

9. The use of the fuming nitric acid should be limited, as a rule, to those cases in which dilatation has been practised, and it should always be applied through a tube, inserted into the cervix uteri for the purpose of protecting the sides of that canal from the action of the acid.

10. The pain produced by the application of any medical agent to the intra-uterine cavity does not bear any relation to the activity of that agent, but is due to one of two causes—either to hyperæsthesia, or to narrowness of the cervical canal, especially of the os internum.—*British Med. Journ.*, Nov. 29, 1884.

—

The Alexander-Adams's Operation for Shortening the Round Ligaments.

Dr. WILLIAM GARDNER, of Glasgow, at the conclusion of a paper in which he reports six cases, says: The class of cases to which I would restrict the operation is the large one of chronic retroflexion with malposition of one or both ovaries, and if one, probably the left (as Lawson Tait has pointed out), owing to the absence of a valve in the left ovarian vein. In simple prolapse the removal of triangles from both anterior and posterior vaginal walls with restoration of the perineal body would, in most cases, enable the uterus to be kept in position by a pessary, and if this failed I should then be disposed to pull up the round ligaments. My method of performing the operation is as follows:—

After shaving the mons veneris and groins, I push the finger into the external abdominal ring, and mark the invaginated skin with the nail of my forefinger on each side. This marks the centre of my first incision, which may be prolonged either upwards or downwards if difficulties occur. The first incision I make two inches long, in the direction of Poupart's ligament, and parallel to it, dividing, at one stroke of the knife, skin, superficial fascia, and fat. Generally one or two small vessels require torsion, or the application of pressure forceps for a short time. I then define the ring thoroughly, and after finding the fibres of the round ligament, I follow them up until it becomes a strong round cord, upon which I fix pressure forceps.

The operation is then repeated on the opposite side till the same stage is reached. An assistant now passes his finger into the vagina and presses the os uteri backwards, whilst I gently but firmly pull up both ligaments until the fundus can be distinctly felt in its normal position through the parietes. The os will then be found directed slightly backwards. In most cases I pull out each ligament from $2\frac{1}{2}$ to 4 inches, and then tie them together, passing a folded pad of gauze under them to keep them on the stretch. I then pass sutures of kangaroo tendon through the skin and ligament, and also round the latter, and bring the edges of the incision closely together. A drainage-tube is passed under the ligament and brought out at the lower end of the incision. Listerian dressing is then applied in the usual way, and the operation may be done either with spray or without, according to the inclination of the operator. In either case the hands of the operator should be well washed, or soaked in carbolic lotion, and all instruments should be kept in carbolic lotion. For the first two or three days after the operation I keep the patient under the influence of opium sufficiently to abolish acute pain. The urine may be drawn off by catheter every four hours if necessary. The uterus ought never to be lifted with the sound at the operation, but should in all cases be drawn up by the ligaments alone, on account of the danger (probably remote) of setting up perimetritic inflammation. It must always be remembered that, previous to undertaking the operation, the uterus must be ascertained to be freely movable and capable of being replaced by the sound. It is not necessary to insert any pessary until the patient is allowed to get up. This may generally be allowed at the end of three weeks, and a well-fitting watch-

spring pessary is then the best support. After six weeks or two months this may be dispensed with.

The results of this operation, so far, have been excellent, and several of the patients have been transformed from a state of chronic invalidism to perfect health. Case I., of the private cases, had been a chronic invalid for five years, and since the operation she has been able to walk a distance of two or three miles at a time without inconvenience, and has been twice pregnant. This case also shows that when there is prolapse of both ovaries into Douglas's pouch with consequent sterility (owing to the impossibility of the fimbriated extremity of the Fallopian tube applying itself to the ovary), this may be remedied by the operation, and pregnancy follow. Another advantage gained by this operation is that it prevents the necessity for Tait's operation of removal of the "uterine appendages" when the ovaries are prolapsed with retroversion or retroflexion of the uterine body. The same result is thereby attained without the obvious disadvantage of the other operation—viz., that of preventing pregnancy in the future. All the difficulties of the operation can be surmounted by a course of operations on the dead body, and any inability to find and pull up the round ligaments is probably due to imperfect performance, as in my second hospital case, where I was only able to find one ligament. I can also imagine another difficulty, although I have never had the misfortune to have to meet it. It is that, owing to previous recurrent attacks of pelvic peritonitis, the ligaments may become so adherent to their peritoneal investments that they may not run when pulled upon. In such cases there would be left to the operator (if symptoms were sufficiently urgent) the *dernier ressort* of removing the uterine appendages from their prolapsed, and, probably, adherent position by Tait's radical operation.—*The Glasgow Med. Journ.*, November, 1884.

—

Ovariectomy, with Suture of the Base of the Tumor into the Abdominal Wound.

Dr. A. RHEINSTAEDTER reports, in the *Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. X., Heft 2, 1884, seven cases of ovariectomy, in which the base of the tumor was sutured into the abdominal wound, with good result in every case. After giving the history of the cases, he concludes his paper with the following description of his operative procedure:—

The longitudinal incision is always quite extensive, and is often carried above the umbilicus. The peritoneum is immediately sutured to the edges of the wound. Immediately after this the presenting tumor is punctured and its size diminished, the incision being held open by the hand and the patient placed upon the back so as to favor the draining away of the fluid contents of the tumor. The opening of the puncture or of the incision into the cyst is then sutured, after which the tumor is gradually drawn out by means of dressing-forceps, the adhesions separated, tied and cut, until the greater part of the tumor has been drawn out of the abdominal wound.

If the exploring hand finds that there is no pedicle, that the tumor is inserted to the broad ligament by a large base, or if the adhesions to the abdominal walls, to the bladder, the uterus, rectum, etc., are such that total extirpation appears too dangerous, he proceeds to suture the base of the tumor into the lower part of the abdominal wound, after having closed the upper part of the wound around the base of the tumor as completely as possible with silver sutures. The sutures which fix the wall of the base of the tumor to the abdominal wall are of solid carbolized silk, and are placed around the base *parallel* to the edges of the wound, at a distance of about 2 cm. from the border. During the application of the sutures the tumor is held up by an assistant, whilst another protects the intes-