ued pressure exerted upon it. It is evident that a full and fair trial of continued pressure cannot be made in this way. Although the inefficiency of the elastic vaginal bag has been repeatedly pointed out and written about, it is still resorted to in such cases: and when it has been found on trial that the patient could not bear its continued use, or that it did not replace the uterus, the operators, often those who might be expected to know better, have generally concluded that the uterus was too sensitive for continued pressure treatment, or that pressure faithfully tried had proved a failure. Often, too, the pelvic pains and tenderness caused simply by the distention have been mistaken for the symptoms of pelvic peritonitis."

There is no better or simpler device for producing the desired pressure than two pieces of elastic rubber tubing (that which is attached to the common household syringe does excellently) passed between the thighs and tied by their middle to the outer end of the stem used, their ends being brought up, before and behind, and tied to a waistband, which may be nothing but a common towel folded and fastened about the body.

By regulating the tension of these elastic cords both the amount and the direction of the pressure can be easily controlled.

(1.) The use of an inflated cushion attached to the upper end of the rigid stem is, so far as I know, new. In this case it was used, as explained before, to prevent the stem from slipping off and by the inverted organ. It answered its purpose perfectly, and moreover made such a soft pad to press against the mucous membrane of the womb that I think it would be a good idea to use such a one, of proper size, in every case. Still the part bears the pressure better than might be expected. The device is a simple one, and it would seem might occur to any one's mind; but in recently looking up cases of inversion reported in the journals, I was interested to find in the *Dublin Journal of Medical Science*, 1881, the report of a case occurring in the practice of Dr. Loombe Athill, of the Rotunda, Dublin, in which the same difficulty was experienced that I had found on my first attempt at reduction in this case (that is, the upper end of the stem could not be kept on the womb). In Athill's case both Aveling's and White's methods and instruments were tried with the same failure, and finally amputation of the displaced organ was resorted to. I have no doubt that a simple contrivance like the one employed by me would have avoided the difficulty and rendered the operation unnecessary.

(2.) *To avoid risk of septicæmia the vaginal stem should be removed at proper intervals and the parts thoroughly cleansed.*

(3.) *All attempts at manual reduction (taxis) during the treatment are to be avoided.* "They are unnecessary, must add to both the mental and the physical sufferings of the patient, and, moreover, rob the method of its greatest advantage, its simplicity."

(4.) *"A pad or other counter-pressure on the abdomen," recommended in such cases by some writers, should not be employed.*

The action of the vaginal walls in gradually and constantly pulling open the cervix, or, when the cervix has resumed its proper position, the constricted portion above, thus aiding the inversion to gradually unroll itself and assume its natural position, does not come into play until the vaginal walls are put upon the stretch, and pressure upon the abdomen tending to keep the

whole uterus low must act to prevent this. Moreover it must oppose the action of the vaginal stem in pushing the inverted fundus upward.

(5.) *Anæsthesia is not to be employed unless specially indicated in the given case.*

The process from first to last is not a painful one. The patient being conscious, the physician can better judge of the amount of pressure which it is advisable to use, and the risk of doing harm is lessened.

The view formerly held that the difficulty of reduction increases in proportion to the duration of the inversion has been proven to be erroneous by the results of cases treated by this method, and in certain cases of acute inversion at childbirth where the shock is very great (as with the patient whose case I report), and hæmorrhage does not make immediate interference a necessity, probably the chances of the patients will be increased by postponing for a while all attempts at reduction. This however is a rule of procedure to be followed in but few cases if the physician is present immediately the accident has happened, but we know that the chance of reduction becoming impossible at a later period is now reduced to a minimum. In my previous case, where complete inversion had existed fourteen months, reduction was accomplished with as much ease as in this case of only four weeks' duration. Post-mortem examinations have taught us that pelvic adhesions are extremely rare in these cases. Barnes concisely states "the possibility of adhesions opposing reduction may be practically disregarded if gradual elastic pressure be employed (in the reduction)."

The "stage of involution after confinement" does not counter-indicate reduction by this method, although attempts at replacement by the other more forcible and rougher methods, during this condition of the parts, are certainly dangerous. In our case reposition was accomplished with perfect ease and success four weeks after confinement. It was not done when I first saw the patient (two weeks previous) because of the want of a suitable instrument. It was not convenient for me to attend to the case during the interval. During this time the placental site, which, in this case, being the lowest portion, received the pressure, had become, in appearance, like the rest of the mucous membrane of the womb, but the patient had had two attacks of flooding, and, moreover, had developed a mild case of "milk legs" with febrile action. Her condition had not improved; she had not gained strength. I doubt, if in another case and provided with a stem-repositor capped by an elastic cushion, such as my inflated Gariel Pessary made, I should fear to bring the steady slight pressure to bear upon even a recent "placental site."

EMBOLISM OF LEFT MIDDLE CEREBRAL ARTERY WITH APHASIA AND AGRAPHIA.¹

BY G. H. LYMAN, M. D.

IN December, 1871, and March, 1874,² I reported two cases of this lesion causing aphasia, in which the diagnosis was confirmed by subsequent autopsies. Although the consensus of opinion as to the location of the organ of speech, or rather as to the part of the brain which governs the symbolization of ideas by words, is now pretty decidedly in favor of the views

¹ Read before the Section for Clinical Medicine, Pathology, and Hygiene of the Suffolk District Medical Society, February 14, 1883.

² Boston Medical and Surgical Journal, vols. lxxxvi. and xc.

of Hughlings Jackson, Broca, and others, every additional case must possess a greater or less degree of interest, and especially so where the recovery from the attendant hemiplegia leaves the patient persistently aphasic, unable to express his ideas, wishes, emotions, otherwise than by signs. The following case is of peculiar interest as an instance of ataxic and amnesic aphasia persisting after perfect convalescence from the primary hemiplegia:—

P. R., aged twenty-four, single, a gardener, entered the City Hospital November 9, 1882, having been taken ill three weeks previously with pain, swelling of the joints, headache, and excessive dyspnoea. Was so far recovered in a fortnight as to be able to return to his work, but the pains recurred, with soreness at the epigastrium, vomiting, swelling of the face, slight cough, and excessive dyspnoea. He has now some pain in the shoulder, none in the chest. Urine acid, specific gravity 1015; no albumen. Dullness in right lower back with abundant crepitant râles on inspiration only. More or less fine moist râles elsewhere over both backs, and some sibilant and fine moist râles in each mammary region. Heart's action slightly intermittent. Pulse soft and easily compressible. The cardiac dullness extends to the right border of the sternum. Apex beat at sixth interspace and one inch to right of nipple. A soft systolic souffle at the apex, and the second sound indistinct; no anasarca. Abdomen distended with flatus.

November 12th. The pulmonary symptoms are much improved, slight dullness, and a few moist râles only remaining. Temperature and pulse normal.

Three days later, on the 15th, he was seized suddenly in the afternoon with a severe colicky pain in the epigastrium, which continued for some time and resulted in partial collapse, pulse slowed, feet cold, and some cyanosis about face and hands. There was no disturbance of the respiration. The following day there was found a loud systolic souffle below the nipple, extending laterally to the right for three inches. The second sounds were distinct and clear, and the impulse marked.

November 22d. There is now no pain over the cardiac area. At the third interspace both sounds are accentuated.

On the 4th of December he had a second attack, more severe than that of November 15th. The heart's action was strong, though the pulse was weak; he had pain in the right side of the head, with sharp pain and buzzing in the right ear. The pupils were normal. Vomiting ensued, followed by a comatose condition, the recovery from which, in a few hours, revealed a right hemiplegia, with face drawn to the left, and complete aphasia. The next day at the visit I found that he had been crying. He apparently understood what was said, but was wholly unable to speak, and was much depressed. The pupils were slightly dilated, but sensitive to the light. Temperature subnormal.

On the 6th had recovered some motion in his arm.

On the 9th could move the right leg a little. Complaints of pain behind the ears and in the right arm and wrist when they are moved. The temperature of the two hands is alike, but there is a marked difference in the radial pulses, the right being almost imperceptible. He said "yes, sir" once quite distinctly, but could not repeat it, and has never since been able to articulate any syllable.

On the 13th the movements of the fingers and hand

much improved. Tries hard to talk, but cannot articulate, the effort resulting only in a rapid ta-ta-ta.

December 14th. He can to-day hold his pen and trace a few letters of his name very imperfectly, and on the 17th could do this much better (see specimens appended, Nos. 1 and 2). It should be noted here that there has never been any paralysis of his tongue. He has always been able to protrude it fully, move it to either side, or up and down, in a perfectly normal way.

On the 19th and 22d he had slight recurrences of epigastric pain, with nausea and vomiting and coolness

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of the extremities, but without cyanosis or any loss of consciousness.

January 1, 1883. To-day his general condition is much improved. The right brachial and radial are still weaker than the left. He writes with more facility, and much better (No. 3), but there is no change in the aphasia.

January 18th. Has continued to improve in health and strength. Has been able for ten days to sit up and walk about. Either hearing or intelligence is somewhat imperfect, for when told to make any particular movement, such as raising his hand or leg, touching his ear or head, the request must be repeated distinctly several times before he can interpret its meaning. There still remains slight loss of power in flexors of right thumb and fingers, but not enough to prevent the holding of a pen or other small object.

January 26th. Has gained in flesh and strength; walks freely about the ward; makes signs for water, milk, watch, or anything he needs, with the repetitions of "ta-ta" in his efforts to talk; touches his mouth, nose, ears, or eyes correctly when told to do so; evidently understands what is said, and associates words with ideas, but how far his mental processes enable him to associate his own ideas with words, which he cannot utter, is a matter of conjecture, for although he is unable as yet to pick out the proper letters (from blocks) to make up a word, cases have been reported in which, after a certain lapse of time, the aphasia has disappeared, and the patient has shown that, notwithstanding his inability to utter them, his ideas have been, during the interval, mentally clothed in words.

To summarize this case, we have first an attack of acute rheumatism followed, during an early convalescence, by a cardiac complication, probably endocarditis,

which at the end of a week or more (there being no means of ascertaining how long before his entrance the valvular murmurs had existed) culminated in severe epigastric pain and interference with the normal action of the heart, as shown by cold extremities, cyanosis, and collapse. From this unconsciousness he soon rallied, but as he had neither paralysis nor antecedent history of cerebral disturbance the cause seemed attributable to the local cardiac disease alone, until nearly three weeks later (December 4th) a more severe and convulsive seizure occurred, from which he emerged with right hemiplegia and complete aphasia, indicating with reasonable certainty the true nature of the affection. On two subsequent occasions there were slight recurrences of the epigastric pain without aggravation of the cerebral symptoms.

The case presents several interesting points. The rapid, and with the exception of slight weakness in the flexors of the right thumb and fingers, complete recovery from hemiplegia. The absence throughout of any paralysis of the tongue. The complete aphasia and partial agraphia.

The diagnosis I assume to be embolism of the left middle cerebral artery, for although aphasia, as is now well known, may be due to other lesions, such as obstruction in the basilar artery and the resulting loss of nutrition to the pons varolii,—obstruction of left carotid by aneurismal enlargements, by tumors or disease affecting the posterior part of the left third frontal convolution, which is supposed to control the power of articulate speech,—yet the history of the case, the suddenness of the attack without premonitory symptoms, would seem to exclude any of these hypotheses. The only reasonable doubt, as it seems to me, would be in the bare possibility of hæmorrhagic effusion, but of this there is no evidence, while that of detachment of a fibrinous mass from the cardiac valves is very strong.

The aphasia is unmistakably ataxic, and in all probability amnemonic. When shown his name, Pat Ryan, on the bed card, he writes, as is seen in the accompanying specimens, Byan. He insisted, on his attention being called to the difference, that he was right, and with some excitement indicated by signs to the ward-master that he wanted something from his trousers, in the pocket of which was a letter from his father signed distinctly Ryan. He yielded, and reluctantly wrote the letter with the proper curve (No. 3). When told to touch the various parts of his head, nose, ears, eyes, chin, etc., he did so, and correctly, but only after the request was repeated distinctly several times. With a set of ivory block letters he was, after earnest and repeated efforts, unable to arrange his name. He would pick them over and over, and then begin, perhaps, with B, not P, the remaining letters being all wrong, but when spelt for him he readily recognized his error. When told to write any word other than his name he was utterly unable to do so, making only a series of unintelligible letters (No. 4). Though he is evidently intelligent, and able to indicate all his wants by appropriate signs, walking freely about the ward, and laughing heartily at any ridiculous occurrence, the question of the degree of impairment of his memory for words must remain doubtful while the ataxia persists; should that eventually disappear, as in some reported cases it has done, his memory of and ability to use words in their proper significance can be tested. Within a few days, January 27th, when asked to write his name he wrote Patran (No. 5).

When his card was shown and then taken from him, he, with some hesitation, wrote it correctly. Otherwise from memory alone he never got beyond a series of unmeaning letters. February 2d, when asked where he was born, could not remember, and wrote it only after referring to his father's letter (No. 6).

Lugem 4

Padten 5
Patran.

Blarney 6

With regard to the agraphia the above history shows that it was decidedly amnemonic, and not ataxic, for, as we have seen, he could only write a word if shown a copy, except occasionally his own name, and even that was not wholly correct. All the earlier tests were confined to his name, and this he had tried so often as apparently to have partially retained it in memory.

In a late number of the Boston Medical and Surgical Journal, December 28, 1882, attention is called to another phenomenon supposed to be connected with these cases of agraphia, the "*écriture en miroir*," so called. So far as this one case goes, it is confirmatory of M. Durand's opinion that this mirrored writing is not pathognomonic of the lesions producing aphasia, for, as shown by very many trials, this patient wrote from left to right and the reverse indifferently, sometimes one way, and sometimes the other. Only once, January

Right hand 7
P. Ryan

I had a line from home yesterday they are all very well

25th (No. 7), did he spontaneously begin from right to left, and with inverted letters, requiring examination by reflection in a small mirror. A letter written by him before his illness shows that he was well educated for his position in life. It was exceptionally well expressed, and the grammar and orthography faultless. A specimen of the writing (No. 8) is appended for comparison.