multiplication véritable de ces derniers microbes. Leur présence s'explique parce que le bacille fusiforme, de même que le spirille, est capable de se fixer sur la taniolle sous-jacente à l'infection fus-spirillaire est souvent congestionnée et d'une consistance assez dure, et l'on peut alors penser, en présence de l'ulcération et de l'inflammation de la taniolle, que le bacille fusiforme, de même que le bacille fusiforme et les spirilles : ces microbes semblent avoir une certaine predilection pour les ulcerations de reconnaitre la nature syphilitique de l'ulcération, dissimulée sous la fausse membrane. Il faudra, naturellement, tenir compte des accidents simultans d'origine spécifique : rossole, plaques muqueuses, alopsia. Dans les syphilides, les ganglions cervices sont tuméfiés en même temps que les ganglions cervicaux sont tumefiés en même temps que les ganglions sous-maxillaires. Enfin le traitement servira de guide dans la recherche de l'infection syphilitique, même si elle est compliquée par "pierre de touche" ou de criterium essentiel. L'angine à bacilles fusiformes et la syphilis, comme nous l'avons énoncé, sont un chancre syphilitique. Cependant et n'est jamais aussi nette que dans le chancre spécifique.

"pierre de touche" ou de criterium essentiel. L'angine à bacilles fusiformes est guérie en quelques jours si l'on ôte deux fois par jour la lésion avec un tampon imprégné de sérum de clou. Ce traitement est sans effet si y a de graves complications et si l'on ne l'associe pas à de l'iodure et de l'iodure de potassium démentirait la guérison de l'infection syphilitique, même si elle est compliquée par l'infection fus-spirillaire ; ce traitement n'amène, au contraire, aucune amélioration de l'angine que j'ai décrite.


TREATMENT OF COMPLETE UTERINE AND VAGINAL PROLAPSE.

BY FREDERICK HOLME WIGGIN, M.D., FORMERLY VICE-PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION AND PRESIDENT OF THE NEW YORK STATE MEDICAL ASSOCIATION; FELLOW OF THE NEW YORK ACADEMY OF MEDICINE; VISITING SURGEON TO THE NEW YORK CITY HOSPITAL; AND GYNECOLOGIST TO ST. ELIZABETH'S HOSPITAL, ETC.

So much diversity of opinion still exists among gynecic surgeons as to the proper treatment to be employed for the cure of complete uterine and vaginal prolapse that it seems timely again to bring this subject forward for discussion; and for this reason I desire to place before you for consideration the method of treatment which in my experience has proved the most satisfactory. Before

1 A paper read at the annual meeting of the American Medical Association, held at Atlantic City, N.J., on June 9th, 1904, before the Section on Obstetrics and Diseases of Women.
doing this, however, a few words in regard to the pathologic of the disorder may be of interest. The condition is best described as a reducible hernia through the posterior vaginal wall which contains the attached uterus and its ligaments, besides the uterus, the tubes, the ovaries, the bladder, and the rectum, a large portion of the small intestines. The causation of the disorder, as is well known, is found in the process of delivery, or the accentuation of the condition through the拉着 of the muscles forming the pelvic floor which are usually in the median line and is usually due to the passage of the child's head during parturition. This separation of the tissues which hold the rectum in its proper position, allows the lower anterior portion of the gut to bulge upward and forward into the vagina, pushing the vaginal tissues before it. This abnormal position of the bowel is increased by every act of defecation and straining at stool and is also added to by the lifting of heavy weights. As the muscular force employed follows the line of least resistance it tends in these cases not to expel the bowel contents through the anus, as it should, but instead to force the gut forward through the hernial opening into the vagina. The difficulty experienced by the sufferer in emptying her rectum causes her to exert an ever-increasing force and gradually and steadily, day by day, the rectocele increases in size, force in a downward direction being necessarily applied to the stretched uterus and its ligaments which in a normal condition serve simply as stays holding it in place, are gradually stretched and lengthened, allowing greater freedom of position to the descending organ. As the uterus descends the bladder goes with it. The descending process is hastened, after it has fairly begun, by the added weight of the small intestines, which being contained largely in the pelvis find their way by gravity to the lowest point. Thus after a period of a longer or shorter duration, varying usually in accordance with the natural vigour of the patient and the amount and character of the work she is called upon by reason of her environment to perform, a complete inversion of the vagina occurs and a hernial sac of large size appears outside the body and we have the condition known as complete uterine and vaginal prolapse to deal with. This complete form of the disease does not, as a rule, appear until rather late in life, although the patient has probably suffered from much discomfort and disability for many years.

In the surgical treatment of this disorder much ingenuity has been displayed. Various operations on the anterior and posterior vaginal walls, as well as the removal of the uterus in whole or in part, have been recommended, but unfortunately without very satisfactory results. In my opinion, these disappointing results have been due to the operator's failure in most instances to recognize the fact that the vaginal wall in these cases is a hernial sac with other contents than the uterus, tubes, ovaries, bladder and rectum, and that consequently the simple repair of the external perineal body, the removal of a larger or smaller portion of the vaginal walls, or even the removal of the uterus itself, would not correct the greatest cause of the difficulty, namely, the abnormal position of the small intestines. In the elderly patients suffering from this disease who have come under my observation, many of them having external tumours of large size, the uterus has not been found abnormally elongated and consequently could not be considered a factor in the causation of the trouble and many patients have come under observation upon whom a hysterectomy for the cure of this disorder had been previously performed by other surgeons who stated that their tumours were larger than before operation.

In view of the foregoing facts it seems clear that the operative procedures required for the successful treatment of the class of cases under consideration are those that will obliterate the inverted and stretched vaginal wall—which is in reality a hernial sac—and then restore the damaged perineal structures and distended anterior vaginal wall as nearly as possible to their normal condition. The technique which has, in my experience, best answered these requirements has been the following. The patient on coming under observation is placed in bed in the recumbent posture and the tumour is reduced, gravity being employed to help retain the parts in their normal position by raising the foot of the bed about six inches. Tampons moistened with glycozone are placed in position and the parts treated until all the ulcerated portions of the vaginal walls have healed, the general condition of the patient being meanwhile carefully looked after. The next step in the procedure is the performance of a laparotomy after the usual preparations have been made, the patient being placed in the Trendelenburg posture before the abdomen is opened for the purpose of obtaining the aid of gravity in drawing the parts back into their normal position. The bowels are usually in these cases found to be more or less attached to the vaginal wall by adhesions which must be broken up. The uterus, which, as has been previously stated, is in elderly women usually small, is found and pulled upward by the aid of bullet forceps, drawing the vaginal wall upward also. When this has been accomplished a needle armed with large size kangaroo tendon is passed through the fibres of the uterus at the point of its attachment to the round ligament and carried down the broad ligament in the form of a purse-string suture (see Fig. 1) and back again, the needle being finally made to emerge at about the point of entrance, so that when the two ends of the suture are drawn upon the broad ligament on that side is folded up and drawn together, thus doing away with its excessive length and giving the uterus a new point of attachment near the insertion of this ligament at the pelvic brim (see Fig. 2).

The same process is repeated on the opposite side. The abdominal cavity is then flushed with saline solution, some of which is allowed to remain, and the wound in the abdominal wall is rapidly closed by means of buried sutures and protected by a cellodion dressing. If the patient is then in ordinary good condition repair of the pelvic floor and reduction in size of the anterior vaginal wall are undertaken. In my experience there is usually no difficulty in accomplishing this, for all the operative measures necessary to
The patients are elderly and do not bear prolonged operative procedures well, or those involving much loss of blood, hence the importance of removing the uterus in whole or in part when it is not at fault in the treatment of this disorder.

Many operations such as have just been described have been performed by me during the last few years on women whose ages ranged from 60 to 83 years, without mortality and with short and satisfactory results.

New York City.

CARCINOMA OF THE UTERUS AND ITS SURGICAL TREATMENT.

3v EDWARD T. THRING, F.R.C.S. ENG., L.R.C.P. LOND., SURGEON TO THE PRINCE ALFRED HOSPITAL, SYDNEY, ETC.

The following brief notes of six cases of carcinoma of the uterus are given simply as examples of the method which, I believe, gives the best final result in those instances in which removal of the uterus is justified.

CASE 1.-The patient, a nullipara, married, aged 32 years, was first seen on Dec. 15th, 1894. She gave a history of repeated attacks of pelvic peritonitis, probably the result of an infective salpingitis. The menses had been regular every four weeks; of late there had been occasional blood-stained discharge between the periods. On examination the cervix was fixed and retroverted; both ovaries were cystic and of about the size of a large orange. From the posterior lip of the cervix was a fungating mass which bled readily on being touched. A portion removed for microscopic examination showed it to be carcinoma. Operation was performed on Dec. 24th. The uterus, ovaries, Fallopian tubes, and broad ligament were removed; also the gland in the left side of the pelvis. The leakage of urine in Case 4 was, I believe, the result of trophic changes either in the base of the bladder or in the right internal iliac artery itself was ligatured and not the anterior division of it or the uterine trunk. That there was no lesion at the operation is proved by the fact that there was no leakage until the fourth day after. I have seen this happen three times, and in each case the leakage only lasted a few days and ceased spontaneously, and in each of the three cases either the right or left internal iliac artery had been tied and divided. In two cases this was done to facilitate access to the deeper glands which is apparently used at the Johns Hopkins Hospital in such cases.

The chief point, however, to which I desire to call attention is the fact that in all these cases the pelvic glands were the seat of carcinomatous deposit secondary to the uterine growth. In one only could it be demonstrated before operation that there was involvement of pelvic glands. In Case 6 the disease is more advanced in those of the left side. The patient then last seen a short time ago was well and there were no physical signs of recurrence.

I have given the above brief notes of these six instances simply to show the method I have used in my private practice and I was therefore able to follow them more closely than is usually possible in hospital practice. They are only a small number of those operated upon during the past ten years but they demonstrate the points which I wish to emphasise.

In each case the growth was examined microscopically. In each the gland was removed for microscopic examination. It is often difficult to obtain sufficient to cover over the exposed ureters and base of the bladder, I have therefore drawn off the urine into the vagina, although a considerable amount was also drawn off through the urethra. This leakage gradually diminished and ceased completely on the twelfth day. I have received a letter from this patient on Jan. 26th, 1905, in which she says that she is, and has been, perfectly well since her convalescence after the operation.

CASE 2.—The patient, a multipara, married, aged 33 years, was first seen on Jan. 2nd, 1903. The menses had been regular every four weeks. She was well for nearly six months; this was sometimes blood-stained. On examination the cervix was seen; this bled readily on being touched. A portion removed for microscopic examination showed it to be carcinoma. Operation was performed on March 21st. The uterus and appendages, broad ligament and pelvic glands, were removed. The glands on both sides were infiltrated with carcinomatous deposit. The fungating mass was a cylindrical-ruled carcinoma. The patient is now (February, 1905) well.

CASE 3.—The patient, a multipara, married, aged 34 years, was first seen on Jan. 14th, 1904. The uterus was atrophic; the right internal iliac artery of the right side than to reach the uterine artery. On examination the cervix was fungating and bleeding growth from the right side of the pelvis. The right ovary, egg, slightly moveable, could be felt. Operation was performed on Jan. 14th. The uterus and appendages, broad ligament, and pelvic glands were removed. The glands on both sides were infiltrated by carcinomatous deposit; this was more advanced in those of the left side. The patient lived for six years well; she then became ill and died during the seventh year from "Bright's disease." She was not under my care at that time.

CASE 4.—The patient, a nullipara, married, aged 50 years, was first seen on Feb. 16th, 1897. She complained of pain in the left side of the pelvis. The menopause occurred and since then there had been slight irregular bleedings. Of late a bad-smelling discharge had been present. On examination the uterus was still of normal size—i.e., not atrophied; it occupied a good position, was tender to touch, and slight bleeding occurred after examination. Operation was performed on August 25th. The uterus and appendages, together with the broad ligament and the pelvic glands on both sides, were removed. They are only a small number of those operated upon during the past ten years but they demonstrate the points which I wish to emphasise.

In each case the leakage in Case 4 was, I believe, the result of trophic changes either in the base of the bladder or in the right internal iliac artery of the right side or in the right internal iliac artery itself was ligatured and not the anterior division of it or the uterine trunk. There was a bad-smelling discharge which bled readily on being touched. A portion removed for microscopic examination showed it to be carcinoma. On examination the cervix was seen; this bled readily on being touched. A portion removed for microscopic examination showed it to be carcinoma. Operation was performed on August 25th. The uterus and appendages, together with the broad ligament and the pelvic glands on both sides, were removed. They are only a small number of those operated upon during the past ten years but they demonstrate the points which I wish to emphasise.

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