

infer therefore that (39-12) 27 persons died during this period who had not submitted themselves to the Pasteur treatment. The mortality among those not treated as compared with the number bitten is stated to have been 15.9% in 1887 and 13.33% in 1888.

(To be continued.)

THE AVOIDANCE OF SCAR IN THE TREATMENT OF CERVICAL ABSCESS; WITH THREE CASES.¹

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IN the treatment of abscess of the neck the avoidance of scar is of great importance, for while a cicatrix in certain portions of the body is not noticeable, as in the axilla, the deformity of a long ragged scar upon the neck is considerable.

The three following cases were very large collections of pus. The general custom in treating such cases is to make a free incision, and, of course, the longer the cut the greater the scar.

My object in reporting these cases is to show that this is not necessary and to call attention to the possibility of opening, draining and curing large abscesses with little or no resultant scar.

CASE I. Male, age twenty-six, was referred to me by Dr. J. T. Bowen in February, 1890, with one enlarged gland in the upper cervical region. It was painful, the skin over it was reddened, and there was an indistinct sensation of fluid to the touch. I advised against cutting at that time for several reasons. I was not at all certain that pus was present, in which case the inflammatory process might cease and its products be absorbed. There was a doubtful specific history, with the possibility of a cure by treatment; and if it did prove to be the ordinary glandular abscess, I preferred to let the gland tissue be as thoroughly destroyed as possible before operating.

He was treated by Dr. Bowen, for about one month, with iodide and mercury; but there was no improvement, and he returned to me with an undoubted glandular abscess. Other glands lower down in the neck had enlarged, and were evidently going to break down.

I then explained to him the method of treatment I wished to carry out, which was to make very short incisions, when necessary, and by curetting through these small openings every day or two to remove as much broken-down gland tissue as would easily come away; that if this proved successful, he would have only trifling scars as a result of his trouble; but that if the case did not progress favorably I should be obliged to make a long cut and remove at once all the affected glands, which would leave him with a long scar after recovery.

He left the treatment to me, and I made a short cut down into the abscess which had already formed. I curetted the cavity with a very small curette, syringed it with creolin and put a short wick of corrosive gauze into the opening.

The other glands enlarged slowly. At the end of three weeks they seemed to be well broken down and I made two short incisions over the thinnest points. A large quantity of pus came out and the probe showed that although there were apparently several cavities

they were all connected, making really one abscess cavity extending from the root of the neck to a point behind the ear.

I syringed out with creolin, put short wicks of corrosive gauze into the cuts and applied an oakum pad. I saw him every day. At each visit I passed a small curette through the openings and removed as much gland tissue as would easily come. Some days I scraped out a number of pieces and at other times very little would come away.

It was four weeks before there was any improvement. The curette then brought out nothing resembling gland tissue, although there was still considerable pus formation. He had a long sinus running down the neck and branching toward the sternum. This sinus commenced to close near the opening and as it did so it left deep pockets of pus. I prevented this tendency by passing olive-pointed urethral bougies starting with a small one and dilating up to No. 19. After dilating I scraped the walls of the sinus. The effect of the dilatation was very satisfactory. It kept the sinus open, gave free drainage and allowed it to heal up from the bottom.

The result was a cure in about six weeks with three small stellate cicatrices.

CASE II. Male, age twenty-eight, was referred to me by Dr. J. S. Howe, in April, 1890. He had an enormous abscess in the front of the neck, completely filling the space of the right side between the lower jaw and the clavicle. It was wholly subcutaneous and there was no point where there was any indication of thinning.

I made a very short cut in a line with one of the folds of the neck and let out a large quantity of pus.

I syringed the cavity with creolin, but as there were no indications for so doing did not curette. I put gauze into the opening and covered it with an oakum pad. I did not see him again for several weeks, when he was entirely well. According to instructions he had kept the cut open until there was no more oozing from it. There had been some serous discharge which gradually dried up.

The scar can be seen only by careful inspection.

CASE III. A girl, age fourteen, came to the Surgical Department of the Boston Dispensary, during my service last spring. She had a large inflammatory cake in the back of the neck. It was very painful, the skin was reddened, but at the first visit, no pus could be detected. She poulticed it for several days, when it was evident that pus was present.

I made a short cut at the base of the scalp and found pus about half an inch below the surface. The abscess cavity was large and extended well down into the back of the neck. It was syringed out every day, the cut kept open with gauze, and recovery was rapid, leaving a very short linear cicatrix.

In the first case reported, I was, at times, strongly tempted to open up the whole diseased area and end the trouble. For four weeks there was no progress. The gland substance came away slowly and there was considerably pus formation.

I was very much afraid that I was simply prolonging the duration of the process and that it would finally end in the usual long cut and subsequent scar. But it did heal without necessitating this and instead of having a three-inch scar as a permanent disfigurement, the patient has only trifling marks as a reminder of his trouble.

¹ Read before the Boston Society for Medical Observation, November, 1892.

In the two other cases, I am sure that recovery was as rapid as could possibly have taken place after a most radical incision.

The detail of the above treatment is, of course, very simple, the important point being to make the cut as short as possible — from one-quarter to three-eighths of an inch long — and to depend upon the small curette and syringe, if subsequent treatment is necessary. In such cases as the second one, where the abscess cavity can be completely emptied at once, nothing is needed beyond keeping the cut open until there is no more oozing.

I wish to call attention to the method of treating sinuses that I employed in the first case, by dilatation with olive-pointed bougies. I started with a No. 11, which is not much larger than a large probe. The olive point followed the sinus just as an ordinary probe does, and by going from one size to the next larger, I got a gradual, but at the same time rapid dilatation up to No. 19. I know of no other method which would have prevented, as this did, the necessity for counter openings certainly, or perhaps, opening up the whole fistulous tract.

THE INFLUENCE OF MORBID CONDITIONS OF THE UTERINE ADNEXA UPON REFLEX PHENOMENA.¹

BY CHARLES P. STRONG, M.D.

THE object of these notes of my personal observation is not to form a conclusive and exhaustive essay upon this subject, but to suggest for discussion the principles of justification of surgical procedure in certain of these cases.

Broadly viewed, functional neuroses associated with tubo-ovarian disease may be divided into two classes: those in which the physical characteristics of the latter are so prominent as to merit recognition and treatment by themselves; and those in which there are no grossly apparent changes, but a reflex nervous condition for which no other adequate cause may be found. Of the latter class I make two subdivisions, according as there is periodicity of symptoms associated with the menstrual flow, or irregularity in this regard. In the former of these two subdivisions attention is naturally directed to a uterine source; in the latter it may not be.

I do not wish to consider the first division with its obvious pathological changes. With regard to the second division, at the outset the most reliable guide — statistical evidence — is not available. The personal bias of the investigator, and his attitude towards gynecological knowledge as a special study, influence his judgment — the cases occupy such debatable ground. A most skilful pelvic surgeon, whose experience was great, said recently to me that he had failed to find any patient of the class under consideration benefited by surgical treatment. An oppositely extreme view is asserted by many a neurologist. Consequently the experience of each operator must be his own guide. There is still one further limitation to be considered in the discussion, and that is that other than surgical means have been employed and proved futile in correcting the nervous symptoms.

The series of reflex disturbance are cephalic, spinal, gastric, and cardiac — one or all; their variations manifold.

¹ Read before the Obstetrical Society of Boston, October 8, 1892.

The influence upon the nervous system, of abdominal surgery, in ablation of tubes and ovaries, has recently been prominently brought into notice by the report of a number of cases of distinct mental derangement or insanity following this procedure. Therefore, there is the fact established that profound impressions may be made upon the nerve centres by this operation. Chronic, decided cases of reflex disturbance can only be reached by measures which induce profound disturbance of the nerve centres; and to be permanent it is necessary that such impression be of a lasting nature. Consider first the subdivision in which there is association of menstruation and active neurotic manifestations. The typical patient of this class may be free to enjoy life but a few days out of each month. Whichever organs are reflexly affected begin their symptoms at a varying interval before, and check them at a varying interval subsequent to, the catamenia. If it be found that by removing the tubes and ovaries in a certain number of these cases these symptoms are put an end to, the inference seems to me but logical that we, as conscientious operators, under the limitation set down in the early part of this paper, are at liberty to elect this operation, and not be generically classed as mutilators of women.

When the patient is included among those of the second subdivision, our course is perhaps less readily determined; but once determined, our actions should be none the less decided. Our clinics, both private and public, contain no inconsiderable number of sufferers of this type; they pass from physician to physician, hospital to hospital; and finally, what was functional becomes organic, and the nervous invalid is such no longer, but has true physical disease. These are the patients to whom in many cases a return to health may be assured by performing a comparatively early operation.

Relative to the total number of oöliotomies for tubo-ovarian disease, the cases for which this operation is to be performed are few. I have the notes of ten and the recollection of some few more. The results have been satisfactory. Five of these are now self-supporting, two are very greatly benefited, although the time is too short, less than one year since operation, to speak with absolute certainty as to cure. The others I have no longer under observation. My negative evidence in favor of the operation is equally strong. There has been no death or unfavorable termination in any case.

In these cases the examination before operation showed no changes in tube or ovaries that could be considered sufficient, in themselves, to demand removal of these organs. The specimens removed have when practicable been submitted to a microscopical examination, and in each case there has been found chronic interstitial change, and usually a slight catarrhal condition of the tubes.

I shall report in more detail two cases only. Miss C. became a patient of mine in 1887. She had received local treatment for some years previous. In brief, her symptoms were — beginning seven or eight days before menstruation — pain in the back, nausea and vomiting, faintness and dizziness, with intense pain in the occipital and frontal regions. With these symptoms she went to bed, where she remained until the menstrual flow had entirely ceased, and then, weak and prostrated, began her convalescence. Dysmenorrhœa was also very intense. No form of treatment had