waking hours and falling during sleep without corresponding variation in pulse, the tongue being meanwhile fairly clean, the appetite moderate, the bowels regular, the general appearance good, and the lochia normal. Aconite, quinine, antipyrin had no appreciable effect; the only remedies which seemed to do any good were potas. bromid. and hypodermic injections of morphia. That the high temperature caused the glycosuria, or that glycosuria caused the elevation of temperature, is not at all probable; both conditions seem rather to have been due to some peculiar nervous influence. Sugar has frequently been found in the urine of puerperal women during lactation. M. Blot was the first to claim that its presence is then physiological. He found it in about half the cases of pregnancy which came under his observation, beginning to appear coincidentally with the milk, increasing in quantity as the milk increased, decreasing as it decreased, and finally disappearing when lactation ended. M. Leconte, on the other hand, disputed Blot's conclusions, denied the existence normally of sugar in the urine of nursing women, and said that Blot mistook uric acid for sugar. Beneke and others have confirmed Blot's observations. When sugar is found in the urine of nursing women, it is *lactose*, not *glucose*. In this case sugar was not found till after lactation had been established for several days; it increased as the temperature rose and the milk became scanty, and decreased when the temperature fell and the milk became more abundant. Lactation had evidently nothing to do with the appearance of sugar. That the nervous element played an important part in producing glycosuria is readily seen by a

glance at the accompanying chart. When nervous phenomena began sugar appeared; as they became more intense the sugar increased; when they disappeared the sugar also disappeared. The sugar in this case was *glucose*, not *lactose*; the clinical analyses made at the hospital were confirmed by Dr. R. F. Ruttan in the chemical laboratory of McGill University. It is singular that antipyrin, which is usually so effectual in high temperatures of nervous origin, seemed to be powerless in this case.

DATE.	Time of Obs.		Temp.	Pulse.	Sp. gr. of Urine.	Percentage of Sugar.
	A.M.	P.M.				
October 10.....	8	.....	98.6	85	1012	00
" 11.....	8	7	97.8	80	.....	.....
" 12.....	8	7	99.2	80	.....	.....
" 13.....	8	7	98.4	75	.....	.....
" 14.....	8	7	98.4	75	.....	.....
" 15.....	8	7	97.8	73	.....	.....
" 16.....	8	7	98.4	80	.....	.....
" 17.....	8	7	97.6	73	.....	.....
" 18.....	8	7	98.4	80	.....	.....
" 19.....	8	7	97.8	73	.....	.....
" 20.....	8	7	98.4	70	.....	.....
" 21.....	8	7	98.4	72	.....	.....
" 22.....	8	7	98.4	75	.....	.....
" 23.....	8	7	98.4	80	.....	.....
" 24.....	8	7	98.4	73	.....	.....
" 25.....	8	7	98.6	83	.....	.....
" 26.....	8	7	99.4	85	1018	Trace
" 27.....	8	7	100.4	105	.....	.....
" 28.....	12	.....	103.2	100	.....	.....
" 29.....	4	.....	98.6	95	.....	.....
" 30.....	9	.....	102.2	105	1020	Small Amount.
" 31.....	.....	12	101.2	105	.....	.....
" 1.....	.....	7	104.2	105	.....	.....
" 2.....	.....	9	105.2	105	.....	.....
" 3.....	.....	11	102	95	.....	.....
" 4.....	.....	12	103.2	95	.....	.....
" 5.....	.....	.....	103.2	100	.....	.....
" 6.....	4	.....	103.2	100	.....	.....
" 7.....	8	.....	103.2	100	.....	.....
" 8.....	.....	1	105.2	102	.....	.....
" 9.....	.....	2	104.2	104	.....	.....
" 10.....	.....	3	104.4	102	.....	.....
" 11.....	.....	5	104.6	100	1020	2%
" 12.....	.....	6	104.4	110	.....	.....
" 13.....	.....	8	104.6	110	.....	.....
" 14.....	.....	10	105.4	104	.....	.....
" 15.....	.....	11	102.4	100	.....	.....
" 16.....	.....	12	103.4	98	.....	.....
" 17.....	1	.....	100.2	95	.....	.....
" 18.....	2	.....	100.2	95	.....	.....
" 19.....	4	.....	98.6	95	.....	.....
" 20.....	6	.....	100.2	100	.....	.....
" 21.....	8	.....	100.2	106	.....	.....
" 22.....	9	.....	103.4	104	1025	5%
" 23.....	.....	1	104.2	104	.....	.....
" 24.....	.....	5	103.6	104	.....	.....
" 25.....	.....	9	103.2	103	.....	.....
" 26.....	.....	10	104.2	99	.....	.....
" 27.....	.....	11	100.6	102	.....	.....
" 28.....	.....	12	103.2	100	.....	.....

October 22.....	2	.....	100.2	100	.....	.....
	4	.....	102.2	94	.....	.....
	6	.....	103.2	96	.....	.....
	9	.....	101.2	98	.....	.....
		1	101.2	100	1028	1%
		3	101.2	98	.....	.....
		5	100.4	96	.....	.....
		8	101.2	99	.....	.....
		11	100.2	100	.....	.....
" 23.....	1	.....	100.4	100	.....	.....
	3	.....	100.6	98	.....	.....
	5	.....	98.6	95	.....	.....
	7	.....	98.6	95	.....	.....
	9	.....	98.2	90	.....	.....
	12	.....	99.2	95	1025	3%
		4	100.6	100	.....	.....
		6	101.6	100	.....	.....
" 24.....		8	102.8	105	.....	.....
	8	.....	98.6	90	1025	Small Amount
" 25.....		7	102.6	99	.....	Small Amount
	8	.....	102.2	103	1025	Small Amount
" 26.....		7	102.2	105	.....	.....
	8	.....	98.6	73	.....	.....
" 27.....		7	98.8	73	1022	Trace
	8	.....	98	70	.....	.....
" 28.....		7	98.6	85	1022	None
	8	.....	97.8	70	.....	.....
" 29.....		7	98.6	80	1025	Trace
	8	.....	97.8	70	.....	.....
" 30.....		7	98	73	1025	1%
	8	.....	98.6	70	.....	.....
" 31.....		7	98.6	73	1025	1%
	8	.....	98.6	70	.....	.....
v ember 1.....	8	.....	97.6	75	1020	1½%
	8	.....	97.4	70	.....	.....
" 2.....		7	97.8	73	1022	1½%
	8	.....	97.6	80	.....	.....
" 3.....		7	97.6	76	1018	Trace
	8	.....	102.6	100	.....	.....
		7	101.6	110	1015	Trace
" 4.....	3	.....	102.4	100	.....	.....
	5	.....	101.2	95	.....	.....
	6	.....	100.8	95	1015	None
	8	.....	101.2	85	.....	.....
		5	97.6	70	.....	.....
" 5.....	8	.....	96.6	75	1018	None

Amount of urine passed daily, 40 to 45 oz.

CASE II.—A. B., aged 37, V para; was admitted into the Montreal Maternity in October, 1888. Her history is decidedly neurotic. Her father and mother are living; the father healthy, but the mother subject to neuralgia and severe headache. She herself has suffered all her life from neuralgia and headache; her children are all epileptic. She began to menstruate at 18, her periods being regular and painless. She married when 22, and subsequently bore four children at full term; no miscarriages. With her *first* child (1863) labor and convalescence were normal. After her *second* (1865) she suffered from proclivencia, which required operation. After her *third* (1877) the proclivencia was greater and accompanied by obstinate leucorrhœa; a second

perineal operation was performed. With her *fourth* (1885) labor lasted upwards of sixty hours, and was finally terminated with forceps. From the time labor became active till about three days after confinement she was delirious, with a few short lucid intervals. The severe lacerations of both cervix and perineum which resulted were repaired about thirteen months afterwards. All through the present pregnancy she has suffered severely from morning-sickness, and since June has been at times much troubled with œdema of feet and legs. Micturition has latterly been frequent and painful. During the past two months she has had a number of "fits," probably epileptic. The attacks always came early in the morning, before she was out of bed; she was generally found lying on the floor insensible, and consciousness did not usually return for about an hour. She remembered nothing of the attack, but always felt very sore and tired afterwards. During the last three months of pregnancy false labor pains have caused her much discomfort; for weeks she expected confinement daily, and on several occasions spent the night in the labor-ward. These pains were so constant and distressing that she could get very little sleep; during her last week a chloral draught was necessary every night. The urine contained neither sugar nor albumen. Labor proper began December 2nd, about 5 P.M.; the pains were strong and frequent, but labor progressed very slowly. The scar-tissue of the cervix would not yield and the anterior lip capped over the advancing head. Repeated hot vaginal douches and chloral draughts had but little effect. About 5 A.M. the following day nervous symptoms began. She had delusions, chiefly of vision; began to talk and sing, and at times became maniacal, threatening to throw herself out of the window, etc. The pulse ran up to 110, vomiting set in, and the head symptoms became gradually worse. A hypodermic of Liq. Op. Sedativ. and a very hot douche seemed to give some relief; suddenly a violent pain tore the head through the cervix and the child was delivered at 10 A.M. The head symptoms immediately declined and the pulse became quieter. At 5 P.M. 25 oz. of urine were drawn off with a catheter, and on examination it was found to have a spe-

cific gravity of 1015 and to contain six per cent of sugar, but no albumen. A vaginal examination showed the cervix to be deeply lacerated. With the exception of the glycosuria the convalescence was normal, and the patient was discharged on the fifteenth day. The quantity of urine passed daily ranged from forty to fifty ounces, and showed a sp. gr. of 1015 to 1018. Micturition was not frequent, not more than three times daily. There was no elevation of temperature throughout. During the first week she complained of excessive thirst, and occasionally of hunger, palpitation, and tendency to vomit.

Sugar was found present in the following quantities :

December	3rd—	6 per cent.
“	4th—	8 “
“	5th—	6 “
“	6th—	3 “
“	7th—	2 “
“	8th—	2 “
“	9th—	1 “
“	10th—	A trace.

A subsequent examination of the urine showed the presence of some albumen, but no sugar. Lactation was established on the third day. It will be noticed that sugar was found in large amount a few hours after the severe nervous strain of labor, and gradually diminished as convalescence progressed.

PROGRESSIVE FACIAL HEMIATROPHY.

BY JAMES STEWART, M.D.,

Professor of Pharmacology and Therapeutics, McGill University.

(Read before the *Medico-Chirurgical Society of Montreal*.)

The patient, the subject of the above trouble, is a boy fourteen years of age. It was about two years ago that his parents noticed a difference between the two sides of the face. This difference, they considered, was owing to a swelling of the right side. After some time they consulted their family physician, who told them that the difference was owing to wasting of the left side and not to swelling of the right.

The previous and recent general health of the boy has been excellent. Eighteen months before any change was noticed he

was severely frost-bitten in the left cheek and ear. There is no history obtainable of any wasting affection in any other members of the family. The striking difference between the two sides of the face is illustrated by the accompanying cut. The atrophy,



it will be noticed, affects only those portions of the face innervated by the two lower divisions of the fifth nerve. The skin, the subcutaneous tissues, the muscles and the bones are all atrophied. The muscles have, however, suffered less than any of the other structures. The skin of the affected part is felt to be considerably thinner than on the healthy side. It is also

of a slightly paler hue. The fine hairs covering the face are finer and smoother than those on the corresponding parts of the opposite side. The lower jaw is not only thinner on the left side, but also shorter. There is also a distinct atrophy of the bones of the upper jaw. The teeth appear to be as well developed on the left as on the right side. It is difficult to estimate the degree of pure muscular wasting. It is certainly not very great. The muscles act to voluntary impulses apparently as well on one side as the other. The following is the result of repeated electrical examinations :

The faradic irritability of the facial nerve is normal, and equal on the two sides.

The response to faradization of the muscles of the left side is as well marked as it is on the right (normal side).

The response to galvanization of the left facial nerve is not different from that of the right.

The galvanization of the muscles of the left face show, however, a readier response than do those of the right.

Contraction is obtained on the left from $1\frac{1}{2}$ M A, while it takes 3 M A to bring about a similar contraction on the right.

There is no change in the normal formula, the $KSZ < AOZ$ and ASZ .

There is no increase in the mechanical irritability of the muscles or facial nerve on the left side.

Owing to atrophy of the turbinated bones on the left side, the left nostril is wider than the right.

There is distinct atrophy of the left half of the tongue, more marked towards its anterior part.

The arches of the palate are normally and equally developed. There is no deviation of the uvula.

There is no affection of any of the special senses. He sees, hears, smells and tastes as well on the left side as he does on the right. There is no disturbance of either superficial or deep sensation on the atrophic side.

Repeated measurements with a surface thermometer and a differential calorimeter failed to elicit any difference in the temperature of the two sides of the face. There is no difference to

be detected in the size of the globe of the eye, neither is there any retraction or other change noticeable. The left disc is normal. The secretion of saliva and of tears does not seem to be lessened on the left side. There is no atrophy to be detected elsewhere.

REMARKS.

Until recently it was supposed by some that facial hemiatrophy was caused by disease of the sympathetic, while others looked upon it as due to disease of the fifth nerve. Mendel (*Neurol. Centralblatt*, July 15, 1888) has reported the results of a very thorough examination he made of the fifth nerve in a case of facial hemiatrophy, of many years standing, in a woman. This patient had also atrophy in the region innervated by the left musculo-spiral nerve. She died from phthisis. Her case was first described by Romberg, and more recently by Virchow. The symptoms were those of a typical left facial hemiatrophy. Mendel found all the branches of the left fifth, from their origin to their termination, the seat of a proliferating interstitial neuritis. A marked and similar difference was found in the size of the right and left descending roots of the fifth, and also in the substantia ferruginea, the alleged nucleus of the so-called trophic root of the fifth. The examination in this case proves conclusively that in at least certain cases of facial hemiatrophy we have to do with a neuritis of the fifth. In the case here reported it is very probable that the frostbite was the cause, but whether the first changes are nuclear or peripheral it is impossible to determine. Mendel labors to prove the possibility of a neuritis inducing solely trophic changes without any impairment of motion or sensation. Before the subject is clear, our knowledge must be much extended.

Retrospect Department.

QUARTERLY RETROSPECT OF GYNÆCOLOGY.

PREPARED BY T. JOHNSON-ALLOWAY, M.D.,

Instructor in Gynæcology, McGill University; Assistant Surgeon to the Montreal General Hospital; Gynæcologist to the Montreal Dispensary.

Alexander's Operation for Shortening the Round Ligaments (twenty-three cases), by Dr. Paul F. Mundé of New York, is the subject of a paper of very great interest and value, appearing in the *American Journal of Obstetrics*, November 1888. This operation is of special interest to the writer from the fact that he reported a successful case some three years ago (*Canada Med. and Surg. Journal*), the patient being a lady who had been an invalid for years, and had received no benefit from other forms of treatment. This lady remains perfectly well and active to the present day, her uterus being held in the anteverted position. Several of my friends saw that there was a useful field for this operation in the relief of a class of most intractable cases, and in a short time I had a number of similar cases in view for operation. Suddenly, however, there appeared on the scene a case which put an end for the time to our aspirations. This was the case of a young widowed English-woman who had been operated upon unsuccessfully, leaving as the result of the operation an enormous inguinal hernia. The uterus was still retro-displaced, and the hernial blemish rendered this poor woman an object of very great misery. She went the rounds of all our clinics, praying every one she consulted to operate upon her for the relief of the hernia, but the grave character of the case was such that I do not think she succeeded so far as I am aware. The moral effect this case had upon the professional mind was such that many became prejudiced against the procedure, and spoke in society debates of the horrors in the shape of herniæ and fatal results from septic peritonitis which awaited those who were unwary enough to undertake the operation. About this time Dr. Mundé reported six cases, in some of which he failed to find the ligaments, and said he was confident the structures were not there, or that they were so rudi-

mentary and attenuated that it was not possible to make any use of them. After this publication from so well known and able a surgeon there started a hue and cry that the ligaments only existed in women that had borne a large number of children, and who were the subjects of advanced uterine hyperplasia and hypertrophy of the round ligaments. During discussions at the British Gynæcological Society Mr. Lawson Tait and some others spoke against the procedure, saying that it was unscientific in principal and that he would not perform it. In Germany it has been altogether pooh-poohed, being, as it were, altogether too refined and delicate a procedure to suit the heroic tendencies of the average German surgeon—a feeling which is solely the outcome of an utter disregard for human life and a knowledge of their own personal safety. Ventral fixation or hysterorrhaphy has been freely performed in Germany for retro-displacements and prolapse, instead of Alexander's operation. It is, however, well known that the indications for these two operations are separate and distinct. Hysterorrhaphy is applicable to those cases only where old inflammatory remnants have caused the uterus and annexa to be fixed in their displaced position; and these are the very cases where it is distinctly taught that Alexander's operation is inapplicable. We hear that a certain Western surgeon is doing a large number of Alexander's operations without an anæsthetic, simply using hypodermics of cocaine. This use of cocaine cannot be too strongly condemned, and may be looked upon as a species of surgical gymnastics incompatible with scientific work. In a majority of cases, as Dr. Mundé shows, plastic operations require to be done on the cervix and vagina at the same sitting, and this fact alone would tend to show how absurd the employment of a local anæsthetic would be. In Dr. Mundé's paper he proposes to discuss Alexander's operation under three headings:

1. Can the round ligaments always be easily found, drawn out, and the uterus thus be elevated and anteverted?

3. In which form of displacement of the uterus is the operation indicated, justifiable, and likely to be followed by complete and lasting relief?

3. Is the elevation and suspension of the uterus by shortening the round ligaments alone sufficient, and is the result permanent? Or does the latter operation require an additional one on the vagina or pelvic floor to insure a complete and enduring recovery?

In answering the first of these propositions, Dr. Munde states that after several trials and some reflection he has come to the conclusion that his great difficulty in the beginning of his experience was due to a too great observance of detail in the minute anatomy of the part, and that when he learned to cut down boldly from the spine of the pubis, reaching the ring with one stroke, he found no difficulty of discovering the ligaments. This method of Munde's is quite natural, as we can easily understand how a careful and prolonged dissection through the overlying parts would cause the ligament to be pulled to one side by a retractor or forceps, or parts taken up and pulled upon, and in this way made to look like the ligament to an inexperienced operator. "As soon as the ligament on each side has been found, the uterus is anteverted by a repositor. The ligaments are sutured with silk-worm gut into the wound and the latter removed in fourteen days. Before closing the last suture a split-bone drain is inserted into the lower angle of the wound, which is then dressed with sublimate gauze and a spica bandage applied. After the patient assumes the erect posture a Hodge pessary is worn for six months.

Can the uterus always be elevated and anteverted by drawing upon the round ligaments? Dr. Mundé answers this question decidedly in the affirmative, and requires but fifteen minutes to accomplish the operation on each side.

In answer to the second proposition, the author mentions long-standing retroversion or retroflexion especially when associated with descensus. Very old women, he thinks, do not form good subjects for the operation.

In answer to the third proposition, the author is of opinion that whenever the perineum had been destroyed or the pelvic floor injured, involving prolapse of the vaginal walls and uterus, it is advisable to increase the efficiency of Alexander's operation by narrowing the vagina and restoring the perineum.

We think the author right, however, in advising the shortening of the round ligaments first and then operating upon the vagina if it should be found necessary. Dr. Mundé concludes his paper in terms of satisfaction with the results of his experience with the operation, and states that of his 23 cases all were hopeful but two.

A Second Series of One Thousand Consecutive Cases of Abdominal Surgery is the title of a paper by Mr. Lawson Tait, read before the Birmingham and Midland County Branch. Mr. Tait begins by saying that he has succeeded in reducing the death-rate in this his latest series of one thousand cases to 5.3 per cent., as compared with his first series of 9.2 per cent. He attributes this gain in his second series to the omission of the clamp and other imperfections arising from the traditions of his elders, and states that his mortality in the treatment of ovarian and parovarian cystoma has fallen from 8.1 to 3.3 per cent. This, however, does not represent the full gain, because in the first series he had a large number of unfinished operations with a mortality of 50 per cent. These occurred in connection with the treatment of sessile ovarian tumors and imbedded cysts of the broad ligament, the removal of which he now completes, and in this way reduces his mortality. Mr. Tait says he is now in a position to state that there does not exist a cystic tumor of the abdomen which cannot be removed, and that this is also true of solid tumors of a non-malignant character, except of those connected with the spleen or liver.

In his second series he records six unfinished operations in contrast with thirty in his first series, both, however, showing a mortality of 50 per cent. He states that at the post-mortem of these six cases he became convinced that had he screwed up a little more courage he could have reduced this number to three, and accordingly blames himself on his shortcoming. This admission is very kind, and encouraging to the rest of the surgical world; but when Mr. Tait's courage fails, who shall say "go on." There now follow some very admirable statements, which we most certainly feel the truth of and agree with the author upon. "A man who has a large proportion of unfinished opera-

tions is a bad surgeon, worse than one who has a high mortality," and we would add that it shows an unfitness for the work. Besides increased experience and manual dexterity in reducing the number of unfinished operations and death-rate, Mr. Tait adduces as a prominent cause the fact that the mind of the general profession is now rapidly freeing itself from the shackles of the ancient authorities on abdominal surgery, and is opening itself to the new rules of progress. Mr. Tait here states that it is only within his own particular little halo (Birmingham and the Midland district) that the surgeons are not in this respect a disgrace to our art, and that the day for plain speaking has arrived. Surgeons should not be permitted to treat a pelvic abscess with a pessary any more than a mammary abscess with a splint, instances of which nonsense, he states, he experiences every week. If this sort of thing obtains outside of Birmingham, it is certainly a disgrace to the profession in England, as Mr. Tait says, but we do not think it does any more than we do in regard to our own country, where such a thing could not possibly happen owing to the manner in which our men are taught.

In speaking of the advisability of operating early, instead of following Sir Spencer Wells' advice to keep the patient on her feet as long as you can, Mr. Tait says that it is far better to open the abdomen a few times unnecessarily than that we should deliberately limit the powers of our art in this foolish way. Mr. Tait records fifty-three exploratory incisions in his second series as against ninety-four in his first. He says that these incisions take the place of tappings, which latter he never practices. A very remarkable result often follows these exploratory incisions when drainage has been employed; ascetic fluid has disappeared permanently and tumors of the liver, spleen, and of other kinds, have also disappeared and the patients cured.

In the group of operations for chronic inflammatory disease of the uterine appendages, Mr. Tait records a mortality of 3.4 per cent. (263 cases) as against a mortality of five per cent. in his former series, a diminution largely due, he says, to increased experience. In this group there was not a single case of incomplete operation, and when we remember that these operations

are more difficult, and should have a higher mortality than the mere removal of tumors, it speaks much for Mr. Tait's dexterity. In speaking of the ultimate result following these appendage operations, Mr. Tait pays a high tribute to Dr. Arthur Johnston of Danville, Ky., for having discovered that there is a large nerve trunk entering (or leaving) the cornu of the uterus, in the angle between the round ligament and the tube, which seems to have a powerful agency in the process of menstruation. This nerve should be secured in the ligature during the operation. Mr. Tait next touches upon the treatment of uterine myoma by electricity, and has been rather disturbed of late by the receipt of a pamphlet entitled "Electricity *versus* Tait." The author's views on this subject are well known, but are well worth reading in the present paper. As a contrast to the electrical method of treatment of myoma uteri he submits a group of 148 cases of removal of the appendages with three deaths, a mortality of 2.03 per cent. as against 99 in former series with a mortality of 7 per cent.

The next group is that of 88 hysterectomies, with a mortality of 11.3 per cent. as against 54 cases with a mortality of 35.7 per cent. in his first series. Mr. Tait feels very keenly upon this point of high mortality in his first series, and comments bitterly upon the conduct of Dr. Keith in refusing to allow him to witness his (Keith's) method, the secret of which consisted in ligaturing the broad ligaments separately and stripping them off the uterus, thus preventing occlusion of the rectum by taking off strain. Tait has now had 31 consecutive recoveries following hysterectomy, and thinks that he will ere long bring the mortality down to that of ovariectomy.

Mr. Tait has operated 26 times in cases of suppurative peritonitis and saved 22 patients, and he therefore pleads strongly for the early operative treatment. We do not keep pus long in the pleura, why should we allow it to remain in the peritoneum. Mr. Tait, however, speaks with bated breath concerning abdominal section in the treatment of puerperal peritonitis. He has operated four times with only one recovery, but says he *nearly* had two other recoveries, and had he had twelve hours of a start

he would have reduced his mortality from 75 per cent. to 25. We think this remark of Mr. Tait's a most valuable one, and involves a very grave lesson to the physician accoucheur. If it should set him thinking, he may come to the belief that it will be better to put medicines aside and place the whole responsibility upon the surgeon; but let him see that he does so early and not wait until the only satisfaction he can obtain will be in the form of moral support. Mr. Tait even goes so far, in commenting upon this subject, as to advise the removal of the uterus. The inflammatory mischief is so often in the uterus itself, and the chances of recovery are so fractional, that any kind of effort seems legitimate.

Mr. Tait concludes his essay with his views in regard to removal of the pregnant uterus by abdominal section when it was impossible to deliver the child through the natural passages. He states that he has performed the old Cæsarian section three times in his life, and that the mother died in every case. He has also done one operation according to the Säger method with a fatal result. These fatalities so impressed him that he attributed their cause to the "puerperal condition," but this he now acknowledges to be incorrect, as he has lately performed four operations on the principle laid down by Porro, with the happy result of recovery in every case. Mr. Tait, however, has altered the method so much that it is not, in detail of performance, a Porro, but only so in principle—*i. e.*, the removal of the uterus to save the mother from the danger of suppurative metritis and the possibility of having the same trouble over again. The author calls his new method "amputation of the pregnant uterus," and is performed as follows: An incision is made large enough to admit the hand; a rubber drainage-tube is stopped over the fundus and brought down so as to encircle the cervix. This tube is tied with a single hitch knot sufficiently tight to arrest the circulation. The uterus is then opened and the child withdrawn, followed by removal of placenta. The uterus is now brought out through the abdominal wound, the ligature tightened afresh, and knitting needles passed through the rubber tube and cervix. The uterus is next amputated about three-quarters of

an inch above the needles ; the wound is closed in the usual way and the stump dressed with perchloride of iron. Mr. Tait says it takes less time to perform the operation than it does to describe it, and that any inexperienced young practitioner can perform it successfully if the patient has not been mauled about by ineffectual attempts to deliver, and that its mortality will not exceed that of ovariectomy.

The Mortality of Abdominal Section.—At a late meeting of the Royal Medical and Chirurgical Society, Mr. W. A. Meredith (*Lancet*, October 27, 1888) read a paper, the purpose of which was to draw attention to certain points affecting the present death-rate after abdominal section, and with this view operations for ovarian growths were chosen, as being to some extent representative of the entire subject under consideration. As a basis for the inquiry, the results of the author's own work in this connection, amounting to 126 operations, were examined with regard to the chief causes influencing the mortality, special reference being made to the ten deaths which occurred in the series of 104 completed ovariectomies. All the operations were performed with strict antiseptic precautions, including the use of the carbolyzed spray. He was now less inclined than formerly to look upon the latter as an absolute essential to the safeguards of antiseptic abdominal surgery, but he still considered it valuable as the most convenient and effectual means of antiseptic irrigation at our disposal when dealing with the peritoneal cavity. Both ovaries were removed in seventeen cases, two of which terminated fatally, but in neither instance was the result in any way attributable to the removal of the second ovary. Complete enucleation was performed in five cases, all successful, the resulting rent in the broad ligament being closed by means of a continuous silk suture. He advocated the use of the drainage tube in all cases of ruptured or inflamed cysts, in any case in which irritating or septic fluid had escaped into the peritoneum, in all operations complicated by serious injury to bowel or urinary bladder, in every instance in which washing out had been resorted to, and in all cases of severe operation in middle-aged or elderly women. For washing out the peritoneum, where

necessary, he advocated the use of plain, recently boiled water, cooled as required by the addition of a saturated solution of boric acid. Discussing the mortality, he was inclined to believe that in a large series of cases the average death-rate would never be less than five or six per cent. Of the ten deaths in his series, two were from septicæmia, one from intestinal obstruction, one from hemorrhage, one from dysenteric diarrhæa, two from chest complications, and three from exhaustion; three of these deaths were from preventable causes. Twelve successful operations for the removal of the diseased uterine appendages were next reviewed. In seven patients, in whom both appendages were removed, complete arrest of menstruation followed. He had found that in cases of chronic ovarian mischief about 90 per cent. were the subjects of obstinate constipation, and in them tonic purgative treatment, by lessening pelvic congestion and preventing the formation of scybala, was followed by marked relief of symptoms. Included in a series of ten exploratory operations were two incomplete ovariectomies. Both patients had been tapped, and the death of one was directly due to the difficulties encountered in the attempt to separate universal adhesions which had resulted from this treatment. In conclusion, it was shown that the increased success of abdominal section for ovarian disease during the past ten years was chiefly attributable to the diminution in the number of deaths from septicæmia. For purposes of comparison he took three successive groups of operations, which represented three separate periods during the last twelve years, and gave their average death-rate from septicæmia alone. In 100 consecutive cases taken from Sir Spencer Wells' work, when the clamp was used and before the employment of antiseptics, the mortality was ten, or one to every ten patients. In 150 cases recorded by Mr. Thornton in the sixty-fourth volume of the *Medical and Surgical Transactions*, which were treated antiseptically and with intra-peritoneal ligature of the pedicle, there were five deaths, or one to every thirty patients. In his own series of 104 cases there were two deaths, or one to every fifty-two patients. The chief factors which had contributed to this success, he thought, were as follows: (1) The general

adoption of the intra-peritoneal treatment of the ovarian pedicle ; (2) the application of the antiseptic system to abdominal surgery ; (3) the gradual abandonment of the practice of tapping abdominal cysts ; (4) the increase in our knowledge respecting the proper use and management of the drainage tube ; (5) the recent introduction of the plan of freely washing out the peritoneal cavity in cases complicated by the extravasation of blood or other fluid.

Dysmenorrhœa, Rapid Dilatation of the Cervix.—This is a favorite subject with Dr. Goodell in his clinical lectures. In my experience it is no doubt a most satisfactory operation in many cases of severe dysmenorrhœa. To obtain good results and safety it has, however, to be properly done, and this means experience. I am in the habit of combining with dilatation some cutting whenever the tension upon the instrument becomes extreme. I always excise the posterior segment of the cervical wall at the same time.

“The patient is 25 years of age. Puberty began at 14, and ever since she has had severe and obstinate dysmenorrhœa. She comes to us now not so much for the pain during menstruation as for pain produced by coition, a condition to which we apply the term dyspareunia. When a woman who has never borne children complains of dysmenorrhœa, the cause in the great majority of cases is ante flexion. The natural condition of the womb, as you know, is ante flexion. Retroversion and retroflexion, on the other hand, are usually the result of lack of involution after labor. The uterus is too heavy and falls backward, and we have, according to the degree of plasticity of the organ, retroversion or retroflexion. If the organ is easily bent, we have a flexion, but if the tissue is firm and the ligaments somewhat relaxed, there will be retroversion. As I have told you, this patient has had dysmenorrhœa since puberty, but since her marriage, three years ago, the pain has become much worse. The fact of painful menstruations indicates that she has one or two conditions, or possibly both of them. There is either an exaggerated ante flexion or stenosis of the cervical canal, or both. If the bend in the neck of the womb is great, no fluid can escape. The blood

collects in the cavity of the womb, distending it, and at last the canal is straightened and the fluid escapes with a gush. Sometimes the occurrences of this sudden escape of blood is not recognized by the patient, but on close inquiry she will tell you that the pain goes on increasing until it reaches its acme, when there will be a sudden diminution in its intensity, when it will again gradually increase. There is often some difficulty in deciding whether or not a patient has stenosis by angulation, for during the intermenstrual period the sound may readily pass, but at the time of the period the mucous membrane becomes swollen and the canal is occluded. In married women who do not become pregnant there is superadded the congestions from coition. The accumulation of fluid in the cavity in the uterus at the menstrual periods leads to hypertrophy of the uterine muscle, so that we have the monthly congestions and the engorgements from coition acting on an organ already enlarged. As a result, we have a subacute form of endometritis, and the ovaries also become congested and tender. The cervix, which ordinarily is very insensitive, will at times become the seat of exquisite sensibility. This, in my experience, is most frequently seen in those who are employing preventive measures to avoid conception. This woman is anxious to have children, and it is evident that her condition is not the result of any evil practice. Anteflexion of itself calls for no treatment, but when it causes dysmenorrhœa, and when the pain is not due to irritability of the womb, the anteflexion should be relieved.

“The patient has now been placed thoroughly under the influence of ether. There is a decided anteflexion, and the sound gives a measurement of three inches. The best method for the treatment of this condition is dilatation. This is much better than the cutting operation, which consists in slitting up the posterior lip of the cervix to the vaginal junction and then introducing a knife within the canal and cutting the little spur of tissue that remains. This is not so successful as dilatation, and is far more dangerous. Many lives have been sacrificed by the bloody operation, as it has been termed. I have performed the operation of dilatation in 317 cases and have never had any alarming

symptoms. In a few instances there has been a slight metritis, with some involvement of the peri uterine peritoneum. I shall now proceed to the performance of the operation in this case. We employ thorough antiseptics throughout the operation. The vagina is first cleansed with a 1 to 1000 solution of corrosive sublimate. After introducing a speculum, I catch the cervix with a tenaculum and hold it while I introduce Ellinger's dilator, and then reverse it. This readily passes. When it does not enter at first, introduce it as far as it will go and separate the blades. Then close it and introduce it a little further, and in this way you can soon tunnel your way through the canal. Care should be taken to see that there are shoulders on the dilator to prevent it from entering too deeply into the cavity of the womb. The shoulders should be two inches from the extremity of the instrument, and there should be at least half an inch between the ends of the dilator and the fundus of the womb. If the blades were in contact with the fundus of the womb, they would be liable to tear the tissue as they were opened and cause serious results. Having the dilator properly introduced, I gradually separate the blades, not using too much force at once. I have torn the cervix while dilating. The tear did not give any trouble, but there was a certain amount of hemorrhage. This was controlled by the application of Monsel's solution and the introduction of a tampon. I have now dilated as far as can be done with this instrument. I next employ a much more powerful dilator, the blades of which have no tendency to feather. Having slowly dilated to one inch and a quarter, I remove the ether, and allow the instrument to remain until the patient begins to show that she feels it. Before the beginning of this operation, I always direct that an opium suppository be introduced into the rectum, so that it will have begun to act by the time that the effect of the anæsthetic has passed off. Before removing the dilator the vagina is again thoroughly cleansed with the corrosive sublimate solution, and some of it is allowed to enter the cavity of the uterus. This is perfectly safe when the os is in the patulous condition. The dilator is now withdrawn and a ten-grain suppository of iodoform is slipped into the vagina. I can confidently recommend this

operation to you in such cases as this. Occasionally it is necessary to repeat the dilation, but one operation almost always gives decided, if not complete, relief.—*Dr. Goodell, Clin. Lect.*

Pelvic Inflammations.—The management of pelvic inflammations naturally divides itself into that for the acute or immediate stage, and that for the chronic or remote form—the latter embracing the treatment of the residues or remnants of the inflammatory process. The therapy of acute inflammations is not considered as within the scope of this review; nevertheless, it may be remarked that it is important to prevent or modify the attacks, as far as possible, by the thorough use of antiseptics during labor or after delivery. It may be laid down as essential that the hands of the accoucheur should be absolutely sterilized to begin with; that in instrumental labors, or in any case where it has been necessary to invade the uterus either with hands or instruments to effect delivery, the womb should be irrigated with an antiseptic liquid that is an undoubted germicide; and that this process should be repeated in any such case where the temperature rises above 100°F., with a tendency to steadily increase, sufficiently often to keep it free from sepsis. Under proper antiseptic precautions in midwifery, pelvic inflammations will often be prevented or their ravages diminished. When a woman does not effect a “good getting up” after delivery, and she complains of deep-seated pelvic pains, especially if associated with a slight rise in temperature which continues for days or weeks, the suspicion is very strong that there are exudations lurking somewhere in the pelvic cavity, for which a careful search should be made. If they should be discovered, appropriate treatment with a view to promote their absorption should be instituted. We have usually obtained benefit from a careful tamponment of the vagina, medicating the tampons according to the nature of the case. This furnishes support, rest to the parts, and elastic pressure, all of which greatly facilitate absorption of the exudate and tend to relieve pain. It is a valuable adjunct in the management of all the residues of pelvic inflammations in the preparatory or initial stage of treatment, and sometimes seems to effect a complete cure, rendering the appeal to more radical measures un-

necessary. The principle of elevating the uterus and its appendages out of the lower pelvis, releasing them to a considerable extent from impaction and thereby promoting nutritive changes, is undoubtedly a correct one; but its usefulness is restricted within certain limitations. Its contra-indications appear to be fever, subacute or chronic peritonitis, strong adhesions and abscesses. Its use should never be persisted in when it causes pain, but when it affords relief, its employment is pretty certain to be followed by good results. In doubtful cases it would be well to proceed cautiously at first until its efficacy is tested, after which, if favorably indicated, we may go ahead with confidence. The residues due to laceration of the cervix or other portions of the utero-vaginal tract usually require surgical measures for their cure. One of the important benefits of trachelorrhaphy is found in its prevention of, or the relief it affords from, those secondary conditions liable to follow in the train of an unrepaired cervical rent—either tissue changes, reflex neuroses, or an extension of the inflammatory products into other organs or tissues. Hence, in making the operation, it is expedient to excise all cicatricial tissue and hypertrophic thickening of the everted cervix. In displaced uteri, caused by inflammatory remnants, a reasonable effort to free the organs from their moorings and restore them to their proper positions may be made, but it should not be attempted with the uterine sound or other intra-uterine redresser. The sound has little or no place in the management of these cases, either for purposes of diagnosis or treatment. Pessaries, too, are of no avail, and may do positive harm if resorted to before the uterus is made to move freely in the pelvic cavity. If this mobility can be re-established through any agency free from harm or danger, then a suitable pessary may prove serviceable. The formation of pus in the pelvic cavity is not an infrequent ending to either acute or chronic inflammation, and when established, furnishes an interesting field for the surgeon. When large abscesses form as the result of acute inflammations, it is not difficult to decide upon the proper course to pursue; but such is not always the case when old residues finally break down into pus sacs. In the former the symptoms are urgent, some-

thing must be done, and that quickly, or disaster may result. Moreover, the location of the abscess is not, as a general rule, difficult to define, nor the pus itself out of easy reach. Not so in the so-called chronic abscesses, especially where the pus centres are small, as they frequently are when they originate in the hardened masses of exudation—generally remote from the surface—and, perhaps, surrounded by thickened walls or further obscured by overlying structures. These conditions not only increase the difficulties of diagnosis, but the abscess is not as easily evacuated. It may be justifiable in doubtful cases, but where yet there is a strong suspicion of pus, to clear up the doubt by exploratory puncture; if pus is thereby revealed, the opening can be enlarged by divulsion with a steel dilator, the contents evacuated, the cavity antiseptically irrigated, and a drainage tube inserted. If, under incision and drainage, the cavity does not close promptly, or if it secretes unhealthy pus, it should be washed out frequently with antiseptic solutions; or it may be packed with iodoform gauze. Finally, if it remain latent very long, and its pyogenic surface is converted into cicatricial membrane, the curette may be demanded before a cure is effected. Pus is an enemy for which diligent search should be made, unleashed when found, and the case further treated in accordance with the modern surgical rules applicable. It may be that the abscess can best be treated through the vagina, and the opening and drainage conducted through its walls. This will most likely be the case in low-down pus collections; but if it is impossible, or even very difficult, to reach the abscess through this route, then it may best be treated by abdominal section and drainage, and the careful stitching of the abscess walls to the margins of the incision. In conclusion he would draw attention to (1) the importance of early attention to even the *soi-disant* minor pelvic inflammations; (2) the suggestion of a simpler classification of pelvic inflammations; (3) the influence inflammatory remnants exert upon the health of women; (4) the great value, *inter alia*, of support and pressure in their management; (5) the thorough trial of all intermediate therapeutics before (6) the final resort to surgical relief by abdominal section.—*Dr. W. W. Potter, Buffalo.*

In this article Dr. Potter does not speak definitely of the most important part of the treatment of chronic pelvic inflammations—enforced rest in bed. Without this we can get nothing but disappointment. Bandl, in his writings upon this subject, has probably done more in a scientific way than any living man, and his observations should be studied by all.

Ovarian Tumors.—Dr. Poupinel has published a series of observations made in the histological laboratory of the Collège de France on a large number of ovarian cysts. He has found that ovarian cysts may exhibit every grade between the pure dermoid and the pure mucoid multilocular, or common ovarian cyst. These grades constitute what he terms “mixed ovarian tumors.” The epithelial lining of the purest mucoid cyst is extremely variable, it may be cylindrical, cubical, goblet-celled, metatypical, or even ciliated. He has seen three cases where the epithelium was entirely ciliated. [He says nothing throughout his paper of papillomatous or hilum-cysts. Ciliated epithelium is strongly suggestive of an origin from the Wolffian tubules which are found in the hilum and which stray sparingly into the parenchyma in our species; hence, in the reporter’s opinion, the occasional presence of papillomatous amidst mucoid or glandular cysts.] Sometimes the epithelium is mixed. In mixed ovarian tumors the epithelial lining of the cysts may be yet more varied, that is, cubical, goblet-celled, polymorphous, ciliated, stratified, or truly epidermic. In some cases the cyst is lined with skin bearing hair and sebaceous and sudoriparous glands, partly with uniform or polymorphous epithelium. Lastly, in dermoid cysts the lining of the cyst is, as a rule, purely cutaneous. Sometimes it is mixed with what appears to be true mucous membrane. The stroma or intercystic material in multilocular cysts is, as a rule, entirely made up of young, perfect, or myxomatous connective tissue. Both bone and cartilage may develop in the stroma. In the mixed ovarian tumors osseous and enchondromatous deposits in the stroma are not so closely connected with the neighboring secondary cysts as are similar formations in pure dermoid tumors. Lastly, the stroma may contain plain or striated muscle-cells or nerve-tissue (teratoma of Virchow, Le-

bert's third variety of ovarian cyst). All the above-named conditions may be bilateral. Brodowsky has found ciliated epithelium in a pair of ovarian cysts. On the other hand, one ovary may form a mixed cyst, the opposite a mucoid or dermoid cyst. Dermoid cysts may become cancerous or even sarcomatous or colloid. Thus he endeavors to establish, by demonstrating gradations, the identity (in origin at least) of dermoid cysts and common ovarian multilocular tumors. The former are cysts lined internally with skin, which may bear epidermic appendages and glands found in connection with normal skin. The common multilocular cyst is lined with what must be considered, to all intents and purposes, as mucous membrane, which secretes a mucoid fluid, and which may bear involutions representing glands. In other characters the two varieties of tumor are similar. Thus mucoid cysts may give rise to so-called secondary deposits. Evidence has been brought forward to prove that dermoid cysts may do the same. In Frankel's two cases there was probably rupture of the ovarian cyst and implantation of dermoid elements on the peritoneum. Kolaczek's case is not absolutely clear; the surface of the ovarian cyst was smooth and entire, quite different from the small piliferous cysts found in the peritoneum. Moore's case (*Trans. of the Pathological Soc.*) is of high interest. There was evidence of rupture of the main cyst, or the cyst may have developed pedunculated secondary growths, the pedicles afterwards undergoing atrophy. Moore believed that rupture of the main cyst explained the secondary deposits. ["The rupture of an ordinary ovarian cyst usually causes a fatal peritonitis; but a dry cyst, such as these, would produce mischief in its bursting, which might be limited and consistent with recovery. Such peritonitis had occurred in the present case." Thus wrote Moore in 1866. Further experience has proved that rupture of an "ordinary ovarian cyst" may only give rise to trifling symptoms. The accident may also cause dissemination of glandular growths, or of secondary cysts. In this respect the multilocular may resemble the dermoid ovarian tumor, for in both forms rupture may disseminate the intracystic growths; but whether true metastasis occurs in either is doubtful. Again, in both forms, I believe,

exogenous cysts, or secondary cysts which protrude from the main wall of the tumor, may become detached and adhere to omentum or intestine.] Dr. Poupinel finds that the mucous or common multilocular cysts are most frequent in adult life (from 35 to 45). The mixed forms appear between the ages of 15 and 25. All three types are said by Dr. Poupinel to be rare in childhood, but, relatively, dermoid tumors are then common. [Indeed, nearly all the ovarian cysts which have been removed from patients under puberty have proved to be dermoid. In the foetus, ovarian cysts may be papillomatous, or even malignant. Winckel figures in his text-book an adenomatous ovarian tumor, and simple follicular cysts are very common in the foetus.] Dr. Poupinel rejects learned hypotheses on the origin of dermoid cysts. They are not more mysterious in their nature than common multilocular cysts; the former develop skin, the latter mucous membrane, and mucous membrane is as wonderful as cutis and epidermis.

Prolapsus Uteri.—(Dr. C. Cohn in the *Ztsch. f. Gyn.*)—

1. The continuous catgut suture gives the securest guarantee of primary union, in addition to relative ease and rapidity in the performance of the operations. The superficial union of the wound obtainable by this means gives a firm cicatrix which is favorable to a permanent result. 2. Colpo-perinæorrhaphy may be the means of permanently curing even extensive conditions of prolapse. Hegar's method answers fully the demands which may be made upon it. The reasons for failure, as regards complete healing, in nearly half of the author's cases are: (a) A portion of the cases which are referred to recurrence of the cause of operation are not recurrences in the proper sense of the term, but simply cases in which healing did not take place; (b) a portion of the recurrences are attributable to incompleteness of the operation, only anterior colporrhaphy having been done; (c) the other recurrences are due to such factors as severe parturition, quick repetition of pregnancy, and particular anatomical conditions of the posterior vaginal wall. In order to obtain permanent results from operations of this character it is desirable in conditions of prolapse to operate upon the posterior vaginal wall

at the earliest possible moment. Narrow the vagina as much as possible throughout its entire extent, by the high operation of posterior colporrhaphy. Make as high a perineum as possible, bringing forward the narrow introitus. The higher the perineum the firmer the pelvic floor. The more the vagina is drawn forward the more favorable will be the chances of permanent recovery.

Ventral Fixation for Uterine Displacement.—Mrs. —, 33 years old; married eight years previously; has had three normal labors; since her seventh year, has menstruated profusely for four or five days once in four weeks. She has suffered for five years from continuous pain in the sacral and hypogastric region, which must be due to retroflexion of the uterus and perimetritis. The pain is relieved temporarily by a pessary; but the latter invariably causes a recurrence of pelvic inflammation, and she has been compelled to take to her bed recently fifteen times on this account. Consequently she could no longer endure a pessary. Every attempt caused unbearable pain, and the uterus was bent so sharply posteriorly that the fundus lay deep between the cervix and the rectum. Ventral fixation was performed by Leopold's method, without removing the tubes or ovaries. The patient made an excellent recovery in every way, with complete relief from all her suffering, and she was once more able to perform all her domestic duties. An examination made fifteen months later showed that the uterus was erect, with the fundus firmly attached to the abdominal wall, but painless and quite movable. It did not interfere with the bladder or other organs, and menstruation was perfectly normal. None of the complaints caused by the retroflexion had returned.

Mrs. —, 46 years old; widow for two years; had been married twenty years previous, and given birth twice in normal labor. The patient had complained for a long time of continuous and severe sacral pains, which incapacitated her for work. The uterus was of a normal size, retroflected and movable. The left parametrium was very sensitive. All attempts to retain the uterus in a normal position failed. In an examination under ether, the uterus could be raised to the abdominal wall by the

sound. In doing so, false membranes between the uterus and rectum were put on the stretch, and could be easily felt from the rectum. When the uterus was drawn downward with the bullet forceps, the right utero-sacral ligament was felt thickened, per rectum, the right ovary the size of a plum, somewhat movable, and the left adnexa matted down in the immediate vicinity and not to be distinctly distinguished from each other. Ventral fixation was decided upon. After opening the abdominal cavity, the left tube was found enlarged to the size of the finger and its outer extremity closed. The adhesions were carefully separated by the fingers, and the tube with the ovary was removed. The right tube and ovary appeared microscopically normal, and were left behind. The uterus was then freed from its adhesions to the rectum and fastened to the anterior abdominal wall. The patient made a good recovery, and began to sit up on the fourteenth day after the operation. But from this time on she complained of the sacral pain, from which she had been free after the operation. Seven months later, an examination showed that the uterus was well fixed anteriorly, and the pelvic organs free from sensitiveness. The general condition of the patient had improved very much, and she was able to attend to her housework. The sacral pain was better, but still present. This case is an instructive one, as it shows that merely anteverting the uterus does not necessarily relieve all the suffering. The history of pelvic inflammation probably explains the persistent pain. The same thing has been observed after castration; and Hegar has directed our attention to the presence of small nodules of inflammatory exudation which will escape detection on examination and yet press on nerve-trunks or filaments in such a manner as to cause severe pain. Such nodules or exudations will, of course, persist after a laparotomy, and then the pain will continue.

Miss —, aged 34, had a severe fall at the age of 15. The uterus was retroverted, and replaced occasionally without using any support to that organ. Her chief symptoms were profuse menstruation every three weeks, with extreme dysmenorrhœa and violent congestive headache. Her mind is somewhat affected at these times. She easily forgets what has taken place, and is

much bewildered and sometimes hysterical. She is able to walk but a short distance, and has continuous pelvic pain, especially on the right side. On examination, the uterus was found sharply retroflected, and there were two exquisitely sensitive bodies, the size of plums, low down in the cul-de-sac of Douglas. These were the ovaries, the right being larger than the left. Any attempt to replace the uterus or introduce the sound caused intense suffering, and spasms of an hysterical character. No kind of pessary or ordinary tampon in the vagina could be endured. A year of careful local and general treatment was spent in vain hope of allaying the sensitiveness of the ovaries and uterus. Ventral fixation of the uterus, if practicable, was the only resource left. Accordingly laparotomy was performed, the abdominal incision being two and a half inches long, separated the uterus, tubes and ovaries from their adhesions posteriorly, stitched the uterus to the anterior abdominal wall, and removed the tubes and ovaries. The right ovary was much enlarged and showed some small cysts of varying size in its substance. The patient was a little chilled in her bath the day of the operation, and had a sharp attack of neuralgia that night, with slight increase of temperature. This soon subsided, and since the second day the pulse and temperature have been nearly normal. The dressing was removed on the twelfth day. The wound had healed apparently by primary adhesion, was perfectly dry, and the cotton showed no stain whatever, except a little blood absorbed when first applied.—*Dr. G. R. Southwick in N. E. Med. Gazette.*

A very interesting discussion has recently taken place at the New York Academy of Medicine on this important subject. Dr. C. C. Lee was the reader of the paper. He showed that Dr. Howard Kelly of Philadelphia had given the name hysterorraphy to the process of sewing the displaced uterus to the anterior wall of the abdomen.

Dr. Lee gave the histories of six cases in which he had performed primary hysterorrhaphy. The operation had been done so frequently, secondary to laparotomy for other purposes, that he did not refer to his experience with such cases. In all the six

there was retroversion of the uterus, with strong adhesions and attendant symptoms which all other means had failed to relieve. Laparotomy was performed and the adhesions broken up, although usually with much difficulty, and the uterus was fastened by suture to the anterior abdominal wall. In one case the uterine appendages had previously been removed, but the patient continued to menstruate and to suffer severe pain. Finally he again performed laparotomy, broke up perimetritic adhesions fastened the uterus to the abdominal wall, and there had been relief, although the final result could not be stated, the operation having been done the present month. In one instance the operation failed to give relief. Although the operation was sometimes difficult of performance, yet it was certainly less dangerous than extirpation of the uterine appendages or of a morbid growth, and it often gave relief from severe symptoms. It was indicated in retroflexion of the uterus with fixation, great suffering which finally ruined the health, where pessaries were not borne, and if borne had no effect. Unless it should be supplanted by the massage and gymnastics practised by Brandt, hysterorrhaphy would be a great blessing to many patients. He had not practised Brandt's method, but he had felt sceptical regarding its claims. Regarding the relative value of hysterorrhaphy and Alexander's operation he thought it useless to speak, for they were indicated in different classes of cases. If there were no adhesions, no fixation of the displaced uterus, even the most enterprising laparotomist would hesitate to advise hysterorrhaphy, while it had been claimed that in only such cases was Alexander's operation to be performed. Regarding the steps in the operation, Dr. Lee said that after a number of experiments he had concluded that the sutures should not be passed through the fundus uteri, which was often excessively vascular, but through the proximal end or edge of the broad ligament, so as to encircle the round ligament, and above, not only through the parietal peritoneum, but through the supra-peritoneal fat; for otherwise they were liable to tear through and allow the womb to fall back again. While silkworm gut answered well if previously soaked to make it flexible, the very best material was fine Chinese twisted silk rendered aseptic.

Catgut was inadmissible from liability to rapid absorption, and silver wire was much more likely to tear the broad ligaments. The aim was to have the ligature remain and become encysted. In separating the adhesions the fingers alone were to be used, and the adhesions about the ends of the broad ligament were to be torn through first, and when the uterus was drawn up one could better distinguish the utero-sacral ligaments from adhesions. The operation was only to be done with all antiseptic precautions. The subsequent treatment was like that in other laparotomies. Thus far he believed no death from hysterorrhaphy had been recorded.

Faradization in Hysterical Spasm.—The following is an instance in which strong cutaneous faradization succeeded at the first attempt, in a form of hysterical spasm: M. S., female, aged 18. Family history—father suffering from “miner’s disease,” mother hepatic. Self—bilio-nervous temperament, never really ill. Lately anæmic. Catamenia regular and painless. Four months ago had a great fright. A fortnight ago began to suffer from clonic spasm of the muscles of the right forearm; leg and face unaffected. The movements ceased only during sleep. Was told she was suffering from chorea, and came to town to be treated. On examination, her appearance and history of ovarian hyperæsthesia, globus, and occasional aphonia, with other symptoms, pointed to the hysterical nature of the seizure. Having a lively recollection of a precisely similar case which I had seen under Prof. Ferrier, at London, and by him designated “crank-handle spasm,” I adopted the same treatment as was practised on that occasion, with the same signal and instantaneous success. With one electrode upon the supinator longus, a strong faradic current was applied with the dry faradic brush to the surface of the forearm. After one or two applications, and in less than a minute, the spasmodic movements ceased. Complete control was re-established over the limb, and patient was able to write home without the least tremor of the hand. She was placed upon an iron and quinine tonic, ordered rest and change of air, etc. A week later she came again, and there had not been any recurrence. I was led, of course, to the use of strong cutaneous

faradization by the recollection of its success in Prof. Ferrier's similar case. The *modus operandi*, probably, was that the strong irritation exercised an inhibitory effect directly on the motor stimulation, which was the cause of the seizures.—*Dr. J. W. Springthorp in Australian Med. Journal.*

Endometritis.—Endometritis was formerly regarded as the local expression of a diathesis, and was to be combated by constitutional measures only. Every endometritis, however, whether simple or fungous, cervical or corporal, superficial or profound, is infectious in character. The recognition of these facts naturally conducts us to a rational treatment, the destruction of the infective material and the cure of the lesions determined by it. The appalling disasters that inspired our predecessors with a not unwholesome fear of even the slightest surgical interference with the cervix are easily explained by the infectious field of operation. Hence, our first care must be to prepare the patient—the vagina must be rendered aseptic. I have long insisted on this, and here, if possible, asepsis is more imperative than any other surgical procedure—it should be the inviolable rule. The uterine cavity is closed or nearly so, the cervical canal permitting but difficult access from without and imperfect escape of secretions from within. These secretions accumulate, and when they become purulent the uterine cavity may not be inaptly compared to an abscess with an insufficient fistulous tract. This comparison reveals the necessity of immediate intervention. Every purulent cavity should be opened, thoroughly and antiseptically. The purulent cavity of the uterus is no exception. Dilatation of the cervical canal facilitates not only the escape of pent-up secretions but also the application of remedies to the diseased mucous membrane. Moreover, it renders diagnosis possible by sight and touch.—*Dr. Verchère in Fr. Médicale.*

One-Child Sterility.—Out of 1,081 gynæcological cases Dr. Kleinwächter (*London Medical Recorder*) noted ninety where the patients had borne one child at a more or less distant period, and had remained sterile since, although still cohabiting with their husbands. In twenty-one of the cases the single pregnancy had ended before term. He divided the causes of this kind of

barrenness into ten groups: 1. Sequelæ of inflammatory processes beginning during the puerperium. 2. Catarrhal endometritis. 3. Sequelæ of inflammatory processes traced to a non-puerperal origin. 4. Displacements of the uterus. 5. New growths in the uterus. 6. Constitutional sources of sterility established after the first pregnancy. 7. Impaired potency of the husband. 8. Excessive involution or atrophy of the uterus. 9. New growths in the ovary. 10. Uncertain or unknown causes. These groups are arranged in order of frequency. Forty-three were traced to uterine and extra-uterine pelvic inflammations; that is, to the first three groups; nineteen to displacements and tumors. Dr. Kleinwachter admitted that the causes grouped above as 2 and 4 were not proved in every case to be uncomplicated. He declared that the seven cases making up group 7 were well authenticated by the clinical history, the condition in question appearing to act in a positively deleterious manner on the genital apparatus of the woman. Under group 6 were included cases where anæmia, cachexia, obesity, or emaciation arose after the first pregnancy.

Pathological Anatomy of Ovarian Dermoids with especial reference to their mode of origin is the substance of a monograph read before the British Gynæcological Society by Mr. J. Bland Sutton. The method of investigation adopted was as follows: (1) To ascertain, if possible, the portion of the ovary in which dermoids arise. (2) To find, and trace, if possible, intermediate characters between dermoids and other forms of ovarian cysts. For both purposes it was absolutely necessary to receive fresh material and to be able to deal with the specimens as freely as one could wish. The human ovary, and indeed that of most, if not all mammals, consists of three distinct parts, each giving rise to cysts presenting distinctive features. These cyst-regions are:

1. *The Oöphoron.* This is the region in which ova are found.

2. *The Paroöphoron.* This is termed by a few authors "the tissue of the hilum." It is composed almost entirely of mesonephritic remains (Wolffian body) in varying stages of retrogression.

3. *The Parovarium.* This represents the segmental tubes

and duct of the mesonephros, and consists of three parts—(a) Kobelt's tubes; (b) the vertical tubes of the parovarium; (c) Gartner's duct.

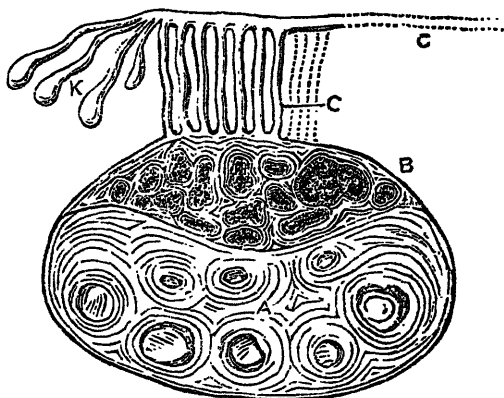


Diagram representing what may be called the *cyst regions* of the human ovary. A, Oöphoron; B, Paroöphoron; C, Parovarium, with K, Kobelt's tubes, and G, Gartner's duct.

These three parts can easily be made out in the human ovary, and in the ovary of many of the higher mammals, but the proportion of the parts to each other vary considerably in different groups, and at the present time he was engaged in investigating this question. The cysts which arise in connection with the ovary and parovarium may be conveniently arranged in three groups according to the region in which they arise:

1. *Oöphoron*—Unilocular cysts; multilocular cysts; cystic corpora lutea; dermoids.

2. *Paroöphoron*—Papillary (proliferous) cysts.

3. *Parovarium*—Parovarian cysts; Kobelt's tubes; pedunculated cysts hanging from the broad ligament.

His first efforts were directed towards ascertaining the relation of dermoids to these three regions of the ovary. In all the examples of ovarian dermoids dissected for the purpose, it was easy to demonstrate that the parovarium was unconnected with them, but in several cases this structure differed in minor particulars from the usual arrangement of the tubules. Another

interesting fact was the frequent association of malformation of the Fallopian tube with dermoids. In some cases there was an accessory abdominal ostium; in others the tube would have no abdominal opening whatever. These conditions have but little bearing on the pathology of ovarian dermoids, for they seem to be quite as frequently associated with other forms of ovarian cystomata. It now became necessary, seeing that ovarian dermoids have no connection with the parovarium, to ascertain as far as possible to which district of the ovary they belong. When a cyst attains a large size this task is an impossible one, but in dermoids of the size of a walnut, and sometimes when they are as large as an orange, it is easy to show that they originate in the oöphoron, and a series of observations carried out for this purpose has had the result of convincing him that ovarian dermoids arise in the same portion of the ovary as multilocular cystic tumors. These cysts arise in Graafian follicles, and it was his intention to proceed to show that ovarian dermoids also arise in these follicles. Having localized the situation of ovarian dermoids to the oöphoron, the task became simple, but laborious, for it involved a large amount of histological work. In the early stages, cysts arising in corpora lutea are easily recognised without the aid of a microscope, on account of the peculiar yellow tissue which forms the wall of the cyst. The multilocular cystic tumors arise in dilated follicles. As we are able definitely to determine the origin of oöphorite cysts in general from the Graafian follicles, it is necessary that we should compare their histological features with dermoids and analyse their points of agreement and difference. When an ordinary oöphorite cyst is compared with a typical dermoid the difference is very striking. In the simple non-dermoid ovarian cyst we find the interior lined by a single layer of flattened epithelium, and this may be difficult of detection. The dermoid, on the other hand, may present skin, hair, sweat and sebaceous glands, teeth, and even a mamma. Should the non-dermoid ovarian cyst be multilocular, the individual cavities may, if not too large, present a membrana granulosa; in the dermoid, the loculi are lined with skin furnished with hair, etc. Occasionally we find a multilocular ovarian cyst

and one little loculus may present a small patch of piliferous skin. Such a combination is far from rare. If we select a highly organized multilocular ovarian cyst, and one of the simplest ovarian dermoids, we shall find that in complexity of tissue the former far exceeds the latter. The glandular cyst presents us with the most perfect columnar epithelium, which not only covers the interior of the cyst but dips into the underlying tissues and forms mucous glands of great complexity, and when suitably stained forms striking objects under the microscope. Between cysts lined with simple flattened epithelium and those presenting glandular masses every gradation may be traced. The lining membrane of some of these cysts is indistinguishable from mucous membrane. The cystic spaces described by Dr. Wilson Fox in his well-known paper (*Medico-Chirurg. Trans.*, vol. xlvii, p. 227) as being formed by the coalescence of adjacent papillæ, are, as a matter of fact, in most cases acini of mucous glands. The larger ones are retention cysts, and are analogous in structure to similar cysts occurring at the cervix uteri and in connection with the labia. It may also be mentioned, as tending to show the close connection between ovarian glandular cysts and dermoids, it is no unusual thing to find mucous cysts in the smaller loculi in the walls of dermoids. We must now proceed to consider the simplest form of an ovarian dermoid. If a cyst in the ovary presents the smallest piece of skin, furnished with only two or three hairs, its dermoid character is established. The presence of a tooth without any skin is sufficient. As a matter of fact every gradation may be traced from the membrana granulosa of an ovarian follicle to the glandular cutaneous lining of a dermoid. In some specimens the epithelial investment is indistinguishable from that lining a unilocular cyst, yet in one small portion of the cyst wall a few hairs on a patch of skin place them in the category of dermoids. Thus far we know that ovarian dermoids resemble non-dermoid ovarian cysts in that they usually consist of one large cyst surrounded by numerous smaller ones. We have already seen that a multilocular cyst of the ovary may present only one tiny patch of dermoid tissue, though the tumor is composed of a multitude of cavities great

and small. There are good grounds for the belief that if all multilocular ovarian tumors were systematically examined, patches of dermoid tissue in the cyst would be found to occur with very great frequency. Lastly, an ovarian dermoid may be multilocular, all its cavities presenting skin, hair or teeth, or all three structures in the same cyst. Thus, in the general disposition of the cavities, single, multiple and mixed dermoids and non-dermoid ovarian cystomata are in agreement. The most highly organized ovarian dermoids are those which contain a well-developed mammary gland capable of secreting a fluid resembling milk. The histological characters of the skin found in ovarian dermoids differs in many ways from that covering the exterior of the body. The epidermis is extremely thin, and it is rare to find papillæ. The sebaceous glands are of very large size and many of them very dilated, as though there had been difficulty in getting rid of the secretion. Sebaceous retention cysts are not uncommon; the sweat glands do not present the twisted ducts with which we are so familiar in true skin. The hairs, too, for the most part, are of very simple structure and resemble lanugo.

One of the first objections which will be urged against the opinions put forward in this paper is this: It is contrary to ordinary teaching that the epithelium of a Graafian follicle is capable of undergoing such variety of shape. But epithelium may change its characters, and a ready method of demonstrating it exists in uterine myomata. When a submucous myoma projects into the uterine cavity its surface is covered with columnar ciliated cells. If, later, the tumor protrudes beyond the vagina, the surface cells will become stratified, whilst those cells lining recesses in the mucous membrane of the exposed parts retain their columnar ciliated condition. Similar changes may be studied in the mucous membrane covering the surface of piles. Again, no one who has studied the anatomy of the various forms of ovarian cystomata can doubt that the multilocular cystomata arise in Graafian follicles. Yet it would be difficult to distinguish between the epithelial lining of many multilocular cysts and the epithelium of a mucous membrane, even to its

glandular recesses. If such a complex cyst as this can arise from a Graaffian follicle, surely we cannot deny the origin of a dermoid from the same source, for skin and mucous membrane are fundamentally identical. Skin covers the exterior of the body, has sebaceous glands, and is furnished with hair. Mucous membrane lines the internal cavities of the body, and has mucous glands. In some mammals, the hare, the buccal mucous membrane is furnished with hair on the inside of the cheek. On the other hand, mucous membrane may have sebaceous glands, as, *e.g.*, that covering the nymphæ. In order to obtain teeth in a cyst lined with mucous membrane we need only calcify some of the cellular projections and a dermoid is the result. Calcific patches and cartilage are not peculiar to dermoids; they have been seen in non-dermoid ovarian cysts. Finally, although there are striking differences between simple ovarian cysts and complex dermoids, nevertheless the difference between a complex ovarian cyst and a simple dermoid is practically nil, and, as a matter of fact, the glandular ovarian cysts are often structurally more complex than many dermoids, and there is no escape from the conclusion that *ovarian dermoids, like oöphoritic cysts in general, originate in Graafian follicles*. The chief reasons may be summarized as follows—

1. The localization of multilocular cysts and dermoids to the oöphoron.

2. The frequent association of a dermoid with a multilocular ovarian cyst.

3. The extreme frequency with which dermoids occur in the ovary can only be accounted for by some functional peculiarity. The only peculiarity it possesses in this respect is the formation of Graafian follicles.

4. Transitional stages can be traced from the membrana granulosa to mucous membrane, mucous glands and teeth on the one hand, to skin, glands, hair, teeth and mammæ on the other.

It must be borne in mind that a distinction exists between dermoids occurring in such situations as the angle of the orbit, tongue, neck, etc., and ovarian dermoids. Finally, it is high

time that some explanation should be offered to account for the origin of ovarian dermoids which shall be more satisfactory than such expressions as *fœtus in fœtu*, *pangenesiis*, *parthenogenesis*, *excess of formative nisus*, *hypererchesis*, and other guesses equally vague and unsupported by facts.

On Perineorrhaphy, by Dr. Vilhelm Heiberg.—This article by Dr. Heiberg of Copenhagen deals more especially with the method of operating introduced by Mr. Lawson Tait. After a short resumé of the operation, a brief description of Tait's method is given. The author mentions fourteen cases of lacerated perineum that have been operated on by him after Tait's method, and the result in every case has been most satisfactory, a good, broad, firm perineum being the result, even in cases in which the tear has passed through the sphincter. Dr. Heiberg has tied all bleeding points, though he notes that without ligaturing the vessels "as soon as the deep sutures are put in, the hemorrhage is arrested." He also used strict antiseptic precautions in every case, carbolic or sublimate solutions being the antiseptic preferred. In conclusion, Dr. Heiberg thinks great praise is due to Tait for thus simplifying the operation, and he believes most surgeons, if they once try this method, will prefer it to any other, whether in complete or incomplete tears.—*Birmingham Med. Review*.

Notes on Uterine Versions and Flexions, by Dr. Jacobi.—Out of thirty-five cases of retroflexion, three complained of no symptoms whatever, thirteen experienced no relief from wearing a pessary, fifteen were partially relieved, and four were completely cured. In the opinion of the author, the symptoms in most of these cases of flexion are attributable to an endometritis, or metritis, with venous hyperæmia of the uterus.—*Amer. Jour. Obstetrics*.

The Etiological Relation of Cervical Laceration to Uterine Disease, by Dr. B. H. Wells.—A careful study of 400 cases has led the author to conclude that (1) deep cervical tears do not increase but lessen somewhat the productive fertility of those in whom they have occurred. (2) Cervical tears increase the proportion of backward and downward displacements. (3) While

the average depth of the uterine cavity is but slightly increased in length, the frequency of hyperplasia uteri increases in proportion to the severity of the laceration. (4) Eversions and erosions, where there is a torn cervix, occur more often conjointly than singly, each reacting to increase or induce the other ; both their frequency and importance increase rapidly in proportion to the depth of the tear. (5) Cervical laceration tends to produce disease of the uterus and predisposes to the development of cancer. (6) As the result of cervical laceration chronic parametritis is apt to supervene ; oöphoritis and salpingitis, though not directly, are frequently indirectly started by cervical tears ; various neuroses are frequently present and only cured by an operation on the cervix.—*Ibid.*

Moseley on the Influence of Cicatricial Tissue in the Angles of the Lacerated Cervix.—The author deals with this subject from a strictly clinical standpoint, and his endeavor is to demonstrate that the so-called cicatricial plug deep in the angles of the lacerated cervix does set up numerous and varied symptoms, and is the cause of, or perpetuates, the anæmia so commonly present in these cases. The presence of this “cicatricial plug” is denied by some gynæcologists and entirely ignored by others. Amongst those who acknowledge the presence of this plug and the train of symptoms often set up by its presence are Mundé and Emmet. Dr. Moseley is astonished that its presence is denied, as his experience has led him to believe that this plug is present in almost every case of lacerated cervix, and that it generally extends more deeply on the inner side of the uterus than on the outer side. This extension inwards of the cicatricial plug is, in the author’s opinion, the reason that its complete removal can be effected more easily and with less hemorrhage than if the plug extended high up on the outer side of the uterus. Several cases are narrated in which this “plug” was removed from patients suffering various symptoms ; and in every case the complete removal of the mass was followed by complete amelioration of the symptoms. In conclusion, the author advocates the complete and thorough removal of all cicatricial tissue from the angles of a lacerated cervix ; by doing so our patients

will be cured and the cause of gynæcology advanced.—*Trans. Alumni Assoc. of Woman's Hospital, N. Y.*

Goffe on the Differentiation of Pelvic Cellulitis—After discussing the views held on this subject by various authorities, as Worrat in France, Aran, Bernutz and Goupil, Simpson, Graily Hewitt, Emmet and others, the author concludes that “cellulitis has been dethroned from the prominent position it has held in uterine pathology, and as a serious complication in gynæcological cases. In its place have come salpingitis and peri-salpingitis, oöphoritis and peri-oöphoritis, lymphadenitis and peritonic bands and adhesions.” The presence of cellulitis he does not deny in all pelvic inflammations, but clinical experience, together with the examinations made at autopsies and laparotomies, has demonstrated to him that cellulitis does not play the rôle formerly attributed to it. The serous membrane is the tissue chiefly attacked in all pelvic inflammations; cellulitis being secondary and of slight importance, as it is comparatively harmless in its action.—*Ibid.*

The Significance and Localization of Pain in Pelvic Disease, by Dr. H. C. Coe, an interesting article read before the New York Neurological Society in 1887. In a short resumé the author concludes: (1) That pelvic pain has its origin more often in the perimetral tissues than in any particular organ, being due to irritation of nerve trunks rather than nerve endings. (2) That the reflex, or transferred, pains commonly referred to certain lesions in the pelvic organs, may radiate from inflammatory foci in the peritoneum or connective tissue surrounding these organs. (3) That operations upon, or complete removal of, such diseased organs may fail to remove the pain for the reasons stated. (4) That this pain, like other nerve pains, may be sensibly relieved by the proper application of electricity.—*Jour. Amer. Med. Ass.*

Reviews and Notices of Books.

A Handbook of Surface Anatomy and Landmarks.

By BERTRAM C. A. WINDLE, M.A., M.D. London: H. K. Lewis, 136 Gower St. 1888.

This little work on Surface Anatomy is an excellent one, and will prove of much service not only to the student but to the practitioner both of surgery and medicine. It is much more elaborate in its details than the old favorite "Landmarks" of Holden, and in consequence will not be so popular with students. Many important surgical points are referred to in connection with surface anatomy, and students are instructed how to properly examine the various orifices of the body. There is nothing very new in this work, but it is an excellent compendium of what is known on the subject and which has appeared in various works. The printing and paper is excellent, but the illustrations are rather meagre. We have, however, no hesitation in recommending it as a companion to every student who wishes to apply his anatomical knowledge to the living or dead subject.

A Manual of Ophthalmic Practice. By CHARLES HIGGENS, F.R.C.S.E., Ophthalmic Surgeon to Guy's Hospital, Lecturer in Ophthalmology at Guy's Hospital Medical School, Surgeon to the French Hospital. With illustrations; 314 pages. London: H. K. Lewis, 136 Gower street. 1888.

The author of this little work professes to have been guided in its preparation by fourteen years' experience as a practical teacher of ophthalmology, and to have aimed at making a concise volume for the use of students and general practitioners. The first four chapters are devoted to optical and general outlines, the examination of the eyeball and its appendages, including the use of the ophthalmoscope, the errors of refraction and their correction. A good deal of space has been allotted to the latter, and the author has certainly succeeded in presenting the subject in a clear and comprehensive manner; indeed we know of none other small work on ophthalmology in which this part

of the subject is, for a beginner, so briefly and yet so fully discussed.

The succeeding seven chapters are devoted to diseases and injuries of the eye and their treatment. In regard to these we think the author has erred somewhat in not going beyond mere outlines; the main facts, however, both in regard to diagnosis and treatment, are carefully recorded.

Part II treats of operations. A description of the marked conditions requiring operation is also reserved for this part of the work. In this departure from the ordinary arrangement there is an avoidance of repetition that is not without advantage. The general style of the book is familiar and easy. It will doubtless meet the wants of those who seek a general rather than a detailed knowledge of ophthalmology.

Manual of Obstetrics, Gynæcology and Pediatrics.

By KENNETH N. FENWICK, M.D. Kingston: John Henderson & Co. 1889.

The author informs us in his preface that his object is to furnish an outline of the main facts in obstetrics and diseases of women and children, together with a synopsis of the physical signs of diseases of the chest and diseases of the skin. To cover such an extensive field in 244 pages necessitates a great amount of condensation. The manual is really a syllabus of the author's sessional lectures, prepared specially for the use of his students; supplemented by his own teachings, it will no doubt be of great service to them. Such manuals, however, serve only a limited purpose, and should never be permitted to supersede standard systematic works.

The Life Insurance Examiner: A Practical Treatise upon Medical Examination for Life Insurance.

By CHARLES F. STILLMAN, M.D. New York: The Spectator Co. 1888.

This book contains a large amount of information drawn from many different sources conveniently arranged for the use of the life-insurance examiner. The standard works on this subject by

Sieveling, Allen and Levan have been liberally drawn upon, while Loomis, Pepper, Da Costa, Quain, Holmes, Ziemssen, Taylor and others have been also freely consulted. This manual is well indexed, concise and practical, and should be in the hands of every insurance examiner.

Diseases of the Heart and Circulation in Infancy and Adolescence. By JOHN M. KEATING, M.D., and W. A. EDWARDS, M.D. Philadelphia: P. Blakiston & Co. 1888.

The authors in their preface give as the *raison d'être* of this work the absence of any satisfactory description of diseases of the heart in the various otherwise excellent treatises on diseases of children. They have certainly filled the blank in the present small octavo volume, and given us a very full and interesting account of this most important subject. The various chapters deal with—Congenital Diseases of the Heart and Cyanosis; Acute and Chronic Endocarditis and Pericarditis; Myocarditis; Valvular Disease; Cardiac Neuroses; and, lastly, Diseases of the Blood, including Chlorosis, Pernicious Anæmia, Leukæmia, Hæmoplasia, etc. We regret that, as this work is intended for the physician, not for the student, any space should be given to elementary remarks on methods of study, details of instruments, etc., with which the reader presumably should be thoroughly acquainted. The details of cases have been selected carefully, and are, in general, of a most interesting nature. The photographs, unfortunately, show nothing in particular. We can, however, cordially recommend the work as an excellent presentation of a very important series of affections.

A Manual of General Pathology, designed as an Introduction to the Practice of Medicine. By JOSEPH FRANK PAYNE, M.D., Oxon, F.R.C.P., etc. With 153 illustrations. Philadelphia: Lea Bros. & Co. 1888.

This work is well conceived and fairly well executed. That balance in matter and treatment so desirable in a work for students is well maintained. Pathology is at last becoming

something more than morbid anatomy, and it is refreshing to find this fact recognized in a work written by an Englishman. Physiology, as the forerunner of Pathology, takes its proper place, and histology is relegated to that intermediate position it should hold in a work on general pathology. The illustrations are well chosen and sufficiently clear to be useful. The discussions are calculated to develop the student's mind without wearying him; while the mode of presentation of the entire subject is good. We are glad to notice that the dogmatic style is disappearing from works intended for students, as it is an evidence that their teachers believe that their minds possess some elasticity, and that they should not be mere storehouses for such facts as the lecturer may see fit to drive into them. The work is, upon the whole, quite up to the present state of knowledge. This is well illustrated by the chapter on fever, in which, among other things, recent public lectures are noticed. Notwithstanding, the perusal of even so good a work as this impresses the thoughtful reader with the fact that pathology is still in a very crude and inco-ordinated condition. How much of breadth of view and grasp of wider groups of facts is still unattained becomes clear on reading such a chapter as that on inflammation. The nervous system must be made to play a greater part in all our works on physiology and pathology before we can expect to have far-reaching views. But this subject is only beginning to attract that extra share of attention it deserves. We think the work is needed, and that it is, upon the whole, a good one, to be welcomed by the profession and especially by the teachers of pathology.

Treatise on the Diseases of Women, for the use of Students and Practitioners. By ALEXANDER J. C. SKENE, Professor of Gynæcology in the Long Island College Hospital, Brooklyn. New York: Appleton & Co.

The many friends and admirers of the able and genial Brooklyn professor will hail with pleasure the advent of this book. It is dedicated to Thomas Keith, for whom Dr. Skene never loses an opportunity to express his admiration.

The first chapter is on the methods of observation, and in it

the author makes some timely remarks on the importance of teaching medical students to observe, weigh and classify the evidences of disease rather than cram with knowledge from books and lectures. Next comes the chapter on methods of examination, which we think, with advantage to the student, might have been more fully elaborated. It, however, contains the best description we have read of the methods of using Sims' speculum. It ought to be of great service to the student in learning what to all seems to be a very difficult matter. The only bivalve speculum recommended is the Cusco, which we believe to be far inferior to Goodell's base-expanding instrument, or some of its modifications. In the next chapter the development of the organs is considered and the common anomalies briefly described. Next comes a description of the diseases of the external organs. Due attention is given to the various operations for the repair of injuries of the perineum and pelvic floor, but no mention is made of Tait's flap-splitting operation, which we think far the best, especially for the restoration of the sphincter ani. In this operation no tissue is removed, and the method of passing the sutures makes it so comparatively painless that morphia is needed only in rare exceptions.

In the treatment of the inflammatory affections of the uterus the author makes a timely remark as to the indiscriminate use of the hot-water douche, which, although most valuable, is used much too indiscriminately and with heroic persistency. For intra-uterine applications the author uses a glass instillation tube or pipette. We prefer the intra-uterine syringe. Laceration of the cervix is treated with the fullness its importance deserves. For the denudation of the flaps and excision of cicatricial tissue in the angle Dr. Skene has devised a hawk-bill scissors, which he praises very highly. The sutures used are of waxed braided silk. We have for some time used Chinese silk for this purpose and think it has advantages over wire. In the after-treatment a dry tampon is laid against the cervix. We have for the last two years used iodoform-gauze dressing, and believe that the results have been better than by irrigation, while the nursing is much simplified.

The chapters on uterine myoma are fairly good, the Apostoli

treatment receiving a brief description and perhaps its due meed of commendation. In speaking of cancer of the cervix, the author repeats the statements of Dr. James B. Hunter of New York on the milk of *Aveloz*. This is the juice of one of the *Euphorbiaceæ*. Dr. Hunter, as a result of his experience of this remedy, says: "All that could be said was that they (the cases in which he had used it) were in some respects better as to the arrest of the disease and as to the comfort of the patients during its progress than those afforded by many of the usual methods. As far as he could judge at present, he should not use the *aveloz* with any expectation of effecting a cure, but it seems probable that it may do more than some other remedies towards arresting the progress of the disease and perhaps prolonging the period during which surgical treatment may be employed with some hope or promise of success. He had not lost sight of the fact that some cases of cancer of the cervix undergo changes in their progress that might erroneously be attributed to the remedies used; but after making due allowance for that source of error, there still remains something to be said in favor of the drug in question." For total vaginal extirpation of the uterus in cancer Dr. Skene has no favor.

The chapter on the menopause and its disorders is, for its length, one of the best we have ever read. In this, as in many other subjects, the author introduces illustrative cases and so greatly adds to the value of his descriptions. The chapters on diseases of the ovaries and the various necessary operations are all that can be desired. The same may be said of the pelvic inflammations and *hæmatocele*.

The most conspicuous feature of Dr. Skene's work, however, is the large share of attention devoted to the diseases of the female bladder and urethra. It occupies no less than three hundred and twenty pages, and, as might have been expected from the attention the author has long devoted to this department of gynecology, it is excellent. The book closes with a most interesting and valuable chapter on gynecology as related to insanity in women. The author has had probably a unique field for acquiring experience in this line, as for some years he

has had charge of the gynæcological practice of the King's County Insane Asylum at Flatbush, where there are four hundred female patients.

We conclude our notice of this work by saying that it is excellent in every aspect, and is illustrated by many woodcuts and a number of beautiful colored plates. The publishers' part has been admirably done.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, October 19th, 1888.

WM. GARDNER, M.D., PRESIDENT, IN THE CHAIR.

(Continued from page 477.)

Abdominal Section.—DR. WM. GARDNER related a case in which, at the request of Drs. Rodger and England of this city, he had done an abdominal section. Three weeks before the illness in question the patient, a lad of 16, had had an attack of severe abdominal pain and vomiting. This yielded to a hypodermatic injection of morphia, and in a day or two he returned to his work. The present symptoms consisted of very severe abdominal pain, vomiting, constipation, marked distension of the abdomen, and an elastic swelling of the size of a duck's egg in the region of the right inguinal canal. The pulse was rapid and the face anxious. On examination of the scrotum, only one testicle (the left) was found. The finger could be passed into the external opening of the right inguinal canal, but nothing could be detected. The patient had been etherized by the gentlemen in charge and the swelling manipulated, but without result. Under the circumstances, with a suspicion of strangulation and peritonitis, it was decided to open the abdomen. This was accordingly done by lamplight. The incision made was long enough to admit only two fingers. On incising the peritoneum a quantity of turbid serum escaped. All the ordinary hernia regions were examined and nothing discovered. The swelling in the region of the right inguinal canal was found to be solely in the abdominal wall. Nothing else having been discovered

the opening was closed. The symptoms were all much relieved for three or four days, then the abdominal distension began to increase and became very marked on the eighth day, causing anxiety for the union of the wound. Happily the bowels began to act freely and the boy rapidly recovered, and is now quite well. The swelling in the groin has completely disappeared.

Case of Severe Syphilis.—DR. BELL exhibited specimens from a case of syphilis that had died from tuberculosis of the lungs. The patient was a young girl who contracted the disease in 1886; eight months after was in hospital with severe rupia. This spring she came back suffering from hæmoptysis and some indefinite lung trouble. Patient was put on antisyphilitic treatment, but obstinate diarrhoea set in, the lung complications became more marked, and she finally died from the pulmonary disease, just twenty months after the primary affection. When last in hospital there was severe ulceration of the palate, nose and epiglottis. The post-mortem, performed by Dr. Lafleur, showed the lungs to be both moderately consolidated, hyperæmic on section, and filled with small tubercles, some of which were caseating. The base of the left lung, which was firmly adherent to the diaphragm, was honeycombed by numerous cavities about half an inch in diameter, surrounded by thick, dense and slaty-colored walls. This was the focus of infection for the other parts of the lungs. In both pleural cavities there were extensive recent adhesions. The right half of the epiglottis had been destroyed by previous disease, leaving an irregular cicatrized ledge extending obliquely from its base on the right side to a point a little to the left of its apex. There was no evidence of tuberculosis in the larynx. The liver, kidneys, spleen and intestinal mucosa showed marked amyloid degeneration, and contained a few isolated tubercles. There was no evidence of visceral syphilis. Between the clitoris and the meatus there was an oblong, slightly depressed scar three-quarters of an inch long and half an inch wide. On the trunk and upper extremities there were numerous irregular, white, depressed cicatrices, from a quarter of an inch to two and a half inches in diameter. The right ala of the nose was deficient, and showed cicatricial

contraction. There was extensive destruction of the nasal bones and of the soft palate, the hard palate was perforated, and the uvula entirely destroyed. In the brain there were six localized areas of softening. The contents of these were thick greenish-yellow semifluid matter, sometimes infiltrated with blood. None of these areas were bounded by an inflammatory zone. They occupied the following positions: 1, Superficial portion of left caudate nucleus, half an inch wide, hemorrhagic. (2) In the anterior horn of right lateral ventricle, between the corpus striatum and the white matter, one-quarter of an inch in diameter, contents thick and greenish-yellow. (3) In the centre of the right optic thalamus, about three lines in diameter. (4) In a convolution of the parietal lobe, on the right side, two lines in diameter. (5) In the occipital lobe on the right side, three lines in diameter. (6) In the middle of the left lobe of the cerebellum, a third of an inch in diameter, contents rather softer and hemorrhagic. The membranes and blood-vessels at the base presented no abnormality. The softening was probably due to thrombosis of the smaller arteries. There were no symptoms during patient's life to point to any such condition.

DR. F. W. CAMPBELL had treated the patient in the out-door department, and did not think the lung complications were due to the syphilis so much as to the hard life led by the patient and her general want of nutrition.

DRS. LAFLEUR and BELL were requested to report more fully on the condition of the brain and cord.

Tumor from the site of the Left Kidney.—DR. WM. GARDNER exhibited a tumor which he believed to be the left kidney, removed two days before by median abdominal section. The patient, an unmarried woman of 28, had first noticed the tumor two and a half years previously. It had grown slowly and been moderately painful. On examination it appeared to be of the size of a child's head, was hard, nodular and insensitive, and was so moveable that it could be shifted to any part of the abdominal cavity from its ordinary position on the left side. When the patient lay on her back, its lower end could be felt through the vagina. It could not be felt or pressed into the left loin. Per-

cussion shewed it to be surrounded by intestines. This was unmistakable in the left loin. She was watched for eight days before operation. There was pus in the acid urine constantly. Night-sweats, but no rise of temperature. At the operation the tumor was found to be behind the mesocolon, and the descending colon lay over its left or outer aspect. The peritoneum and its capsule were incised, and the tumor was then easily shelled out. The attachments were at its upper end, and seemed to be the blood-vessels and ureter. The operation was completed by gathering the edges of the capsule together and including them in the silk abdominal sutures. A glass drainage-tube was inserted; this was removed at the end of forty-eight hours. Her progress had been entirely uneventful, and now, the ninth day, recovery is assured. On section, the tumor was moderately firm, the surface greyish-white and fibrous. There are several loculi, some containing pus and others a yellowish transparent fluid. Urine was secreted plentifully from the first; the first two specimens contained some blood but no pus, since then it had contained only a little pus. This latter portion of the evidence seemed conclusive that the tumor was the kidney. All the available facts seem to prove that this was originally a moveable kidney which had become diseased.

Discussion.—DR. RODDICK asked Dr. Gardner if he would have performed the median incision if the diagnosis of kidney tumor had been made out before operation. He was inclined to regard it as a myosarcoma, and related a case in which he had operated for a similar growth in a child which turned out to be myosarcoma.

DR. LAPHORN SMITH congratulated Dr. Gardner on the success of his operation, and said he was glad to see the gynæcologist wresting further territory from the surgeon.

DR. SHEPHERD asked Dr. Gardner if it was not usual in cases of removal of the kidney by the median incision to drain through the loin. He regarded the kidney as rather an anomalous one, as all the vessels seemed to enter the upper end, and no trace of a ureter could be made out. The tumor, if a kidney, was probably functionless.

DR. GARDNER, in reply, said that for such a tumor the median incision was the best; the tumor was so movable that it could not be felt at all from the lumbar region. He was aware that some surgeons recommend drainage through the loin in such cases, but he thought that where the enveloping peritoneum was so loose, and could be so easily brought to the surface, as in this case, and be drained through the abdominal wound, the method adopted by him was preferable. The tumor was given to Dr. Lafleur for examination and report.

Intestinal Obstruction from a large Gallstone.—DR. RUTTAN exhibited a large spherical calculus sent to him for examination by Dr. DeWolf Smith of British Columbia. The patient was an insane inmate of the penitentiary that had died with symptoms of intestinal obstruction. There was no history of biliary colic. The post-mortem showed the lumen of small intestine to be completely filled by the calculus shown at the point of obstruction and for some distance above there was inflammatory thickening. Chemical examination of the calculus showed it to be a compound biliary calculus composed of nucleus of biliary pigment, surrounded by a zone of cholesterine half an inch in radius, made up of radiating plates; about this was an outer zone one-fourth of an inch thick, composed of pigment, salts and cholesterin, making a total diameter of nearly one and a half inches. That the calculus had not increased since its passage from the gall-bladder was probable, as the bile pigments were found unaltered in the outer layers. It is to be regretted that the condition of the gall duct was not noticed at the time, as cases are recorded of much larger calculi than the one shown having reached the intestines through the duct, and not, as is so common, by ulceration through the gall-bladder into the duodenum.

DR. SHEPHERD referred to a gall-bladder seen in the dissecting-room where the duct was large enough to admit the passage of the thumb, and from the bladder itself a skull-capful of calculi was obtained.

DR. RODDICK saw with Dr. Kennedy a case where the most severe symptoms simulating hepatic cancer were relieved by the passage of a calculus as large as a walnut. Patient recovered perfectly.

DR. MILLS thought the exact locality in which the calculus was found in the intestine would be of interest, as if high up in the duodenum the biliary constituents of the outer zone might have been added after the passage of the calculus and the pigments still remain unaltered.

DR. BULLER cited a case where permanent relief had been afforded a patient who suffered from biliary colic by the use of large doses of phosphate of soda.

DR. F. W. CAMPBELL had very little faith in remedial agents for the cure of biliary colic. Phosphate of soda had proved as inefficient as all the others.

DR. GARDNER said that Mr. Lawson Tait's operation of cholecystotomy now afforded a means of relief for obstruction of the duct from biliary calculi.

PRESIDENTIAL ADDRESS.

DR. PERRIGO, the retiring President, then read the following address :—

I think I am safe in saying this is the first time I have been guilty of addressing the members of this Society, and I hope you will pardon my doing so now. Now that the ice is broken, I trust it will not be the last. I am quite ready to acknowledge the fault is altogether my own, but I assure you it has not been due to any want of interest in the Society's work, because I have never yet attended any of the meetings without feeling I had learned something I had not known before, or had my memory refreshed upon some points forgotten. The mistake began, when I first became a member, in not then taking an active part, and as time went on, a natural diffidence in speaking before a gathering overcame any courage or inclination to do so. I do not wish you to consider I am speaking too much of myself in order the more fully to apologise for my shortcomings, but I say this because I see a good many young members who are pursuing the same course. If they allow a certain number of years to pass they will occupy my position and become mere listeners to other workers, to the men, in fact, who make this Society flourish. If the younger members will prepare themselves before the date

of each meeting, read a paper occasionally, be ready to defend it, and not be discouraged at any of the criticism from their more experienced seniors, they will find they will be adding considerably to their own medical knowledge and to the interest of the Society's proceedings.

Speaking upon this point naturally brings me to another, and that is, the growing absence of some of our seniors. No doubt they feel they have earned a well-merited rest from any further active work among us, although still busily engaged in medical education, yet, if they would only consider their presence here as part of their educational work, they would be conferring a benefit upon every member here. Their experience would serve to temper any of the advanced theories occasionally brought forward, and which are so apt to carry away the enthusiastic. Not only that; the mere knowledge of their being present, and of their taking part in the debates, would bring members regularly here who only come occasionally now.

The work of the Society has been unusually interesting during the past year, and of greater volume. There have been sixteen papers read this year, as opposed to twelve during the previous year :

1. Notes on Acetanilide, by Dr. McConnell.
2. Treatment of Ulcers by the Transplantation of large pieces of Skin after Thiersch's method, by Dr. Jas. Bell.
3. Questions suggested by the present Epidemic of Diphtheria in Montreal, by Dr. Armstrong.
4. The Dangers and Accidents of Local Treatment in Puerperal Cases, by Dr. J. C. Cameron.
5. Physiological and Pathological Reversion, by Dr. Mills.
6. Laboratory Notes on Papoid Digestion, by Dr. Ruttan.
7. A case of Diabetes, by Dr. Kennedy.
8. The Pharmacology of Arsenic, by Dr. Stewart.
9. The Bacillus of Scarlatina, by Dr. McConnell.
10. A case of Lightning Shock, by Dr. Mills.
11. Electricity in Gynæcology, by Dr. Smith.
12. Some rare forms of Extravasation of Urine, by Dr. Bell.
13. Poisoning by Bichromate of Potash, by Drs. Ruttan and Lafleur.

14. Some rare cases of Syphilis, by Dr. Roddick.
15. Notes on Tapeworm, by Dr. Spendlove.
15. Orbital Tumor treated by Ligation of the Carotid Artery, by Dr. Buller.

Most of these papers were of the greatest value and interest, and elicited sometimes lengthy discussions, which showed that medical men at present are more apt to think for themselves rather than follow the dicta of big guns miles away. In addition to these papers there have been a large number of pathological specimens exhibited and the clinical history attached to most of them related. It is almost impossible to relate them all, but the more important ones that elicited most discussion were—

1. Resection of the Intestine, by Dr. Jas. Bell.
2. Specimen of Tubercular Cystitis in the practice of Dr. Roddick, and shown by Dr. Johnston.
3. Development of Bone from Periosteum, by Dr. Bell.
4. Calculi from four cases of Lateral Lithotomy, by Dr. Fenwick.
5. Rupture of the Heart, by Dr. Reddy.
6. The Respiratory Organs in a case of Diphtheria which proved fatal two days after the performance of intubation, the tube being shown *in situ*.
7. Dr. Hutchison showed the Sixth Cervical Vertebra, which had been dislocated, and gave a history of the case.
8. Dr. Armstrong showed two Brains, one a case of apoplexy and the other one of cerebral syphilis.
9. Dr. Ross showed a Carcinoma of the Stomach and Liver.
10. Two Uteri extirpated by the vaginal method, one for cancer and the other for chronic endometritis, by Dr. Gardner.
11. A Patella that had been sutured, shown by Dr. Bell, the patient dying from pyæmia from a suppurating ingrown toe-nail.
12. A Perforating Ulcer of the Stomach, shown by Dr. Armstrong.
13. Dr. Lafleur showed for Dr. Shepherd the specimens, and described the post-mortem appearances, in a case of Pyelo-Nephritis, where there was infiltration of urine with sloughing of the urethra.

14. Dr. Roddick showed a Calculus weighing 15 drachms which he had removed by the supra-pubic method, in the case of a man 52 years old. The operation was successful. Twelve years ago he had removed a stone by the lateral operation in the same individual.

15. Dr. Bell showed an Exostosis, the size of a fameuse apple, which he had removed from the inner border of the lower end of the right femur of a young man.

During the year a number of patients have been brought to our meetings, the first being a case of Dr. Bell's, a child of $3\frac{1}{2}$ years old, where osteotomy for bow-legs was performed with favorable results. Dr. Stewart also showed a patient suffering from amyotrophic lateral spinal sclerosis. Dr. Shepherd showed a patient who had, he thought, suffered from a subdiaphragmatic abscess, and described the difficulties attending it. Dr. Armstrong, a case of alopecia areata. Dr. Smith, one of fibroid of the uterus, showing the results of electrical treatment. Dr. Bell also showed a case illustrating the treatment by skin-grafting for severe burn.

Most of us know the difficulty in persuading patients to consent to come before a meeting, and I am sure I am only expressing the feelings of the Society that these gentlemen richly deserve our thanks.

In addition to the papers read, the pathological specimens shown, and the patients brought before us, there have been quite a number of interesting cases related in practice, viz., a case of parasitic onychia and one of amputation of the thigh for periosteal sarcoma, by Dr. Bell; a case of cystine calculi passed per urethram and one of periosteal sarcoma of the femur, by Dr. Roddick; history of cases of intubation, by Dr. Major; a case of cirrhosis of the liver, by Dr. R. L. MacDonnell. Dr. Gardner related the case of a dermoid ovarian cyst in a pregnant woman, this being his second ovariectomy during pregnancy, both mothers being safely delivered afterwards of living and healthy children. Dr. Shepherd related a case of nephrotomy for hydro-nephrosis.

Perhaps the most interesting case related during the year was

that by Dr. Gardner of abdominal section for rupture of a tubal extra-uterine foetation occurring in the practice of Dr. Browne. This case showed in a most conclusive manner the great value of prompt operative interference in cases where there has been an early and accurate diagnosis made. Both physician and surgeon deserve credit for the result of this case, the first of its kind in Canada where abdominal section was resorted to.

Dr. Tr nholme related the cases of seven consecutive successful ovariectomies.

This is, I think, a pretty fair *resum * of the work accomplished during the past year, and compares favorably with that of preceding years.

The question of either enlarging our rooms or of securing more commodious and better ventilated ones elsewhere has frequently come up for discussion. The matter has now been left in the hands of the Council and we may expect their report at an early date. No one will doubt the necessity of more room and better ventilation, but this means an enlarged expenditure, so that the matter of the arrears in subscriptions is becoming an important one. Our financial condition is not such that we can afford to ignore these arrears much longer, and I have no hesitation in saying it is but a false delicacy in allowing them to remain and to go on augmenting. This is a question that also should be placed in the hands of the Council.

Four Cases of Peritonitis during Pregnancy.—DR. A. D. Blackader then read a paper on these cases, which appeared in the December number of this JOURNAL.

Discussion.—DR. HERVEY of Calcutta referred to a case of post-partum hemorrhage which was undoubtedly due to adhesions to the uterus from previous peritonitis.

DR. ALLOWAY said he did not think a pregnant woman was as liable to have peritonitis as others. If Dr. Blackader had been fortunate enough to have had a post-mortem on any of these cases he might have found the peritonitis to be due to a ruptured tube or the remains of an old peritonitis in the form of adhesions. Women who have previously suffered from pelvic

inflammation would naturally be liable to peritonitis from the effects of enlargement of the uterus.

DR. LAPHORN SMITH had a woman under observation who has pelvic adhesions that involved the uterus from an old peritonitis. If these adhesions broke, a peritonitis would very probably result.

DR. WM. GARDNER said that laparotomies often revealed conditions previously unsuspected, and agreed with the previous speakers that the remains of old pelvic trouble might account for some of these cases of peritonitis.

Stated Meeting, Nov. 2nd, 1888.

WM. GARDNER, M.D., PRESIDENT, IN THE CHAIR.

Excision of the Right Knee in a case in which the bones were very extensively diseased.—DR. JAS. BELL exhibited the patient and related the case as follows:—

P. Q., aged 36 years, a farmer, was admitted to hospital with the following history: He had been crippled for eight years with a gradually enlarging knee joint, and for three years past had been unable to walk except with a crutch. On examination, the joint was found to be very much enlarged, doughy to the feel, and tender on movement, which also communicated a sensation of roughness to the hand. Excision was performed, but on making section of the ends of the bones four large sequestra were found in the end of the femur and three in the head of the tibia. These were all wedge-shaped, with their bases towards the joint, and differentiated from the healthy bone by a thin velvety membrane. Two of them were gelatinous masses; the others necrosed bone. They were easily removed, and the cavities which had contained them thoroughly scraped. Owing to the removal of these bodies there was comparatively little healthy bone approximated for union. At the end of six weeks, when the dressings were removed, there was very little union, but now, at the end of three months, union is pretty firm, and will doubtless result in complete consolidation.

Separation of the Epiphysis of the lower end of the Femur.—DR. JAS. BELL exhibited the case and gave the following

history : A. B., a young English immigrant boy, aged 16 years, had been trampled in the stall of a vicious horse five weeks before coming to hospital. On examination, the epiphysis of the lower end of the left femur was found to be displaced outwards about three-quarters of an inch and united in this false position, The lower end of the shaft of the femur had ulcerated through the skin and was projecting inwards towards the right calf, whilst the leg was displaced outwards at a corresponding angle. The patient was anæsthetized, and as the parts were very firmly united, it was thought better not to separate the epiphysis again. The lower end of the shaft was therefore chiselled off and the leg straightened by an osteotomy, the section being made about an inch above the epiphysal line. The boy made a perfect recovery, and is now (four months after operation) a message boy in the city. The movements of the knee-joint are almost perfect, flexion only being slightly limited.

Compound Fracture of the Olecranon.—DR. SHEPHERD exhibited the patient and stated that the separated fragments had been sutured with silk, the result being complete bony union. The patient, aged 25, whilst working on board a ship, was struck on the elbow of the left arm by the fan of a ventilating apparatus. This split the olecranon process vertically and opened up the joint. When he came to the hospital the wound was covered with dirt, and on separating the lips of the wound it was seen that the olecranon process was split into two portions longitudinally, and the joint was opened. After cleansing the wound the separated fragments of bone were brought together with two silk sutures and the wound closed, a small drain being left at the lower end. The dressing of gauze and jute were left on for three weeks, and when removed the wound was found to be perfectly healed and the bone united. The patient went to work a month after the accident, but for a time the movements of the joint were rather limited. The accident happened in July last. At present he has as good motion in the injured elbow as in the other.

Progressive Hemiatrophy of the Face.—DR. STEWART exhibited a case and read a short paper on this affection, which

appears in the present number of the JOURNAL. It was discussed with Dr. Cameron's case of diabetes in a puerperal woman. (*Vide infra*).

Reversion in a Pigeon with Tuberculosis.—DR. T. W. MILLS exhibited a specimen of both physiological and pathological interest in the form of a perfectly white Jacobin pigeon bred by himself from a pair of red birds. Was it a case of albinism, a "sport," or an instance of reversion as understood by Darwin, or what breeders term "throwing back"? Albinism was well known among wild animals (rabbits, squirrels, etc.), and "sports" or the appearance of variations not to be accounted for on any well recognized principles also occurred. Upon the whole, Dr. Mills thought this a case of reversion. A white cross has been known to show itself in (Jacobin) pigeon-breeding after nine years of careful breeding. The subject had been considered important by Darwin, for it was largely upon the evidences of reversion to forms and markings peculiar to wild species that this writer founded his view that our domestic animals were derived from a few wild forms. The bird shown had died two days previously after ailing only about three weeks. It was a late-bred pigeon, and a post-mortem examination showed that the organs contained tubercles in every stage of development and degeneration. The moulting season was a very trying period for birds. Dr. Mills related an observation he had made to illustrate this: A young cockerel getting its second feathers was noticed to be bleeding in the region of the tail. Examination showed that the blood was oozing from the roots of the new feathers. The abundance of blood diverted to the skin, and a corresponding demand for nervous energy in this quarter explained why other parts should suffer, and illustrated the general views he entertained as to the part played by the nervous system in the vital processes and the practical importance of maintaining the balance of function so often disregarded both by brain-workers and by muscle users, as athletes. The case seemed to him very clear. The specimen also illustrated the principles that seemed to hold in regard to tuberculosis among the lower animals—the extreme rapidity of the process and the extensive character of the lesions.

This bird had been ill apparently only three weeks, and was fairly well nourished at death. The tubercles were very widely distributed, the organs inflamed, and bound together by recent adhesions. Owing to enlargement of organs and pressure, the apex of the heart was squeezed to such an extent that it must have been functionless, while the immediate cause of death was in all probability mechanical interference, in part at least.

DR. SHEPHERD said he was much interested in the case of reversion exhibited by Dr. Mills, and stated that it was not at all uncommon in the human family. There is in nearly every person's anatomy some form of reversion to an earlier type. As bearing on these reversions in color, he instanced the occurrence of a red head in a family in which it had not been seen for several generations. He also mentioned a case which had lately come under his observation of a cow having two rudimentary metacarpals developed in the far limb, these being the rudiments of the second and fifth toes.

DR. SMITH asked if such a bird would be fit for food. He had no doubt that many birds were offered for sale that were subjects of tuberculosis.

Diabetes following peculiar nervous symptoms in a Puerperal Woman.—DR. J. C. CAMERON reported the case, which appears in another part of the JOURNAL.

Discussion.—DR. MILLS, in speaking of the cases detailed to the Society by Drs. Stewart and Cameron, referred to the views he had recently presented on the relation of the nervous system to the vital processes at the meetings of the Canadian Medical Association and the Washington Congress (now in course of publication in the *New York Medical Journal*). He thought it would greatly widen our conceptions and give truer views both of physiological and pathological processes if all the vital processes (metabolism) were regarded as a related whole, the parts of which could not be isolated and placed out of relation with the rest. That such had grown up in our minds was the result of book treatment and had no foundation in nature. What was "nutrition"? Could it be considered apart from secretion, heat production, etc. He maintained that it could not without the

danger of getting artificial conceptions. Were these trophic nerves? was a question subordinate to, Does the nervous system in mammals regulate the entire metabolism or only certain phases of it? If it regulated secretion, he did not see, apart even from special evidence, how the conclusion could be avoided that it regulated heat production, etc., for these processes were only *phases* of an inseparable whole while life lasted. It would appear that physiologists had substituted their own artificial conceptions for the real state of the case as it exists. In one sense all nerves were trophic. Dr. Cameron's case was a remarkable, but not isolated instance of the truth of the view that heat production was under the influence of the nervous system; and if so, why not the entire metabolism of the body. If the sugar in the urine in this case was really grape sugar, it was another evidence for such a general view as he was advocating. The narrow views as to diabetes being due to disorder of the liver only must also be abandoned. We were satisfied with explanations that were too simple and also artificial. We constantly forgot how complex the relations among the different parts of the body were.

DR. LAPHORN SMITH said he had seen the temperature rise as high as 103°F. after drinking a cup of hot tea. He had also seen the receipt of bad news cause an elevation of temperature in puerperal women.

DR. RUTTAN asked if lactose had been looked for in this case. Milk sugar in the urine is not at all an uncommon phenomenon in puerperal women, especially when the breast secretion stops or when the child is weaned. Lactose, like glucose, reduces copper, but, unlike it, it does not ferment with yeast. The phenyl hydrazin test would also show the difference between these two carbohydrates.

DR. GEO. ROSS said that the striking observations of Dr. Cameron were of the greatest interest; he was not aware of similar ones. Elevation of temperature in connection with nervous diseases seems to be true. In the puerperal condition the nervous system seems to be particularly liable to disturbance. A similar condition seems to exist in convalescence from typhoid. *Sudden* elevations of temperature are commonly seen after

typhoid from nervous and emotional causes, but are of no serious import. This elevation is quite different from the gradual rise that indicates a relapse. Glycosuria is not usual from the trivial causes which give rise to these elevations of temperature; indeed, elevation of temperature does not usually accompany sugar in the urine. The fact that the temperature dropped at night, became elevated during the day, and yielded to bromide of potassium, was significant of nervous disturbance.

DR. REED, referring to Dr. Stewart's case, related a case of atrophy of the muscles of the face without atrophy of the other tissues. He also referred to cases of elevation of temperature caused by the shock of a railroad accident.

DR. BLACKADER stated that intense fright sometimes produced elevation of temperature.

DR. STEWART said that in the case exhibited by him there was atrophy of bone, muscle and subcutaneous connective tissue. Dr. Cameron's case showed the value of methodical observation. There is an Hippocratic axiom which says that the action of drugs shows the nature of the disease. The fact that the bromide of potassium acted as an antipyretic, points to the neurotic origin of the pyrexia.

Correspondence.

NEW YORK, Dec. 27, 1888.

To the Editors of THE MONTREAL MEDICAL JOURNAL.

The medical department of the University of the City of New York is now experiencing one of those disturbances which most colleges at some time or other have to undergo when a change in the teaching staff does not meet with the approval of the students. Disturbances, however, are of various degrees, and that which took place a few days since well deserves to be classed as superlative. The writer happened to be present a few years ago when one of the professors made an announcement which was agreeable to the students. The vociferous and continued applause that followed made him feel that for once he was brought into contact with the noisy medical student, as he

is usually described. The students stamped, kicked violently the desks in front of them, shouted at the top of their voices, and invented so many ways of keeping up a continued noise, that it was fully fifteen minutes before the professor was allowed to go on with his lecture. So much for the university medical students in their amiable moods. Taken in the opposite condition, one's imagination need not be exerted to any extent to fancy what their powers are. These they have manifested for the past week by driving the professors from the lecture halls by cat-calls, hoots and groans, and it is even added with things of a more tangible nature, to evade which the men of learning had to use all their customary wisdom and more than their customary agility. The rebellion, as it is aptly termed by one of the leading dailies, arose from the dissatisfaction felt by the students with the treatment by the Faculty of Professor F. D. Weisse, the author of a recent work on surgical anatomy. Shortly after the opening of the session Prof. J. W. Wright resigned, and the chair of surgery which was thus vacated was bestowed upon Dr. Lewis A. Stimson, the professor of anatomy. This was considered a just and usual promotion, but it was expected by the students that Prof. F. D. Weisse, who held the chair of Practical and Surgical Anatomy, would be promoted to the chair of Anatomy. This was not done, however, and Prof. Stimson undertook for the time to fill both chairs with some assistance. He soon found the double task too onerous, and one day announced to the class that in the future the lectures on anatomy would be delivered by Dr. Woolsey, a graduate of the College of Physicians and Surgeons of three years standing, and who, since his graduation, had studied abroad. Although a feeling of dissatisfaction had been evident for some time, it was now only that the smouldering embers burst into flame. Excitement became rife, and the Freshmen's voice, probably from its freshness and unimpaired strength by any, as yet, too close and continued application to study, was naturally heard above that of all the others. Here was a man, they said, taken from a rival college to teach them when they had among them a popular graduate of their own institution who was recognized over the world as an authority on anatomy. The students grew more indignant, and the excitement reached its climax when they soon afterwards learned that Prof. Weisse, not pleased with his treat-

ment, had tendered his resignation, to take effect at the end of the term. The students make the charge against Prof. Loomis of wishing to have things in the Faculty all his own way, and that his opposition to the appointment of Dr. Weisse arose from his dislike of having anyone admitted as a member of the governing faculty who would likely exhibit any independence. They blame him, also, as being the instigator of Prof. Wright's resignation, who was quite popular with the students. Prof. Loomis denies these charges, and declares that the statements are all false. The reason which he gives for the non-appointment of Prof. Weisse is that the Faculty have resolved to decide the appointment by competitive examination—an examination which is open for Prof. Weisse as for anyone else. He further says that Prof. Weisse was simply a subordinate in the anatomical department and had no right to succession, as he was not in the order of promotion.

Prof. Weisse's formal statement, as it appears in one of the most reliable morning papers, is rather a lengthy affair. It is to the effect that he first became connected with the University in 1863 in the capacity as assistant to the chair of surgical anatomy. In 1876 he undertook the teaching of practical anatomy under a newly-created title of Professor of Practical and Surgical Anatomy. A form of contract was entered into with the Faculty by which he engaged to run that department without any expense to the Faculty, by which the Faculty promised that he would not be interfered with by the then or any future professor of anatomy. In the spring of 1888 the contract was broken by the Faculty by appointing the then professor of anatomy, Dr. Stimson, on a committee to investigate the efficiency of his teaching. One thing led to another, and it ended in his sending his resignation to the Dean.

The students have been holding noisy indignation meetings, and appointed a committee to call upon the Dean asking that Prof. Weisse be appointed to the vacant chair of anatomy. If this request is not granted they threaten to go over to the Bellevue Medical School. Thus the matter stands, as far as they are concerned, until the expiration of the holidays. There can be little doubt what the action of the Faculty will be in the matter. In the forcible language of the Dean, "If it comes to the point whether this college is to be run by the students or the Faculty we will settle it in short order." When the students' ardor will be cooled off a little by time and reflection they will scarcely carry out their threat, which to many would be an impossibility from a pecuniary point of view, as they would lose their entrance fees.

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SURGICAL MISHAPS.

It has been said that in surgery we learn more from our mistakes than our successes, and there is no doubt some truth in this assertion. We all, however, wish, if possible, to gain this knowledge from the mistakes and mishaps of others, and are always pleased when these are pointed out to us in such a way as to prevent similar misfortunes occurring in our own practice. Some of the accidents of surgery may be classed among those disasters which cannot be foreseen or prevented, but many are preventable, and are due either to gross carelessness or ignorance. We are indebted to Prof. Nussbaum of Munich for a most interesting and instructive monograph entitled *Über Unglücke in der Chirurgie*—a second edition of which has lately appeared. If this be carefully perused by the young practitioner he may be saved much suffering in reputation, mind, and pocket. In speaking of anæsthesia, Prof. Nussbaum recommends ether in cases of weak heart in preference to chloroform, but still he does not think chloroform dangerous, for in between eleven and twelve thousand administrations only one death occurred. This, he says, is not a greater mortality than would follow eleven thousand balls, dinners and such like amusements, and hence chloroform is not a bit more dangerous. It is probably quite as safe as tobogganing or football. Vomiting and retching, our author states, can be easily allayed by the hypodermic injection of a little cocain. No doubt many cases in this country which die after operation from so-called shock are victims of ether badly administered. Not a few etherizers give the anæsthetic recklessly on the supposition that it is a perfectly safe thing, and patients are sometimes poisoned by an overdose of the drug and occasionally die of

asphyxia on the operating table. However, as Nussbaum says, all the deaths which occur during the administration of chloroform or ether are not due to these drugs, for even before the days of anæsthetics sudden death occurred before and during operation. Dupuytren records no less than nine such cases where death occurred before the operation was commenced. One case, a boy with stone in the bladder, was on the operating table, and before commencing Dupuytren marked the perinæum with his finger-nail to show the students the line of incision; while doing this the boy died. We hear occasionally of sudden death following the simple operation of catheterism.

Among the accidents which may follow operation or other traumatism we have tetanus, traumatic delirium, mania, delirium tremens, fat embolism, septicæmia, pyæmia, etc.

These are misfortunes which are not easily prevented and which often prove fatal. The most unfortunate accident of surgery is a death from hemorrhage; children under three months stand operations badly, and a comparatively small amount of hemorrhage may prove fatal. Deaths have occurred from the bleeding after the operation of hairlip or the opening of an abscess. In adults it was formerly thought to be a fatal accident if the jugular or crural veins were wounded. Now, injury of these vessels is no longer dreaded, and they are tied as successfully as arteries. Nussbaum says the best known instrument to arrest hemorrhage is the operator's own finger; it is soft, elastic and impermeable to moisture, it can be easily disinfected, and is the surest means when the exact spot of the hemorrhage cannot be immediately determined; in hemorrhage due to gangrene of the vessels no other method is as good. Sepsis is the greatest misfortune of surgery, and is usually a preventable one. When speaking of fractures, Prof. Nussbaum sagely remarks that the treatment of no affection brings the doctor so many stripes and so little credit as that of fractures; still he contends that only by gross carelessness in the treatment will gangrene supervene in the great majority of cases.

Amputations also may result in many misfortunes. The flaps may be too short and a scar, which is a life-long trouble to the patient, be left over the bone. He relates the case of an individual who came to a klinik for the purpose of hav-

ing one of his legs amputated for incurable multiple ulcers. There were ulcers on both legs and both were bandaged up. The surgeon unfortunately amputated the best leg, and, curious to relate, after this the ulcers on the leg which had been at first condemned rapidly healed. It is said that on the field of battle not a few sound limbs have been amputated in the excitement of the moment, and this, too, by experienced surgeons.

In pulling teeth the jaw has not infrequently been fractured, and Nussbaum relates a case of his own where endeavoring to extract two teeth which were locked together, he dislocated the jaw and finally had to chisel out the teeth. The jaw was replaced and when the patient was recovering from the ether he retched violently and the jaw was again dislocated. It was again replaced and fixed by a bandage. He also relates a case of large tonsil which he endeavored to excise with a tonsillotome. The tonsil was so hard that the cutting part of the instrument broke off. On examining the part he found there was a concretion in the tonsil. He could not find the broken piece of the instrument anywhere—the patient had swallowed it. However, under the persuasive influence of a dose of salts it was passed per rectum a couple of days after. When speaking of the dangers and difficulties of tracheotomy the author relates a story of one of his own pupils in large practice who asked him to help him to perform his first tracheotomy. The child was three years old and thin. The operator boldly cut down and exposed the trachea, as he thought, then incised it and endeavored to introduce the canula, but failing to do so he cried out that the whole trachea was so filled with membrane that the canula could not be introduced. Nussbaum examined the wound and found that the young operator had laid bare the spinal column and incised the inter-vertebral substance and thought he had cut into the trachea which had been pushed aside. Sudden death during or even before the operation of tracheotomy is familiar to surgeons who frequently perform this operation, and the immediate cause is the anæsthetic, which acts badly in cases where the respiration is obstructed. In adults, cocain may be substituted with advantage.

There are many other mishaps alluded to by Nussbaum,

such as the incision of a hernial tumor on the supposition that it is a suppurating gland, which is a much more serious mistake than cutting down on a suppurating gland thinking it is a strangulated hernia; cutting into a bladder and finding no stone; excision of the testicle for hydrocele; cutting off the end of the glans penis in the operation of circumcision; wounding the bladder or ureters in ovariectomy or extirpation of the uterus, etc. But we have already exceeded our limits, and however tempting the further consideration of these misfortunes might be, space does not permit us to more than mention them. At some future time we may return to this most interesting subject.

ALEXANDER'S OPERATION.

How opinions change as time passes on. A few years ago it was thought by a majority of surgeons that Alexander's operation would pass away and not come to the surface again. Of late, however, there have been investigators at work who have brought the claims of Alexander regarding the shortening of the round ligaments again before the notice of the profession. And in this respect it is satisfactory to note that many of the surgeons who failed to get satisfactory results during their first attempts, have now become enthusiastic in praise of its curative powers. In the retrospect of our present issue our reviewer gives a synopsis of a paper recently published on this subject by Dr. Mundé, of New York. In Dr. Mundé's declaration that further experience has caused him to change his opinions, and that, in the majority of cases, the ligaments *can* be found if sought for in a correct manner, we have a very strong argument in favor of the operation and of the benefits which we can fairly hope will accrue from it. The operation has now been performed about three hundred times. In the beginning of its career it was received with universal favor in England, somewhat with indifference in France, and in America only one operator—Polk—had expressed himself completely in its favor, saying it was the most effective of all methods towards the cure of, in particular, prolapse of the uterus. Mundé, although having suffered some failures at first, and much discouragement, always allowed that the operation was rational in theory, and that if the ligaments

could be found and shortened, a permanent cure could be looked for. Many surgeons, however, are yet unwilling to admit that pessaries, perineorrhaphy and elytrorrhaphy, have entirely lost their usefulness, and that every woman with displacement should have her ligaments shortened. When extreme views of this nature were entertained the procedure became open to much abuse, as is the case with every new operation, and when those who held these views failed to obtain cherished results, chiefly through their own insufficiency, they at once began to roundly abuse the method; the finding of the ligaments could not be relied upon; when found they often would not run; when they did run they dragged the peritoneal covering with them, endangering the patient's life from an attack of peritonitis; hernia, septicæmia, and other surgical horrors would result, all of which hallucinations we can now see have been the outcome of hysterical or unstable minds.

In 1886, Dr. Manrique of Paris published a small book upon this operation. The conclusions he reached from a careful and exhaustive study of the subject are as follows: The operation of shortening the round ligaments is perfectly rational from an anatomical and physiological standpoint. It cures deviations and displacements by placing the uterus in such a position that the current of the forces, which gravitate towards the pelvis, will converge behind that organ instead of impinging on its surface. Complete or incomplete prolapse may be cured by this operation, except when complicated by periuterine adhesions. Where cystocele, rectocele or prolapse of vagina complicated with the uterine displacement, elytrorrhaphy should be performed in addition to Alexander's operation. The operation will also restore the prolapsed ovaries if not adherent. It does not interfere with the course of gestation nor the phenomena of labor.

Of the recorded cases of death following Alexander's operation none have been proven on enquiry but one of Alexander's own and one of Bozeman's. In both of these cases the cause of death was pyæmia. From an impartial standpoint, then, Alexander's operation may be said to be free from danger, rational in its aim, and probably effective in results.

There is a historical side to this operation, to which we will

briefly allude. The assertion of Doléris that the operation should be known rather as Alquié's than Alexander's is incorrect and unjust. It seems that in 1840 Alquié suggested the method, but there is absolutely no record of his ever having performed it. In 1864 Deneffe actually performed the operation, but failed to find the ligaments. In 1869 Kœberlé of Strasburg, during a gastrotomy, sewed the left broad ligament in the angle of the abdominal wound and thus permanently cured a retroversion. Up to 1881, therefore, it is clear that no operator designedly shortened the round ligaments with the end in view of curing prolapse of the uterus. It was in this year that Alexander operated and in the following year he published his first four cases. It is evident, therefore, that to Alexander belongs the credit of having shown that the operation was feasible, although theoretically it had suggested itself to others and had once been unsuccessfully attempted.

THE PREVENTION OF TUBERCULOSIS.

Although our knowledge of the relation between human and bovine tuberculosis is far from complete, it has received important additions as the results of the recent tuberculosis congress, held in Paris, and from the report of a committee (medical and lay) appointed last April to enquire into the nature and extent of pleuro-pneumonia and tuberculosis in the United Kingdom.

There appears to be a concensus of opinion that there is greater danger of tubercle being propagated by the use of uncooked milk than from the use of meat from diseased animals.

The English committee recommend such legislation as will bring bovine tuberculosis under the list of contagious diseases. Legislation to this end has already been effected in France. The immediate slaughter of tuberculous animals is strongly recommended.

It will, no doubt, be some time before we can hope for such legislation in this country. We would direct the attention of the members of our different Provincial health boards to this all important matter. They can at least strongly urge the importance to the public health of appointing men to inspect our meat supply, who have the knowledge and experience

necessary to diagnose tuberculosis in the lower animals. It is lamentable that at present this important task is left to butchers.

THE TOE REFLEX.

Dr. Wharton Sinkler, in a recent number of the *Medical News*, describes a peculiar form of tendon reaction seen in cases of pressure myelitis and secondary lateral sclerosis. It is elicited by strongly flexing the great toe while the lower limbs are extended. Immediately after this manoeuvre is performed, the foot becomes flexed, then the leg, and finally the thigh is flexed on the pelvis. At once there follows a return to the formerly extended position of the limb. The contractions occur after forcible and gentle flexion of the toe. In all the observed cases, the ordinary tendon reactions were also much exaggerated.

It is an entirely different phenomenon from Westphal's paradoxical muscular contraction. The latter is brought out by flexing the leg on the foot, when, if present, the foot will be kept in a state of flexion even for some minutes, owing to a tetanic contraction of the tibialis anticus muscle.

STRYCHNINE IN NARCOTIC POISONING.

Dr. Gibson of Edinburgh, in the current number of the *Practitioner*, tells us that he has had much success with the action of strychnine in narcotic poisoning, especially in opium narcotism. He points out the danger of using atropine in these cases. There can be no doubt that the action of atropine as a physiological antagonist to lethal doses of opium has been much overrated. As atropine given in excess paralyzes the respiratory centre, it is clear that the borderland between a stimulating and depressing dose may be overstepped, and as result we have the depressing action of atropine added to that of opium. No such danger is to be feared from the employment of strychnine—even in excess.

As a stimulant to the respiratory centre strychnine is now believed by many to be fully equal to atropine, and as it is free from the dangers attending the administration of the latter in larger doses, it should be employed in preference to

it. Dr. Gibson condemns the method of keeping a narcotised patient awake by walking him about as dangerous. It does certainly appear to be a crude and exhausting way of keeping a person awake. The same end, without exhaustion, may be obtained by the use of the electric brush. An important point to attend to in the treatment of opium poisoning, is to feed the patient and prevent the loss of heat.

—From the numerous instances of a history of injury given by parents in cases of polio-myelitis, it is fair to assume that this disease may be at times due to traumatism. At a recent meeting of the Medical Society of London, Dr. C. E. Beevor exhibited a boy, aged 12, who presented the symptoms of a limited atrophic paralysis of the left arm and spinate muscles coming on after a fall on the left elbow joint. Owing to the absence of any history of anæsthesia, the cause of the paralysis was considered by Dr. Beevor to be due to a polio-myelitis. An important diagnostic feature in this case was a paralysis of the pectoralis major for one movement and not for another. The clavicular part of this muscle acted in the adduction of the humerus, but it failed to contract in raising up the arm when advanced. This would be in favor of a polio-myelitis, as muscles are functionally grouped in the grey matter.

NOTES AND COMMENTS.

In ancient Rome, the worship of Æsculapius, imported from Greece, was almost universal, and the brotherhood of the *Asclepiadæ* formed a vast organization, resembling in many respects the Christian priesthood, with temples, which served the double purpose of shrine and hospital. The temple of the God at Athens has recently been excavated, and in the *British Medical Journal* of Nov. 10th a tantalisingly brief account is given in an abstract of a lecture by Miss Jane Harrison "On Hospitals among the Greeks."

In his delightful story, *Marius the Epicurean*, Mr. Walter Pater gives an admirable description of the organization of, and modes of practice in, these great establishments, at one of which, in the Etrurian hills, Marius sought relief from some boyish sickness. A paragraph of the chapter is worth quoting

in illustration of the belief then prevalent, that all the maladies of the soul might be reached through the subtle gateways of the body—an attitude of mind so opposite to the latest development in therapeutics in which all corporeal ailments are attacked through the soul. “*Salus*—salvation—for the Romans, had come to mean bodily sanity; and the religion of the god of bodily health—*Salvator*, as they called him, absolutely—had a chance just then of becoming the one religion; that mild and philanthropic son of Apollo surviving, or absorbing, all other pagan godheads. The apparatus of the medical art, the salutary mineral or herb, diet or abstinence, and all the varieties of the bath, came to have a kind of sacramental character; so deep was the feeling, in more serious minds, of a moral or spiritual profit in physical health, beyond the obvious advantages one had of it; the body becoming, truly, in that case, but a quiet hand maid of the soul.”

To a physician the touching account of the cure is heightened by the introduction of the great Galen, who was the most distinguished of the *Asclepiadae*.

In a recent essay on *Society in Rome under the Cæsars*, Mr. Inge does not give a very pleasant account of the doctors, though we learn from him that there was one period at least in the world's history when large fortunes were common in the profession. Specialism was carried to an extent as great as in ancient Egypt and there were gynecologists, dentists, oculists, aurists, etc. No legal precautions were taken to prevent incompetent and disreputable persons from practising. Mr. Inge states that there is no direct evidence as to the ordinary amount for doctor's fee at Rome.

Literature has often been enriched by those who have deserted medicine for the muses. But to drink deep draughts at Pierian springs unfits, and when the thirst is truly divine should unfit, a man for the worrying rounds of practice. It is shocking to think that had Goldsmith secured the confidence of the old women in Bankside, Southwark, we should probably never have known the Vicar, Olivia, or Tony Lumpkin. Still worse, to think of what we should have lost had Keats passed on from a successful career at Guy's to obtain even a distin-

guished position as a London Surgeon! Happily, such men soon kick free from the traces in which the average doctor trots to success.

The most conspicuous modern example of success in both fields is offered by the autocrat of the Breakfast Table, who, for many years, occupied the chair of anatomy at Harvard, and who, as a young man, made permanent contributions to practical medicine. In his last book, *One hundred days in Europe*, he mentions having sat next to Mr. Lawson Tait at dinner and he suggests the question "which would give most satisfaction to a thoroughly humane and unselfish being of cultivated intelligence and lively sense—to have written all the plays which Shakespeare has left for an inheritance to mankind or to have snatched from the jaws of death scores of suffering women and restored them to a sound and comfortable existence? I know of no man who could so well make answer to this question as the Autocrat himself. Would he rather go down to posterity as the man who, in this country at least, first roused the profession to a sense of the perils of puerperal fever as an infectious disease—and who thereby has probably saved more lives than Lawson Tait—and whose essay on the subject—*pace* shades of Meigs and Hodge—is a classic in American medical literature, or would he chose to be remembered as the author of the *Pearly Nautilus* and *The Last Leaf*?

All this merely serves to introduce Doctor J. M. Crawford, of Cincinnati, who has been quenching his thirst by a translation of the Kalevala, a series of very ancient poems which form the national epic of the Finns, and which were first collected by two members of our profession, Doctors Topelius and Lönnrot. It is a most creditable piece of work, and competent European critics speak in the highest terms of the way in which the difficult translation has been rendered. When we consider how unproductive our homœopathic brethren have been—except in therapeutical literature—this contribution from a man who occupies the chair of Physiology in one of the western Homœopathic Colleges, is doubly welcome.

For the following, I blame that case of railroad delivery which has evidently given me a most fictitious reputation. A

few days ago I received an urgent summons to come at once to an address at the northern part of the town. On arrival I found my *confrère* looking very tired and distressed after an anxious night with a primipara. He greeted me with the information that one child had been born but that he did not know what to do about the second, as he believed there was hour-glass contraction of the uterus. I assured him that our course of action was clear; we sent at once for an obstetrician. I had difficulty in convincing him that I was not a professor of the art, but he persisted that my reputation was associated in some way with obstetrics, and brought up that north-west case! What I have suffered on account of that baby! To be jeered at by the French journals, to be called by the editor of the *Medical Record* a narrator of funny stories, to be referred to by my friends as Munchausen—these things have been hard to bear, but on the strength of that case to develop a consulting practice in obstetrics, is indeed a warning. Hereafter I shall stick to my last.

WILLIAM OSLER.

Obituary.

RICHARD A. KENNEDY, M.D.

We regret to have to record the death of Dr. R. A. Kennedy, for many years one of the leading obstetric physicians of this city. He was born in this city, January 1st, 1840. Receiving his education in Montreal, he studied medicine at McGill University, and graduated in 1864. Almost immediately afterwards he began practice at Dunham, in the Eastern Townships, but remained only three years, as the field was too contracted and not congenial to his ambition. He returned to Montreal, where he practiced the remainder of his life-time. Dr. Kennedy was a most persevering worker, and soon had acquired an extended clientèle. When the Medical School of Bishop's College was founded, he was offered and accepted the Chair of Anatomy, but two years afterwards was transferred to that of Obstetrics and Gynæcology. This position was more to his liking, and he filled it creditably, earning the reputation of being a most con-

scientific teacher. He held this position, as also that of Registrar, until failing health compelled him to resign. Fifteen years ago he had a severe attack of hemoptysis, which compelled him to leave for southern Colorado, where he remained during one winter. He derived much benefit from his sojourn there, and returned in the spring. He immediately plunged into work again, and was soon busily occupied with one of the largest obstetric practices in the city. He was never free, however, from a slight cough, which he always said was due to his throat, and laughed at his friends, who warned him of over-fatigue and of the possible cause of his disease. He has often said his friends were wrong, and that he would outlive some of them. During the last six years he had several severe attacks of pleurisy, from each of which he took some time to recover. One year ago he decided to return to Colorado, where he remained three months, returning not at all benefited from his trip. He still, notwithstanding the remonstrances of his friends, kept to his work, and literally died in harness.

Dr. Kennedy was also one of the founders of the Western Hospital, and the success of that institution is largely due to his management in its early years. Although not a brilliant man, he was essentially an honest and thoroughly practical physician, and his opinion and assistance in obstetric cases were frequently sought by his brother practitioners.

Medical Items.

—Koenitz looks upon the presence of peptones in the urine of pregnant women as an almost certain sign of the death and maceration of the foetus.

—Dr. Poore, in a lecture recently published in the *Lancet*, advances the opinion that it is not unlikely that all cases of acute yellow atrophy of the liver are due to phosphorus poisoning. Since the recognition of the marked changes occurring in the liver from taking phosphorus in over-doses, the cases of so-called acute yellow atrophy reported have been very few. If there is a true idiopathic acute yellow atrophy it is clinically indistinguishable from phosphorus poisoning.

Publisher's Department.

—Messrs. Eli Lilly & Company, of Indianapolis, have issued a work entitled "Handbook of Pharmacy and Therapeutics." The aim, as stated in the introduction, is to furnish the busy practitioner a reliable means of ready reference, at once concise, systematic and authoritative, to which he may refer with confidence in cases of doubt. Younger members of the profession and medical students will find this little work full of suggestions. It will be sent free to any physician, druggist or medical student by addressing Eli Lilly & Co., Indianapolis, Ind., mentioning this Journal.

MEAT *versus* SALT.—Science teaches us that salt meat has considerably less nutritive power than fresh meat. The same principle applies in a higher degree to a number of liquid extracts of meat, or so-called beef-tea, or bouillons, which are being offered to the English public at prices entirely out of proportion to their real nutritive value. According to analysis by Dr. Rudolph Sendtner, published by the Royal Analytical Institute of Munich, most of these liquid extracts contain only a very small proportion of real extract of meat, but an enormous quantity of salt, with the addition of some flavoring ingredient like celery, or similar stuff; and in analyzing five different sorts Dr. Sendtner obtained the following results:—

No. 1 being considered as one unit of extract of meat.

" 2 is equal to 1.62.

" 3 " 2.43.

" 4 " 2.84.

" 5, the real Liebig Company's Extract of Meat, being equal to 6.20.

And in calculating the quantity of salt added to the different sorts: No. 1 contains 77.83 per cent.

" 2 " 56.70 "

" 3 " 52.68 "

" 4 " 54.69 "

No. 5 (the Company's Extract) contains no added salt at all. This proves to a certainty that the consumer, in using these various sorts of liquid extract of meat (bouillons), pays mainly for a very strong solution of common salt, slightly flavored with some extract of meat and some other ingredient of no nutritive value. Beef-tea made from Liebig Company's Extract of Meat is therefore of far greater nutritive value as a stimulant, and infinitely cheaper at present retail prices. The winter season approaching, this seems to be a useful hint to consumers of beef-tea or bouillon, so as to enable them to get their real money-value.