

stimulating effect on the sympathetic and therefore a dilated pupil on the corresponding side, or a paralytic pressure effect with consequent apparently contracted pupil in the opposite side. All that marked inequalities in the pupils teach us is that on one side or the other some pressure is being exerted, but the exact site of the pressure and its degree remain doubtful, although the pupil reflex may at times help to determine which side is affected.

Tracheal tugging is present but in a slight degree. This sign when elicited is a most valuable one. It is not always present, but when it is it may be almost regarded as pathognomonic of aneurysm. I may say that I have frequently failed to observe it in cases of undoubted thoracic aneurysm, but I have, on the other hand, always found that when it did exist the patient was the subject of this distressing condition. In no other disease have I observed it.

Another sign allied to tracheal tugging is tracheal or expiratory whiff, a peculiar puffing sound heard, during expiration only, when the listener places his ear in front of the patient's mouth. This sign is best heard when the aneurysm involves the second portion of the arch and is pressing directly backwards on the trachea. It may be compared to the puffing sound which is occasionally heard emanating from the exhaust pipe of some small stationary steam engine. It is, of course, synchronous with the systole of the ventricles and is due to the sudden and increased expulsion of air during expiration from the trachea—a series of sound waves during the expiratory tide. Occasionally this sign is more easily detected by allowing the patient to place the bell of the chest piece of the stethoscope in his mouth, holding it in position by his lips and not his teeth. By this manoeuvre the auscultator can at times detect the sign which otherwise would be missed. It is a most valuable auxiliary sign when present and though I should have expected to detect it in our patient I fail to do so. Probably the left bronchus is not extensively impinged upon and hence the sign is absent.

As regards treatment I have little to say that is new or original. But one conviction is firmly fixed in my mind. Notwithstanding the many triumphs which surgery has gained in the domain of medicine the cure or even the amelioration of thoracic aneurysm is not in its category. I have, drawing from my records of hospital practice, seen 17 cases in all, in whom various filaments, wires, horsehair, catgut, and also foreign bodies were introduced into the sac. Included in this number were two cases in which needles connected with an electric battery were introduced into the tumour, and a spark thus passed from one pole to the other. All these measures were taken with a view to favour coagulation. But in every one the result was disastrous. I ought perhaps to qualify this adverse opinion by drawing your attention to the success which has attended ligation of one or more of the large arteries which spring from the arch, as practised by Mr. Richard Barwell and others. But any operative procedure on the sac itself I would discountenance.

Nor would I, with the light of the recent experience of other physicians, advocate the introduction of gelatin injections subcutaneously. To inject a coagulable fluid, say, into the buttock with the hope, and maybe the silent petition, that it may go into the sac is, I think, a hazardous procedure. It may go into the aneurysm. If so, good. But remember you have lost all control over the course of the injection as soon as it is completed. It may not fill, and in some instances it may not even enter the sac, but follow the course of the carotids to the brain, where it is fair to presume the vessels there are in the same unhealthy state as the aorta must be. And if this catastrophe should occur the last state of our patient would be worse than the first.

Nor am I in favour of the prolonged rest in bed, with large doses of potassium iodide, or without that drug. I have seen two cases in whom after a year's sojourn in bed sudden death occurred within a few days of their getting up, although the opinion was expressed that the patients were better and the aneurysms diminished in bulk.

It has always seemed to me that such treatment is as much calculated to do harm as good. The condition of the patient is impaired, his tissues are lessened in tone and in resisting power, as compared with a man who, though an invalid, is allowed to take gentle exercise out of doors, or even to follow some quiet occupation. In support of this I would mention amongst other cases that of a gentleman who showed signs of aortic aneurysm when he was 50 years old. The condition was explained to him, yet he firmly resolved not to rest, but

continued his occupation, taking every precaution, and ultimately died, aged 68 years.

Then I can imagine you asking what treatment I advise in this distressing disease. Briefly I would say that we should be candid with our patient and tell him something of his condition and danger. We should forbid any occupation or even amusement or relaxation which quickens the pulse-rate. Alcohol, especially spirits, should be forbidden; excitement, controversies, and debates should be guarded against; and his general mode of life made as even and uneventful as circumstances will allow. If a labourer, let him, if possible, obtain a post of time-keeper; a hammerman must seek some occupation which is less strenuous. The richer patient should retire from his occupation if it be exacting or exciting, and in short he should, no matter what his age, look on the rest of his life as the evening of his days, which may be a long or a short one, according to the general health of the body and the care which he takes to maintain that health.

Of course, one's experience, however great it may be, does not embrace a large number of cases, and statistics based thereon may be fallacious. But if I may judge by the figures at my disposal, the longevity of cases treated on the above lines is considerably more extended than in those who have been treated by prolonged rest and medication.

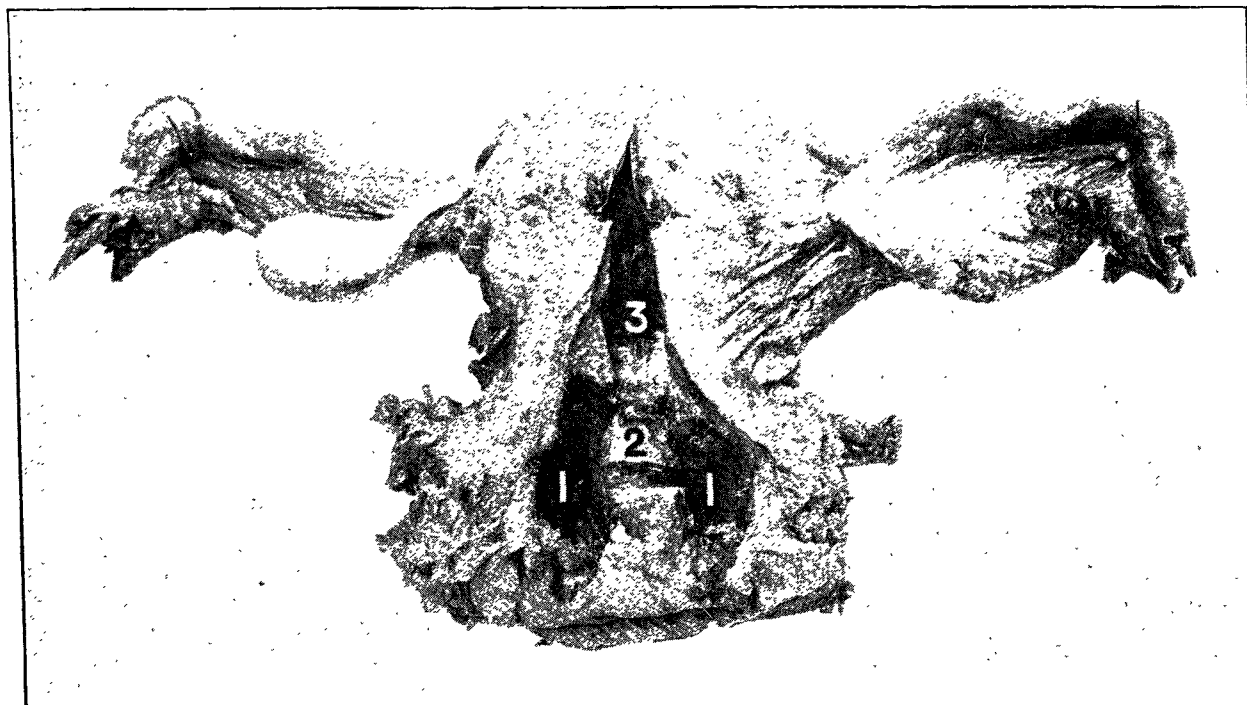
A CASE OF WERTHEIM'S HYSTERECTOMY FOR ADVANCED CARCINOMA OF THE CERVIX.

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THE patient, a married woman, aged 46 years, was admitted into the London Hospital on June 27th, 1907. She had had five children, the last 16 years ago, and two miscarriages, the last 14 years ago. Menstruation had always been regular and painless. Since December, 1906, she had noticed a vaginal discharge "like dirty water" and for three weeks before her admission the discharge had been blood-stained. She had also for the last few weeks suffered from pain in the lower part of the back and in the lower abdomen. The patient was examined under anaesthesia on July 2nd, 1907. Nothing abnormal was discovered on examining the abdomen. On vaginal examination the os uteri was patulous, and its margins were irregular in outline and sharp, especially behind and to the left. The finger passed readily into a chasm occupying the cervical canal and lower part of the body of the uterus, lined by malignant tissue. The discharge from this cavity was extremely offensive. The uterus was very fairly moveable. The malignant ulcer was swabbed freely with pure tincture of iodine and packed with gauze, which was removed on the next day.

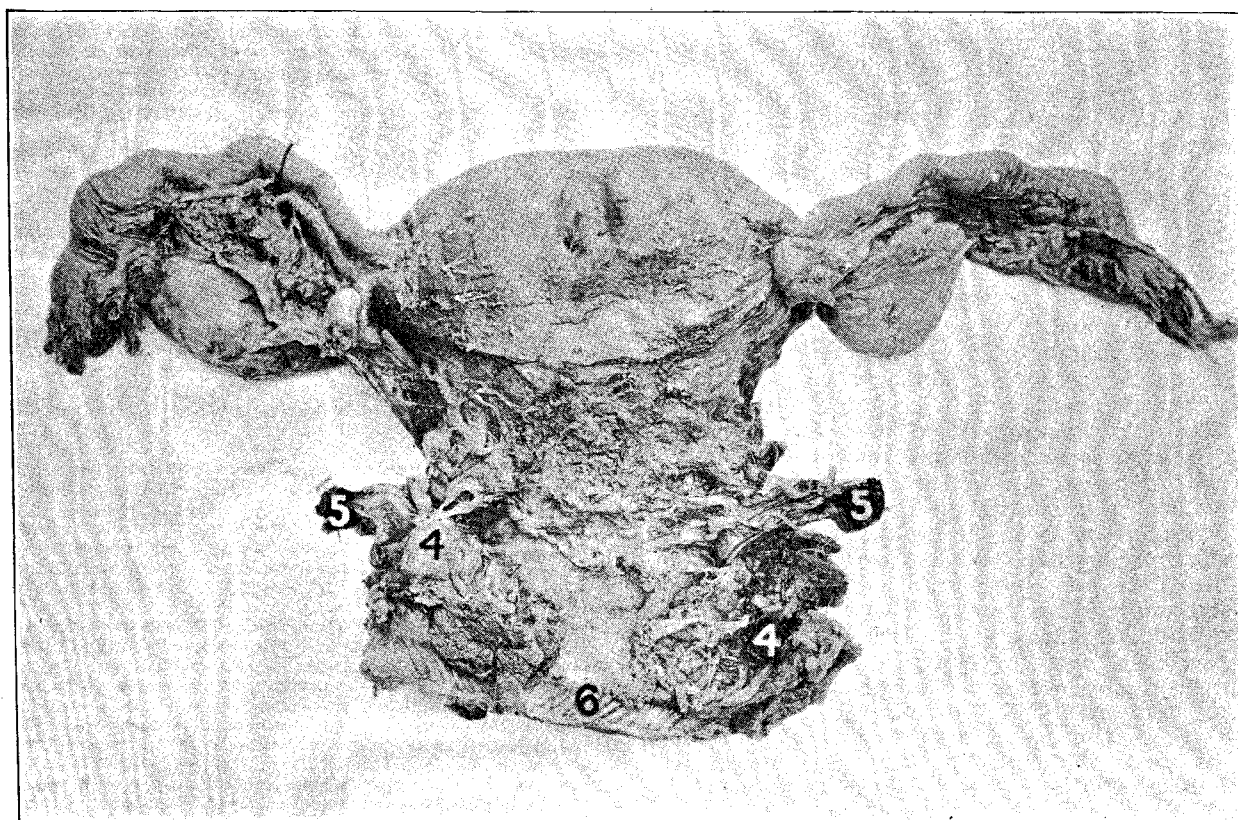
Operation was performed on July 4th, 1907. Abdominal hysterectomy was done by Wertheim's method. There was no particular difficulty in dissecting out the ureters, but a good deal of difficulty was met with in separating the bladder from the supravaginal cervix. There was, however, no evidence that the bladder wall was infiltrated by the new growth, and ultimately the bladder was freed without injury. Before the rectangular clamps were applied to the vagina an attempt was made to disinfect it by injecting from two to three ounces of tincture of iodine with a syringe. The excess was removed by gauze swabs. The clamps were then applied and the vagina cut across below them. A few bleeding points on the cut vaginal walls required ligatures. A gauze drain was then drawn down into the vagina and the peritoneal flaps were sutured over it. The abdominal wound was then completely closed. The patient made a good recovery. The gauze was removed on the sixth day and was rather offensive. From the sixth to the tenth day there was a gradual rise of temperature, which reached 104.2° F. on the tenth day; after this the temperature rapidly declined as the purulent discharge from the vagina diminished. There was no trouble as regards the urine, no incontinence, nor anything abnormal in the urine itself. For the first few days the catheter was passed every six hours. The patient left the hospital on August 7th, 1907. She came to see me just before Christmas and I examined her. The scar at the top of the vagina was quite healthy and there was no sign of recurrence.

FIG. 1.



Posterior aspect of the specimen, which has been laid open from behind. 1 1, The deep excavation caused by the malignant ulcer, which extends highest on the left side. 2, Median ridge on the anterior cervical wall which has escaped ulceration. 3, Cavity of the uterine body.

FIG. 2.



Anterior aspect of the specimen. The cut ends of the uterine arteries (5 5) are well seen. The loose parametric connective tissue (4 4) is also seen. 6 marks the vaginal wall. The serrated marks left by the clamps are clearly seen.

The figures give a good idea of the specimen removed. Fig. 2 especially shows the considerable amount of parametric connective tissue that may be removed in hysterectomy by Wertheim's method. The cut ends of the uterine arteries are seen, which have been tied and divided external to the ureters. In Fig. 1 the uterus has been laid open from behind and the extensive character of the malignant ulceration is well seen; the highest point of the ulcer (on the left side) lies in the body of the uterus. The specimen has been thoroughly examined by Dr. R. D. Maxwell, obstetric registrar at the London Hospital. The growth itself is a squamous carcinoma. Sections taken from the peripheral portion of the parametric connective tissue (Fig. 2, 4 4) show no sign of malignant invasion. The specimen and sections were shown at a meeting of the Obstetrical Section of the Royal Society of Medicine on Jan. 9th last.

Remarks.—Cases of carcinoma of the cervix may, from the clinical point of view, be divided, broadly speaking, into three groups. In the first group are comprised those cases where it is at once evident on examination that no operation, however extensive, would be of any use. In the second group may be placed those cases in which the growth is in an early stage, and where it seems probable that either the supravaginal amputation of the cervix or vaginal hysterectomy would be an effective treatment. This group unfortunately contains only a very small proportion of all the cases. I have for some years given up the supravaginal amputation of the cervix, not because it is not a good operation as regards giving the patient the maximum chance of non-recurrence in suitable cases. Last year at the Obstetrical Society I showed a specimen removed by this operation 20 years ago, and the patient was still free from recurrence. But the supravaginal amputation of the cervix is apt to be followed by troublesome contraction of the opening into the uterine cavity, and this gives rise in many cases to a rather severe form of dysmenorrhœa. So that for early cases of cervical carcinoma I have of late years relied exclusively on vaginal hysterectomy.

The third group of cases contains those in which the disease has attained a considerable degree of advancement when the case is first seen. This is shown perhaps by a very extensive excavation of the substance of the cervix and even of the lower part of the body of the uterus, as in the specimen here figured. Or there may be some slight extension of the disease outside the anatomical boundaries of the uterus; for instance, into the connective tissue of one or other broad ligament, or into the utero-sacral ligaments, or a short distance on to the vaginal walls. Again, the iliac glands may be enlarged and palpable. In all these cases vaginal hysterectomy is useless. It is for cases in this class that Wertheim's hysterectomy is indicated. The preliminary dissection of the ureters enables the operator after drawing them outwards to remove a great deal more of the parametric tissue at the sides of the cervix than is possible by a vaginal hysterectomy or even by abdominal hysterectomy, unless the ureters are separated as described. It also, in some cases, allows of the removal of infiltrated lymphatic glands. In addition, large vaginal flaps may be removed by this operation, with the advantage in many cases that as the vagina is cut across below rectangular clamps the cancerous debris is confined in a pocket formed by the vaginal flaps above the clamps. In some cases it is found that the infiltrated lymphatic glands cannot be removed owing to the growth having spread through the glands and invaded the walls of the external or internal iliac arteries and veins. Therefore it is apparent that in deciding to operate on cases in this group the operation must always in the first instance be of the nature of an exploratory laparotomy, since only in the course of the operation can it be determined whether a complete removal of the diseased parts will be possible or not. In my opinion this third group of cases comprises the largest proportion of all cases at the time when they first come under observation. It is obvious therefore how greatly the operability of cases of cancer of the cervix has been increased by the introduction of Wertheim's method of hysterectomy. By this operation an apparently complete removal of all the diseased tissues is possible in a much larger proportion of cases than before this operation was devised.

The drawbacks to the operation are not inconsiderable. It will probably be admitted by those who have performed it to be the most difficult, and also the longest, operation in gynaecological work. It is necessarily a very severe operation as regards the patient, and the mortality, when it is performed in cases where the disease is at too advanced a stage

for vaginal hysterectomy to be advisable, is at present certainly high. No doubt the more advanced the case the higher the mortality. Probably as the technique of the operation becomes more familiar, and as experience enables the operator to decide what cases are too advanced even for this operation, the mortality will be reduced. The value of the operation as a therapeutic measure can only be estimated when a sufficiently large number of authentic histories of cases operated on becomes available. At present for cases of cancer of the cervix falling in the third group as previously defined, Wertheim's operation, in spite of its drawbacks, seems to be the only treatment offering a fair prospect of relief.

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HERNIA OF THE ILIAC COLON.¹

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"THIS kind of hernia (of the sigmoid) has hardly had the attention it deserves, and although it is not uncommon our museums do not contain many specimens."² This, though written many years ago, is still apparently true. Having recently seen two cases of this condition in hospital and a third in a dissecting-room body, I shall first give a brief description of these cases and then try to explain their pathology and classify them according to the new nomenclature of the lower part of the large intestine.

CASE 1.—This patient, a man, aged 27 years, was admitted to the Royal City of Dublin Hospital on July 2nd, 1906. He had a large scrotal hernia on the left side which was only partly reducible. He said that it had been present for several years and that it had come on gradually after an injury received from falling from his car some five or six years before. At the operation, when the sac had been isolated from the structures of the cord, the contents were still irreducible; the sac was therefore opened. It was then found that it contained a loop of the large intestine which was adherent to its postero-external wall. On trying to separate this loop from the sac some slight and apparently recent adhesions were broken down until about two-thirds of the circumference of the bowel were exposed. It was then seen that the peritoneum covering the gut was reflected on to and formed the sac of the hernia; in other words, the bowel formed a large part of the postero-external wall of the sac. The anterior wall of the sac was then cut away along with the portion of the posterior wall which was below the loop of intestine, the rest of the posterior wall with the loop of bowel was reduced into the abdominal cavity, and the cut edges of the peritoneum were closed by sutures at the level of the internal abdominal ring. The operation was then completed according to Bassini's method. The loop of bowel in this case was between four and six inches long and possessed no mesentery, but was, as it were, invaginated into the sac through the posterior wall.

CASE 2.—For permission to publish this case I am indebted to my colleague Mr. Henry Moore, under whose care the patient was. The patient, a man, aged 44 years, was admitted to the hospital on June 23rd, 1907. About 24 years previously he had slipped while carrying a load of hay, had fallen, and had strained his left thigh. Some months afterwards he had noticed that the left side of the scrotum was enlarging, but he had refused surgical treatment and had for a time worn a suspensory bandage. The scrotum had remained swollen since, but had given no trouble till last Easter, when he began to suffer from dry retching in the mornings and noticed a small lump in his left groin, which enlarged downwards towards the scrotum; it became larger when he coughed. He did not remember receiving any fresh injury. The swelling gave him very severe pain whenever he stooped. At the operation the testis was found to be enlarged, retroverted, and with a well-marked varicose condition of the veins at its upper end. A small irreducible hernia was found in the inguinal canal and on opening the sac a portion of the large intestine was found to be projecting from the posterior and outer wall; it did not lie free in the sac but was only covered by the peritoneum for rather less than two-thirds of its circumference; it was found to be quite impossible to free it from the sac, the peritoneum covering it being evidently continuous with that forming the fundus and neck of the sac. The further steps of the operation were the same as in the preceding case.

CASE 3.—This case was discovered in the body of a very old man, a subject seen in the dissecting room of Trinity College, Dublin. There was a very large femoral hernia on the left side. On opening the abdomen it was found that there was a complete volvulus of the small intestine, the gut being twisted on itself in the direction of the hands of a clock from the duodeno-jejunal flexure to within two inches of the ileo caecal valve. About three feet of the small intestine were contained in the left femoral sac, the neck of which admitted four fingers; on withdrawing the small intestine from the sac a portion of the large intestine was found in the hernia behind it. This proved to be about three inches of the iliac colon, which in this case was in the form of a long loop with an extensive mesentery. Curious to say, this portion of the intestine also presented a volvulus with the twist contra-clockwise.

On looking up the subject of hernia of this part of the

¹ A paper read at a meeting of the Anatomical Section of the Royal Academy of Medicine in Ireland.

² Lockwood: Morbid Anatomy, Pathology, and Treatment of Hernia, 1889, p. 144.