a rule that adhesions are fibrous and not bony. Here we have a condition better adapted for mobilization or removal of the bone. But in this class of cases again, unfortunately, we have changes in the internal ear which seem to go hand in hand sooner or later with many changes around the foot-plate. As it is impossible in any case to determine beforehand the amount of relief, it seems best from the present experience, as I suggested two years ago, to make an opening in the drum membrane in order to note pathological changes as a guide to surgical interference. By means of this exploratory opening access is furnished for a synchotomy, tenotomy, disarticulation of the incudo-stapedial joint, or removal of the incus itself, and mobilization of the stapes by means of a probe. Many of these operations can be done more successfully under cocaine with the aid which the patient is able to give, but stapedectomy should always be done under ether. If any of these measures give relief the removal of the stapes may not be necessary. In cases of chronic aural vertigo the removal of the pressure on the stapes has been found in many instances to relieve the dizziness. Let me briefly report one case which has stood the test of time.

CASE II. M. R., twenty-four years of age. There had been a chronic progressive disease in the right middle ear for two years. For the last year had been troubled a great deal with attacks of dizziness. The drum membrane was opaque, indrawn and the malleus retracted.

The hearing for the watch was: Hearing = R., H $\frac{1}{18}$; whispering voice = $\frac{1}{2}$; tuning fork, C. = a. c., 10", B. C., 12". Konig's rods, 25,000.

The operation was done under ether; triangular incision. The incudo-stapedial joint could not be seen; but by means of a curved knife the articulation was separated and the tendon of the stapedius divided. With a blunt hook the long process of the incus was brought down as far away from the head of the stapes as possible. It is now over one year and a half since the operation and there has been no return of the vertigo. There was practically no change in the hearing. In order to relieve the pressure in this case, disarticulation of the incudo-stapedial joint was all that was necessary. The stapes can be removed at a later operation if necessary.

In considering the results of a personal experience for the last two years, I can say—

(1) That the best results in hearing have been obtained in cases of early removal of the bone, and that this operation is of little use in cases of otitis media insidiosa (sclerosis).

(2) That cases of chronic aural vertigo have been permanently relieved by liberation of the stapes or by extraction of the bone itself.

(3) That in cases of non-suppurative disease of the middle ear, as well as the class of cases the result of a chronic suppurative process, surgical mobilization should first be tried before an attempt is made to remove the stapes.

(4) That most operations for mobilizing the stapes or freeing the oval window must be looked upon as largely experimental, and that in many cases a fracture of the crura occurs at the time of attempted extraction, leaving the base plate.

The *Southern Medical Review*, Houston, Texas, has published one issue, counted the cost, and is no more.

Clinical Department.

A CASE OF CONCEALED UTERINE HEMORRHAGE.

BY ALBERT H. TUTTLE, M.D., CAMBRIDGE, MASS.

I WAS called in consultation by Dr. Slayter, September 20th, to see a young woman, Mrs. M., a fourpara of about thirty years of age, who had been suffering from a sero-sanguinolent discharge from the vagina, of uterine origin, for over a week, and whose pallor and loss of strength indicated something unusual had taken place. Menstruation occurred last on the 25th of May, and was followed by the usual symptoms of pregnancy.

At the time of examination, about four months from the date of last menstruation, the uterus was symmetrically enlarged and at a level with the umbilicus; with a firmness that indicated a nearly solid body, and of a boggy consistency, resembling that of a mole structure. It was freely movable, not tender to the touch, and transmitted no sounds that could be recognized, either placental or fetal. There was no history of uterine pains of a labor-like character, or any symptom of the onset of labor. Vaginal examination showed a badly-lacerated, swollen cervix, with tight cicatricial constriction of the canal, the latter obviously having much to do with the patient's condition. Ballotement was negative. From the absence of signs of life and the peculiarly solid character of the uterus, the conclusion that the fetus was dead was easily reached, and advice was given to clean out the contents of the womb.

The following day, with the assistance of Drs. Slayter and Lockhart, the patient was etherized, the cervix drawn down with forceps, the canal dilated with Wathens's instrument and the fingers, and the contents of the uterus evacuated; nearly a quart of dark tarry-looking blood, with a four months' fetus, somewhat macerated, and the placenta were removed.

The dilatation of the cervix was effected with considerable difficulty, the former tear being slightly increased by the operation, and was not carried sufficiently to admit of the delivery, *in toto*, of the after-coming head. The head was crushed by a finger passed above it, in the uterus, and extracted by the aid of a strong pair of tenaculum forceps, inserted in the firmer structures of the skull, and gentle traction on the body of the fetus. Relaxation of the uterus followed the third stage of delivery, and was met by the intra-uterine injection of tincture of iodine. An uninterrupted recovery followed.

Medical Progress.

RECENT PROGRESS IN GENITO-URINARY SURGERY.

BY F. S. WATSON, M.D.

SURGERY OF THE URETER.

FENGER,¹ at the end of a very valuable and interesting article on this subject, presents the following conclusions:

Catheterization of the ureters from the bladder for purposes of diagnosis of diseases of the kidneys has

¹ *Annals of Surgery*, September, 1894.