such as—(a) completeness of division; (b) the disuse of anæsthetics; (c) the position of the incision; and (d) the non-retention of the catheter in the urethra subsequent to operation—the latter, in particular, being a matter on which I place much weight, to which I attribute the freedom of my later cases from inflammatory and other troubles, and about which I am most at variance with the general practice of other surgeons.

ART. XXIV.—*Some Points in the Diagnosis of Pelvic Hæmatocele.*^a

By WILLIAM J. SMYLY, M.D. Univ. Dubl.; F.K.Q.C.P.I.;
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THE term “pelvic hæmatocele” is generally understood to signify a tumour formed by the extravasation of blood, either into the peritoneal cavity or into the areolar tissue beneath; but by some authors it is restricted, and I think with advantage, to the intra-peritoneal effusions, the term “pelvic hæmatoma” being applied to all other forms.

Although nearly forty years have elapsed since this affection was accurately described, and though in that space of time an enormous literature has accumulated, yet we are not, even at the present moment, in a position to state whether its occurrence be frequent or the reverse. I have been informed by a gynæcologist of large experience, that he had scarcely ever met with a case which he could pronounce, with absolute certainty, to be one of hæmatocele; whilst in the practice of another they appear to occur with remarkable frequency. This divergence of experience also pervades the literature of the subject. Thus, Hugenberger met with but two cases amongst 3,801 patients, and Scanzoni only eight during twenty-eight years' practice. In the Women's Hospital, New York, there were but four cases in twenty-five years, and in Dr. Emmet's private hospital but three. On the other hand, Seyfert, of Prague, reported 60 cases amongst 1,272 patients—equal to five per cent.; and Olshausen almost as large a proportion—namely, 29 out of 764. Dr. Emmet thinks that this varied experience “has been due to different classes of patients, and the different circumstances under which they were treated,” and that physicians visiting patients at their own homes will see a larger proportion of cases than those whose practice is confined chiefly to the office, or to the wards of a hospital. The following statement of Bandl's,

^a Read before the Obstetrical Section of the Academy of Medicine in Ireland on Friday, May 8, 1885.

however, suggests another cause. He says: "Out of 1,500 out-patients, examined during the last two years, we have been able to *demonstrate* retro-uterine hæmatocele in five, but in a much larger number of cases it seemed probable that tumours found posterior to the uterus had originated in blood extravasation." It appears probable that the inclusion, or exclusion, of such uncertain cases, partly accounts for the difference in statistics, and shows that, in spite of the advances made, accuracy in diagnosis is still, in a certain proportion of such cases, impossible. We must, therefore, hail with satisfaction any addition to our means of diagnosis, and put them to the test of practical experience. In the July number of the *Dublin Journal of Medical Science*, in 1884, I drew attention to some very interesting observations by Dr. Dick, of Berne, upon the diagnostic value of urobilin in the tissues and urine of patients suffering from extravasation of blood into the pelvic tissues. The application of the discoveries of Jaffé, Maly, Gerhardt, Bergmann, and others, to gynæcology, was original on the part of Dr. Dick, and have not, so far as I am aware, been confirmed by others. Urobilin is an amorphous, reddish-brown powder, possessing feebly acid characters, slightly soluble in water, but freely so in alcohol and alkaline solutions. Dilute alkaline solutions are the colour of ordinary urine, but on the addition of an acid become red. The addition of a few drops of chloride of zinc to an ammoniacal solution of the pigment, produces a most characteristic green fluorescence. Another valuable test is a remarkable absorption band between the green and blue in the spectrum.

The appearance of urine, containing an excess of this colouring matter, is so peculiar that it at once suggests the idea of something abnormal in its contents. It varies from a light to a dark brown. In many cases there is a deposit of pigment in the skin and conjunctivæ, causing a brownish discoloration, which has been called bilinicterus to distinguish it from ordinary jaundice. In three cases, reported by Dr. Dick, both the bilinicterus and urobilinuria were present. In the first two they were observed in patients in whom the extravasation of blood had been already diagnosticated, and were evidently the result of it; but in the third case it was their presence which led to the diagnosis of hæmatocele. This patient, aged thirty-five, had three children and one abortion, after which she suffered from pelvic inflammation. Having over-exerted herself at the menstrual period, she was suddenly seized with pains in the abdomen, which continued long after, but the flow did not

come on. Dr. Dick first saw the case (in consultation) about five weeks after this. On examination, he found in Douglas' pouch a doughy, irregular tumour, which had displaced the uterus forwards. The skin was markedly yellow, and the urine, which was of a deep coffee-brown colour, contained a large quantity of urobilin. Not having seen the case from the commencement, and the history being indefinite, a certain diagnosis was not possible. However, from the large quantity of urobilin in the urine, and from the colour of the skin, he came to the conclusion that it was a hæmatocele. The tumour gradually reduced in size, and the icterus and urobilin also diminished. At the end of a month the tumour was aspirated, and dark brown blood was drawn off. For four days she went on well; then, however, the menstrual flow came on, attended by increased pains in the abdomen and enlargement of the tumour. Four days after this the icterus returned, and urobilin was again found in the urine. The tumour was again aspirated and a quantity of blood drawn off. After this, however, it rapidly increased in size, until it reached to the umbilicus, but this time there was neither icterus nor urobilinuria. As a rupture of the sac seemed to be imminent, an incision was made into it through the vagina, and a great quantity of putrid matter evacuated. The examining finger passed into a cavity, the walls of which were covered with old blood-clots. After this cavity had been irrigated with a 3 per cent. solution of carbolic acid, and a drainage-tube introduced, the temperature rapidly fell. In this case it was certainly most remarkable that, when the tumour contained blood, there was urobilin in the urine; as the tumour diminished, so did the amount of urobilin; when it re-filled, the pigment re-appeared, both in the urine and in the skin; but on the third occasion, when it became distended with inflammatory and putrid fluids, there was neither icterus nor urobilinuria.

The following case, which I have had under observation, may prove of interest in this connexion. For the notes I am indebted to Mr. Poole, my clinical clerk:—

CASE.—Mary C., aged thirty-one years, was admitted into the City of Dublin Hospital on the 15th of last September. She had had eleven children and one miscarriage. Her youngest child was sixteen months old, and menstruation had been regular, up to the 9th of August, when she missed a period, and supposed herself to be pregnant. A fortnight after this she was seized with violent "cramps" in the hypogastric region, and retching, which continued for two days, after which there

was a remission. Three days after she was again seized with such violent paroxysms of pain, that she rolled about the floor in agony. The abdomen became tympanitic and exquisitely tender; and there was much pain and difficulty in emptying the bladder and rectum, besides which she complained of a dreadful "bearing-down" sensation.

Condition on admission.—The patient presented a peculiar brownish yellow tint. Her pulse was 100 per minute, and her temperature normal. The lower portion of the abdomen was tender to the touch, but a tumour, which was dull upon percussion, and which reached nearly to the umbilicus, could easily be distinguished. This was discovered upon bi-manual examination to be the uterus, and the sound passed into it to a depth of three inches. It had been displaced upwards and forwards by a tumour, which occupied the space between it and the rectum, and which bulged the posterior fornix downwards into the vagina, almost to the vulvar orifice. The surface of this tumour felt smooth, to the touch, soft and elastic.

The night after this examination she suffered from crampy pains, which she said were like those attending a miscarriage, and some clots were expelled, but were unfortunately thrown out before they could be examined.

Next day the urine was drawn off with a catheter, but as it did not present anything abnormal in appearance, I thought it would be useless to have it tested for urobilin; the icterus, too, had faded considerably, and in two or three days more had entirely disappeared. From that time she made a rapid recovery; the tumour was absorbed all but a small lump about as large as a walnut, which can still be felt in Douglas' space, and the uterus returned to its normal position.

The presence of the icterus in this case was well marked, and had I been fortunate enough to have found the urobilin in the urine also, it would have been a valuable confirmation of Dr. Dick's observations. However, as it is, I hope the case will be of interest to the members of the Academy, and that, should examples of this affection come under their care, as no doubt they will, at an earlier stage they may detect these valuable symptoms.

That the case was one of hæmatocele I have no doubt—1st, from the history; 2nd, from the physical character of the tumour; and 3rd, from the rapidity of its absorption. That the extravasation was intra-peritoneal I gathered from the history—the patient being a married woman who had borne children, and who had not menstruated for upwards of six weeks before the accident—the physical characters of the tumour bulging downwards into the vagina, and its median position. Hæmatoma is, on the other hand, said to

occur more frequently during menstruation. It is situated laterally in the pelvis, and often presents a flat or irregular surface towards the vagina, conforming to the base of the broad ligament.

ART. XXV.—*Forcible Fracture and Straightening of the Bones by Manipulation for the Cure of Bowed Legs caused by Rickets.* By L. HEFENSTAL ORMSBY, F.R.C.S.; M.D. Univ. Dubl.; Lecturer on Clinical and Operative Surgery, and Surgeon to the Meath Hospital and County Dublin Infirmary; Surgeon to the Children's Hospital, Dublin.

I. METHOD OF STRAIGHTENING THE BONES IN RICKETY CHILDREN BY FORCIBLE MANIPULATION AND FRACTURE.

II. THE CONDITION AND HISTORY OF TWENTY-FIVE DOUBLE CASES OF FORCIBLE FRACTURE WITH THE SUBSEQUENT RESULTS.

IN the April number of this Journal I drew attention to the treatment by osteotomy of a most common distortion of the lower limbs named genu valgum or knock knees. In the present paper I wish to describe a method of treatment I have extensively adopted with marked success for the cure of bowed legs—another equally unsightly deformity of the lower extremities.

Deformities of the lower limbs very frequently occur as early symptoms of that peculiar form of constitutional disease termed rickets or rachitis—a term which is derived from *ράχις*, the *spine*, as it was thought that distortions occurred in that situation more frequently than in any other part of the body. Glisson, about the year 1651, studied the subject very carefully, and the term rachitis is believed to have been introduced by him. Others contend that it is derived from the old French *riquet*, or else from the German *Rücken*. In this paper I merely intend to draw attention to the treatment of a single symptom of this disease—namely, the occurrence of bowed legs. I would refer for a more extensive account of the subject to the very admirable lectures* of Sir William Jenner, Bart., on the pathology and treatment of this affection. The treatment depends very much on the time when, and the stage at which, the deformity is first recognised.

The constitutional treatment of rickets is nearly altogether *hygienic*. The patient should be allowed to breathe pure air,

* Medical Times and Gazette. Vol. I. March 17, 1860. Page 259, *et seq.*