seventy years). I conclude with the belief that the prompt recognition of the condition and early operation, without the old-fashioned savage attempts at taxis (10 of the cases were operated upon within twenty-four hours), had much to do with the low mortality. When the operation is undertaken, rapidity, thorough antiseptic cleansing of the sac contents, no undue delay over so-called radical cure, and judicious starvation without opium can be relied upon to keep the deaths down to a small percentage.

Liverpool.

VENTRO-HYSTEROPEXY.

By J. O'CONNOR, M.A., M.D., B.Ch., T.C. DUB.

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DURING the past twelve months I have performed abdominal fixation of the uterus for prolapse eight times, and I wish to bring more fully under the notice of the profession the ease and certainty with which this operation may be executed, also the advantages of fibro-serous approximation, so ably advocated by Mr. Greig Smith. Quite recently I had an opportunity of realising the danger in anyone attempting to fix the uterus to the anterior parietes without opening the abdominal cavity. I particularly refer to a method of intra-uterine ventro-fixation recommended by Mr. Shober. On opening the peritoneal cavity, the omentum covered anteriorly the lower abdominal viscera in all directions, notwithstanding the fact that my two-inch incision extended to within half an inch of the pubes. If I had attempted to fix the uterus by a needle passed through the womb without opening the peritoneum, I certainly would have included the omentum; therefore with this experience—and I have seen the same in other cases—I have strong objections to working in the dark. In each of the eight cases there has not been the slightest post-operative complication; all united by first intention, in no instance did the temperature exceed 100° F., and no recurrence of the trouble has been reported, and, although I never order an abdominal belt to be worn afterwards, no ventral hernia has occurred. To my mind the latter mishap is due to deficient care in suturing the parietal wound. Of course a short period only has elapsed, therefore these latter observations can only be tentative. In a way I feel thankful that I have not as yet been afforded the opportunity of examining the class of adhesion that takes place, nor have any of my patients, so far as I know, tested the same by becoming pregnant. As some of them are young doubtless the test will be applied.

The operation is carried out as follows: The patient, having been "acclimatised" to hospital life for a fortnight, during which time sundry repairs are undertaken—curetting the endometrium, excision of the cervix, and colpo-perineorrhaphy, the bowels, if necessary, being well cleared out with repeated doses of magnesium sulphate—the day before the operation the pubic hair is shaved off and the skin of the abdomen scrubbed with soda, soap, and hot water, then washed with turpentine, and a large piece of lint soaked in a 1 in 500 solution of corrosive sublimate applied and fixed on for the night by antiseptic wool and a bandage. On the morning of the operation a large soap and water enema is given, and immediately before the patient is brought into the operating-room the urine is drawn off. The patient having been chloroformed the night's dressing is removed and the skin all round the field of operation is again scrubbed with a sponge soaked in turpentine and lastly thoroughly washed with Watson Cheyne's strong solution:—1. An incision two inches in length is made in the median line and extending to within half an inch of the pubes. All bleeding must be stopped before the peritoneum is picked up with a pair of dissecting forceps and opened; a few pressure forceps are attached to the cut edges of the peritoneum—these help greatly in after manipulations. 2. The left index-finger is passed down below the intestines and omentum to the uterus, with palmar surface, hooking the former upwards. With the tip of the finger steadied on the womb I pass down a Muzaux forceps on the dorsal aspect of the finger, seize the uterus, and pull it up to the wound. 3. An assistant now takes hold of the forceps and the presenting surface is scarified with the point of a scalpel; some trifling oozing takes place, which is easily arrested by sponge pressure. 4. At the lower angle of the wound a curved needle threaded with silk is

passed from without inwards through the rectus muscle and transversalis fascia. The peritoneum being retracted by pressure forceps (previously applied) the needle is then passed for at least a quarter of an inch in depth into the uterus and made to emerge about half an inch from the point of entry. The peritoneum on the opposite side is next held back while the needle is passed from within outwards through the transversalis fascia and rectus muscle. In this manner three sutures at intervals of a third of an inch are inserted. Any bleeding from the needle punctures is arrested by sponge pressure. 5. The peritoneum is again held back on each side and these sutures are tied firmly and the ends cut off. (Care must be taken not to tie too tightly lest the silk sutures should cut through the uterus; firm approximation is all that is necessary.) In this manner the serous covering of the uterus is brought into intimate connexion with the transversalis fascia and recti muscles for half an inch in width and one inch in length. 6. Before closing the upper inch of the wound it is desirable to pass a small sponge held by torsion forceps into the peritoneal cavity in order to remove any blood or clot that may be present. The peritoneum is next closed by a continuous fine silk suture. It is well to pass the first stitch through the peritoneum on the side next the operator, then through the uterus, and, lastly, through the peritoneum on the opposite side. In this way the peritoneum is brought into accurate apposition with the serous coat of the uterus and prevents a subsequent site for ventral hernia. The recti muscles in the upper portion of the wound are then brought together by another continuous fine silk suture and the skin wound closed in the same manner. Iodoform gauze is applied. The first dressing is removed on the eighth day and the suture on the twelfth day. The patient is allowed out of bed on the fourteenth day.

There is one essential in the closure of this or any abdominal wound, and that is that no pocket must be left for the accumulation of serum or blood, for where these factors are thither staphylococci and other micro-organisms gather together—nay, more, thrive.

Buenos Ayres.

A CASE OF AXIAL ROTATION OF THE TESTIS.

By ALFRED SHEEN, M.D. ST. AND.,

SENIOR SURGEON TO THE CARDIFF INFIRMARY.

A YOUTH aged eighteen years jumped over a hedge after a tennis-ball on July 5th, 1895, but felt no ill-effect at the time. On the 6th at 3 A.M. he awoke with severe pain and swelling in the testicle, it being all right when he went to bed. I saw him on the 9th in consultation, when the testicle was found to be considerably enlarged and somewhat tender. The temperature was normal although it had been up to 103° F. I advised immediate incision into the tunica vaginalis to relieve tension, and this was done at the Private Hospital at Cardiff on the 11th. On operation I found a dark-red mass like blood-clot, but not removable, and the testicle was swollen to the size of a small orange, globular in shape. All antiseptic precautions were carried out. The case pursued an aseptic course, the temperature being normal throughout. The stitches, however, gave way and a hernia of the testis resulted; there was no pain. The dead tissue was dry and was cut away with scissors. There was no sensation, common or testicular. It was obvious that the testicle was useless and it was removed on Aug. 9th; on the 20th the wound was dressed for the first time and the stitches were removed, the parts being nearly healed. The patient got up for a time day by day, was out for the first time on the 28th, and went home to London about the middle of September.

The specimen was sent up to the Clinical Research Association and they returned the following report:—"The specimen is an example of that rare condition described as *torsion of the testis*. The substance of the body of the testicle is healthy in itself; there are no signs of chronic inflammation, syphilis, or tubercle. Section of the epididymis shows an abundant extravasation of blood into its tissue, but there is no other lesion. This hæmorrhagic infiltration is due to twisting of the spermatic cord and

vessels (the result of injury) and gives rise to acute swelling and pain so that the cases have been mistaken for herniæ."

There was no question of hernia in this case. My diagnosis was hæmorrhagic orchitis. I had never seen a case of axial rotation, and that possibility did not present itself to my mind. Had the condition been recognised when first seen the cord might perhaps have been untwisted, as was successfully done in a case which is recorded by Mr. G. Nash.¹ A year or two ago Mr. Edmund Owen read a paper dealing with this subject. At a meeting of the Medical Society of London² he brought together references to fourteen cases which have been recognised during the past few years, and said that, as a rule, "it is only the unhappy possessor of an undescended testicle that gets into this very peculiar kind of trouble. It is almost as if nature herself, disappointed with her imperfect work, was anxious to cast it down a Tarpeian rock." Mr. Bryant, in reporting a case, surmises that certain cases of atrophied testicle have been examples of axial rotation, the nature of which has been originally overlooked. Twisting the cord in the lower animals is the French method of producing atrophy of the testes and sterility.

Cardiff.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

GUY'S HOSPITAL.

A CASE OF MALIGNANT STRICTURE OF THE ŒSOPHAGUS;
PERFORATION OF THE AORTA; DEATH FROM
HÆMORRHAGE.

(Under the care of Dr. FREDERICK TAYLOR.)

IT is, happily, rare to find a carcinomatous ulceration of the Œsophagus perforating the walls of an artery of large size; it is still more rare to find it perforating the aorta. In the references given by Dr. Taylor in his paper in the Guy's Hospital Reports the investigations of Altmann in perforation of the thoracic aorta from the Œsophagus are detailed. The comparative rarity of the occurrence is shown, as it happened only four times in 6886 cases, a percentage of 0.058. In 38 instances death was due to hæmorrhage, in only 12 of these was the wall of the artery invaded by cancerous growth and the aorta was involved in only 4. It is not possible to say whether epithelioma is more likely to penetrate than other forms of growth or not, as the microscopic examination is not given in every instance. We have published in our columns³ the notes of a case of perforation in a female lunatic where there were no symptoms of the presence of a growth manifested until the vomiting of about two ounces of blood. Afterwards the patient swallowed the blood and large quantities were passed per anum. The fatal ending does not seem in any case to have been induced by the passing of bougies or tubes. For the notes of the case we are indebted to Dr. L. A. Parry, house physician.

A man aged fifty-two years was admitted into Guy's Hospital under Dr. Taylor on Feb. 20th, 1895, for difficulty in swallowing. His family and previous history have no bearing on the case. His present illness dated from November, 1894—that is, about four months—and commenced with dull, aching pain in the lumbar and interscapular regions and frequent attacks of heartburn. In December, 1894, he began to have difficulty in swallowing, at first solids, then liquids; the food he got down into his Œsophagus he quickly regurgitated; the dysphagia rapidly became worse, he lost a great deal of flesh, and he was admitted into the hospital on Feb. 20th. He was then unable to swallow any solid food, and liquids only with effort. A medium-sized bougie met with definite obstruction thirteen inches from the teeth (seven

inches down the Œsophagus), but a small one was passed through the stricture right into the stomach. It was felt to hitch half way, and it was therefore thought that a pouch was present into which it had slipped. The patient was fed daily by means of a tube and on March 22nd an attempt was made to pass a Symonds's short tube. However, this could not be accomplished, and Mr. Symonds, thinking the cause of failure was probably due to the stricture being sinuous, suggested passing an ordinary feeding-tube and allowing that to remain *in situ* for thirty-six hours, thus hoping to straighten the stricture. This was done and the short tube (Symonds's No. 12, 6 in.) was then placed in position without any difficulty. The patient was able to swallow liquids freely and easily, the tube was not touched, and all went well till April 4th, eleven days later, when the patient suddenly collapsed, became very pale, brought up a large quantity of blood, and died in a few minutes.

Necropsy.—This was made by Dr. J. H. Bryant. There was found to be recent pleurisy at the right base and there were some old pleuritic adhesions over the front of the right lung; both lungs were emphysematous. There was a patch of septic broncho-pneumonia in the right lung, which was adjacent to the Œsophageal growth, the bronchial glands were enlarged from deposit of secondary growth, and there were some patches of early atheroma in the ascending aorta. Seven inches from the commencement of the Œsophagus was a carcinomatous growth which involved two and a quarter inches of the length of the tube; it was hard and had thickened the wall of the tube. The internal surface of the growth was ragged and ulcerated and the ulceration had extended through the coats of the aorta two and a quarter inches from the commencement of the descending aorta. The Œsophagus was dilated above the stricture and the walls were thickened; in the mucous membrane at the upper part there were a few nodules of secondary growth. The stomach was distended and filled with a large blood clot.

Remarks by Dr. FREDERICK TAYLOR.—The above rapid termination of cancer of the Œsophagus is sufficiently rare to make a case of its occurrence worthy of record. In 1885 I had a similar instance under my care which I published among some cases of malignant disease of the chest and abdomen,⁴ and I took the opportunity of referring to eight other recorded cases. On May 20th, 1895, Stadelmann reported to the Berlin Society of Internal Medicine two cases of carcinoma of the Œsophagus opening into the aorta; and at the same meeting Professor Ewald stated that in from forty to fifty cases of carcinoma of the Œsophagus he had only known one to perforate the aorta.⁵ Little, if at all, do the symptoms of cases differ from others of Œsophageal cancer before the occurrence of the fatal hæmorrhage, but in a few there have been preliminary bleedings described as vomiting of blood. Generally the event is quite unforeseen. In most of the cases alluded to in my paper the opening in the aorta was in the lower part of the arch or the upper half of the thoracic aorta; in Stadelmann's two cases the cancers were situated respectively four inches and six inches above the cardiac orifice of the stomach. Any successful or even palliative treatment is, of course, out of the question.

GENERAL HOSPITAL, BIRMINGHAM.

A CASE OF INTRA-PERITONEAL RUPTURE OF THE URINARY
BLADDER IN A WOMAN SUCCESSFULLY TREATED BY
ABDOMINAL SECTION AND SUTURE.

(Under the care of Mr. GEORGE HEATON.)

THERE is at the present time no doubt as to the treatment required for intra-peritoneal rupture of the bladder due to injury. The rent should always be sutured and the peritoneum cleansed, provided it be possible to carry out the necessary procedure. The two conditions which are most likely to prevent a surgeon from adhering to this rule are excessive nervous shock and a hopeless state of the patient from urinary infiltration or as the result of peritonitis. Blum operated successfully on a patient forty hours after the accident, and healthy urine may remain in contact with peritoneum for some days without exciting fatal peritonitis, but success is most likely to be attained if operation be performed soon after the infliction of the damage, inability to make a diagnosis alone justifying delay. One of the most

¹ Brit. Med. Jour., April 9th, 1893.

² THE LANCET, Nov. 18th, 1893.

³ THE LANCET, March 20th, 1880.

⁴ Guy's Hospital Reports, vol. xlix., 1892, p. 123.

⁵ The Medical Week, May 29th, 1895, p. 253.