

MIDWIFERY AND GYNÆCOLOGY.

Puerperal Eclampsia.

Dr. J. E. BURTON, after summarizing the views and facts regarding puerperal eclampsia, concludes:—

1. That puerperal eclampsia is a motor-neurosis associated with loss of consciousness.
2. That it stands in intimate relationship to the convulsions of childhood and to epilepsy.
3. That only one factor in its production is constant, viz: a peculiar condition of the nervous system that may be designated as one of "unstable equilibrium," and that this factor is common also to the convulsions of childhood and to epilepsy.
4. That retention of urinary constituents, when present, vastly increases the tendency to convulsions in pregnancy, but that outside the conditions of pregnancy and childhood such retention is but rarely the cause of convulsions.
5. That nerve irritation—shock, emotion, violent pain, uræmic or other morbid condition of blood, etc.—is capable of setting up sudden vaso-motor spasm of cerebral bloodvessels.
6. That this spasm of bloodvessels, causing sudden anæmia of the brain, is the cause of the convulsions, and, I would add, of the consequent coma.

Dr. Burton reports an interesting case in which he bled to 3 viij, but with little effect. The patient remained comatose for three days and was thoroughly exhausted by the violence and long continuance of the convulsions. For three days she had had no food or medicine except by the rectum, for the coma was so deep that the reflex irritability of the palatal and pharyngeal muscles was absolutely lost. Whatever fluids were put into the mouth, no efforts of swallowing followed.

At this time he determined to inject some food into the stomach. He procured a No. 12 male catheter, and, by means of a piece of India-rubber tubing, attached it to a Higginton's syringe. He then mixed a breakfast-cupful of milk with an ounce of brandy, and about a drachm of Liebig's extract of beef. For an episcure such a compound would perhaps not be palatable, but it was not intended to touch the palate of the patient, so that the flavour was a matter of indifference. He then passed the catheter into the stomach and injected the whole of the mixture, with the comfortable feeling that at any rate the poor creature would not die of starvation. Within an hour consciousness returned, and from this time she was able to swallow. Her progress towards recovery was now uninterrupted.—*Liverpool Med.-Chir. Journ.*, July, 1883.

The Use and Abuse of Pessaries.

This subject has before now been discussed from the point of view of the proper selection of cases in which pessaries are or may be useful. The subject has various bearings. In the first place, the statistics of Vedeler and Herman show that ante flexion is more normal than any other condition in multiparous women, and that flexions, as flexions, do not, as a matter of fact, cause dysmenorrhœa. It is impossible to conclude that, if flexions do not cause the most direct of all uterine symptoms—dysmenorrhœa—they will cause the symptoms known as indirect or remote, for a test of which we refer our readers to the text-books *passim*, and which include almost every ailment to which female flesh is heir. This being the case it follows that flexions, as flexions, should not be treated. But, secondly, we will suppose a typical case in which pessaries are known to do good—namely, more or less descent of the uterus, with or without

retroversion or retroflexion (which are most probably indications of descent), and we will suppose a pessary to be inserted—what amount of attention (*i. e.*, attendance) should this entail? Undoubtedly a woman wearing a pessary should not be sent away ignorant of its presence, and without any directions. She should, therefore, be informed, that such an instrument has been inserted; and she should be given certain directions. Thus, it is advisable at once to tell her that it is well to wash out the vagina once or twice a day with simple water, which will prevent secretions from accumulating, decomposing, and causing an unpleasant smell (which in some cases is had enough to suggest the presence of cancer); she should also be told that soreness, itching, or profuse discharge indicates that the pessary should be seen to, and, generally, that it should not be worn without being seen to three or four times a year. It is also usually advisable that the doctor should satisfy himself in a week or so that the pessary is doing good, and doing no harm, and then, having once started the treatment, the patient should be left to test its efficacy. Now this test implies the removal of some symptoms or symptom, which may justly be attributed to some former morbid condition, and it also implies the locomotion of the patient. Generally speaking, a patient lying down is better without a pessary, whatever displacement is present; thus it is rare for even complete procidentia not to reduce itself, or become much smaller, when the patient lies down, and the symptoms of partial descent, which (if there are any symptoms at all) will include almost certainly a sense of weight and dragging pain in one or other iliac fossa, will disappear, or become greatly diminished, in the recumbent position. A pain which is better when the patient is standing and worse when she is lying, should be regarded with suspicion if supposed to be due to descent or displacement: it is probably nothing of the kind. Thus it is to relieve pains increased by standing that pessaries are most generally useful. If this is not effected, the uterus may be unquestionably in the "normal" position, but the pessary is useless, and, if useless, injurious.

Thus, the proper use of pessaries is first, in most cases, after the insertion of the pessary, to get the patient on her legs; secondly, to satisfy one's self in a few days that it is doing good and is doing no harm; but as soon as both these objects are attained, to send the patient away to test the treatment, with the above directions. It should not be the task of months to fit a woman with a pessary, any more than with a truss.

The following are *not* instances of the proper use of pessaries. To keep the patient in bed for long periods wearing a pessary; to see her every day, every other day, twice a week, for weeks, months, or years. Perhaps such visits are not made to the patient, but to the pessary. However that may be, it is not the pessary, but the patient, who has to pay. What should we say of a surgeon who called for months to see a patient to whom he had given a wooden leg or a truss, and who kept him in bed for long periods; or of an oculist who had fitted a patient with spectacles, and saw him every day for several months, whether the spectacles seemed to suit him or not? It is true that the pessary is a truss in the dark, but that is no reason why the management of a pessary should be a deed of darkness.

Recent investigations have shown that the whole question of displacements has to be reconsidered. It cannot be too widely or too dogmatically stated that prolonged treatment by pessaries, such as we have described, is quite inadmissible and unnecessary; and if unnecessary, injurious not only to the patient—*i. e.*, to her *morale* as well as her purse,—but also, in the best sense, to the practitioner, and if to the patient and the practitioner, then to the public and the profession. It should also be realized that a pessary is a mere form of truss, and that its operations, though removed from the general view, are not occult. Ill-treatment

bids fair to bring this useful form of truss into disrepute, and we are daily expecting to meet the practitioner whose sensitiveness is such that he shrinks from a cure whose name he has learnt to mistrust and dislike; but we feel bound to say we have not come across him yet.—*Lancet*, Nov. 10, 1883.

Castration for Uterine Fibroma.

Dr. WIEDOW, of Freiberg, read a paper on this subject in the Section of Gynæcology at the fifty-sixth deutschen Naturforscher versammlung, in September, 1883.

WIEDOW stated that the value of castration in these cases had been very differently estimated at different times. When this operation was first introduced, the enthusiasm was very great, and it was performed unnecessarily and in improper cases; consequently it fell somewhat into disrepute. He presented a short review of the cases which have been performed up to the present time. There have been 63 cases, of which 12 ended fatally. Hegar operated 21 times, 3 cases dying, giving a mortality of fourteen per cent. In one of his cases, the patient was very much better for six months, and the tumour had decreased, but then menorrhagia set in and at the same time fluctuation was detected in the tumour. The patient died a month later. The autopsy showed a fibro-cystic tumour, the lymph spaces of which were filled with purulent serum. In this case, as in one of Schröder's, the tumour again grew and became very large; the prognosis is unfavourable in these cases.

The results in the remainder of Hegar's 17 cases were very satisfactory. The menopause came on sooner or later, and the tumours decreased in size. Comparative drawings of the tumours before and after the operations were shown, and four of the patients were exhibited for examination. In reply to a question by Schatz as to whether the functions of the ovaries were not already lost, Wiedow stated that they were not.

Freund reported 6 cases operated on by him. The results were favourable; the tumours shrivelled, the bleeding ceased, returning in one case at intervals of four to five weeks. Only in one case was the result not good; in this a very large tumour developed.

Hegar does not so much consider the size of the tumours as the method of operating, and the dangers of one operation over another are to be carefully weighed. Castration seems to be the least dangerous, and the operation is to be recommended if the tumour is not yet of very large size. He remarked that, at the normal climacteric, there a cystic degeneration of very large fibromata may take place, or first shrinking and then subsequent growth, just as after castration. On this account he thinks the prognosis of castration for very voluminous tumours doubtful.—*Centralbl. f. Gynäk.*, Nov. 3, 1883.

The Vaginal Extirpation of Carcinoma of the Uterus.

At the late annual meeting of the British Medical Association, Prof. CARL SCHROEDER, of Berlin, read a paper on the subject, in which he said:—

The operative removal of cancer of the uterus is always indicated when it is thought possible to remove all the tissue involved by the neoplasm. If this seem possible, or even probable, the only reason for abstaining from the operation ought to be severe constitutional diseases threatening life in a measurable space of time, such as tuberculosis or Bright's disease.

The question whether it is possible to operate radically may sometimes be very difficult indeed to answer, and it would be illusion to suppose it possible to