A small piece of camphor may replace the eau de Cologne. This or some similar solution should be used to rinse the mouth at least every night at bed-time, but better after every meal, whenever there is suspicion of acid acting or having acted on the teeth. It should be used several times a day from the commencement of pregnancy. The mouth should be rinsed with it, not only after every dose of mineral acid medicine, but also as soon as possible after acid fruits and whatever tastes acid in the slightest degree. The writer desires to see these three means in use:—

(1.) Rinsing the mouth thoroughly with water after the last meal of the day to remove all food. (2.) Rinsing immediately afterwards with an alkali solution to neutralize any acid or its effects. (3.) Moderate brushing in the morning to remove any mucus secreted during the night.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.¹

CLINICAL SERVICE OF DR. WILLIAM GOODELL,

Professor of Gynecology in the Medical School of the University of Pennsylvania.

Polypus of Cervix Uteri.—Polypi of the womb are usually very easy of recognition. They hang down into the vagina, and by passing your finger through the vulva and along the stem of the polypus you can easily get it or a sound into the womb, and assure yourself that it is really a polypus and not an inverted womb that you are dealing with. Here the diagnosis is more difficult. I find what may be either a very large polypus or an inverted womb hanging down in the vagina and projecting slightly from the vulva. I attempt to guide my finger along the side of this tumor into the womb, but find that I cannot. There seems to be a complete connection all the way round between the sides of this body and those of the cervix uteri. Let me insert one finger into the rectum, and with the other hand make pressure above the pubes. I certainly feel between my finger and hand a solid body, shaped like the womb, and situated exactly where the womb should be. Now if this body is the womb, why am I not able to get my finger into it by following the pedicle of the supposed polypus? It is very strange; let me try once more. Yes, here is one spot where there seems to be an opening, not large enough for my finger, indeed, but I ought to be able to get a small sound through it. I am right; there is a very small orifice here, and by using a little force I am able to push my sound through it. How far does it go beyond this opening? Only one inch and a half. This opening must lead into a womb, and yet one inch and a half is very short measurement. I insert the sound again, and this time it goes in further, two inches and a half. Now with the sound inserted and my hand on the abdomen I am able to map out the exact size and position of the womb, for womb I am sure it is. This womb is not inverted, not even slightly cupped, but is entirely normal. I might make assurance doubly sure by passing my finger into the bladder through the urethra, but I am so certain of my diagnosis that I do not consider this necessary in the present case. I have en-

¹ Reported for the Boston Medical and Surgical Journal.

larged the opening slightly with a dilator, and have succeeded in getting my little finger into the cavity; yes, there is no doubt that the womb is normal and in its usual site. Polypus of the cervix uteri is a somewhat rare affection, although I very often come across cases of polypus of the womb.

This woman tells me that she has been bleeding since last spring. While I have been talking you have noticed this stream of blood slowly issuing from the vagina. What is to be done for her? I think I can cure her entirely by removing the polypus. How do I do this? The woman being now thoroughly etherized I take hold of the polypus, and by pulling upon it bring the cervix well into view. You see how complete is its connection with the cervix except at this one little point. Let me give you a hint. Suppose a polypus is so large as to fill completely the vagina. How are you to get it down and out? Why just put on the forceps and deliver it as you would a child's head. If at any time you meet with a tumor so large as to fill up the whole vagina you may rest assured that it is not an inverted womb; an inverted womb is never of such size.

Having brought the base of the polypus and the cervix uteri well into view (the anterior portion of the neck of the womb has, you see, become slightly hypertrophied) I begin by cutting a little groove through the mucous membrane of the base of the polypus, so as to lodge my wire *écraseur* and keep it from slipping. You know, of course, that my object is to cut this growth bodily off. I might do this with a knife or with the galvano-caustic loop, but the first might cause serious hæmorrhage, and the galvanic battery required for the other is so capricious, so likely to get out of order, that I much prefer the simple wire, not the chain, *écraseur*.

While I have been talking to you I have carefully cut a groove all round the base of the polyp, studiously avoiding any injury to the cervix. This cutting has caused but little bleeding. Now I will get my assistant to fix the wire in place and begin to tighten it very slowly, — *very slowly*, because this is a tough myoma to be removed and if I attempt to do the work of cutting rapidly the wire is very likely to give way. While the assistant is at work let me give you a point about fastening the ends of your wire. There is what is known as the "traveling button" in an *écraseur*. In this case, as I want a crushing action, I have fastened both ends of the wire to this button; each end comes down together, and so the loop simply crushes through this musculo-fibrous mass. But suppose I desired a semi-cutting action; then I should fasten one end of the wire to the "traveling button" and the other end to the handle of the *écraseur*. I am using to-day for my loop a piece of piano wire, — wire used for producing the upper notes of the piano. A gentleman of this city makes what is called a phosphide of iron wire for this purpose, and claims that it is stronger; but I have given his invention a fair trial and do not think it any better than the piano wire. You see how nicely the wire is crushing its way through, without causing any hæmorrhage. A little more, — now, the whole polypus has come away.

What shall be the after-treatment? This woman has the exact sallow complexion which attends malignant disease, but it is due in this case to the effects of the constant drain of blood upon her system. I shall do nothing

for her but inject a little dilute Monsel's solution (one part of Monsel to three of water) into her vagina, and order a moistened sponge to be kept there. I shall put her at once upon a course of dialyzed iron. (The woman suffered but little pain during the week following the operation. She was again brought before the class on the eighth day, and an application of iodine was made to the cervix, which presented the appearance of a simple erosion.)

Dysmenorrhœa from Stenosis and Flexion. — This woman has been bed-ridden for over seven years, and is in a very hysterical condition. By strong moral control I am gradually getting her more and more out of bed. As regards her real troubles I find that she has a bad retroversion of the uterus, with an entirely inelastic vagina and a much contracted cervical canal. I have been treating the retroversion very successfully with pessaries. As regards the treatment of stenosis there is much diversity of opinion. In such cases as this several prominent New York gynecologists teach that incisions should be made into the cervix. By placing the patient under ether and using very powerful dilators, whose blades do not feather, I find that it is very rarely needful to incise the cervix. In using such dilators as the above, which have no shoulders, you should first insert the instrument right up to the fundus of the womb; then, before beginning to dilate, withdraw it half an inch.

Closure of the Vulva for Vesico-Vaginal and Recto-Vaginal Fistula. — Thirteen years ago this woman went into her first labor, during which she was attended by two most excellent obstetricians. It happened to be an arm presentation, giving no chance for turning, but showing a tendency to spontaneous evolution. While one physician was away and the other asleep the child was born. As a result of these complications she had very extensive sloughing of the upper and outer wall of the vagina, in the course of which the base of the bladder and a large portion of the urethra were eaten away. Since that time the woman has menstruated but twice. Last spring she came to me to have the operation for vesico-vaginal fistula performed. This I found utterly impossible; there was nothing from which a flap could be made. So I passed the galvano-caustic wire (insulated completely except at its point) into her rectum, and made an artificial recto-vaginal fistula with the intent of converting the rectum into a bladder. At first the rectum objected to the presence of the urine, and as a result she was constantly obliged to go to stool. Afterwards, however, it became more accustomed to its new office, and she only had a passage two or three times daily. I took this first step in my operation some months ago with a purpose. Artificial recto-vaginal fistulæ are very loath to close up again, and the success of the operation for closure of the vagina depends primarily, of course, upon the integrity of the opening into the rectum. I am going to perform an operation to-day that, so far as I know, has been successfully performed but once before. You will find a note of this case on pages 43, 44, of Dr. W. W. Keen's Toner Lecture for 1876. The case he gives occurred in his own hospital practice. I intend to-day to close up this woman's vulva by sutures. Dr. Keen had to perform some thirteen operations to secure accurate healing of the sides, but the woman upon whom he operated was vastly improved.

I shall begin by shaving off the hair from each side of the vulva where I

intend to put in my stitches. Now that the hair is out of the way I proceed at once to snip off the skin with a pair of curved scissors, beginning below so that the parts may not be obscured by blood. Every now and then a little artery spurts, which I secure at once by a *serre fine*. Scissors do not always behave well in these circumstances; the edges may not be perfectly true; still I prefer their half-crushing action to that of the knife. They do away with a great deal of bleeding. You notice that I have been snipping off the skin and mucous membrane well into the vagina on each side. Every now and then I ask the assistants to relax their hold so that I may fit the sides accurately together and see where I am. Just here at the entrance to the meatus I must work with great caution. If any of the veins of the bulbs were cut I might cause very serious bleeding. I think I have pared off all the mucous membrane needful on each side now, and am ready to put in my sutures. But first I must cut off these "aprons," the nymphæ, for they are no longer of use, and will only interfere with the accurate healing of the sides. These plastic operations are tiresome, but I must resist the temptation to hurry through them for the woman's sake. I put my first suture in on a level with the lower margin of the anus, and pass it through one side with a sweep. Always bring out the stitches on the edge of the denuded surface. I do not expect this to be near as successful an operation as that for ruptured perinæum. I have passed eight sutures through. I have included plenty of tissue in my stitches so that they won't tear out. For this purpose I thrust the needle straight back at first and then bring it round. If these sides do not heal completely I shall have to open the wound again. At the last stitch and that nearest the symphysis pubis I have passed my needle and wire all the way round. The great difficulty always is to see that the points of exit and of entrance of the sutures are exactly opposite. Now I am ready to draw the sides together. As I tighten each suture I syringe out the part carefully so as to wash away all the urine from the sides of the wound. In clamping the sutures I must use very large shot in order to make the fastenings secure. I will use two clamps for each of these lower stitches. The most difficult stitch for healing is the last, that just at the symphysis pubis. All the sutures are now fastened. It makes, you see, a very clean apposition. I shall have a sigmoidal catheter passed through the rectum into the woman's bladder, and the rectum drained by a flexible gutta-percha tube. Of course her knees must be bound together, and she must be given opium enough to dull the pain and to keep her bowels locked for eight or nine days. Be sure that you always put a pad between the knees before binding them together. [When the stitches were removed on the ninth day, the union of the sides was found to be complete except just at the site of the meatus urinarius. At this spot a small fistulous opening remained, through which the urine trickled out. The doctor attributed this opening to the fact that, underestimating the strength of the sphincter ani, he had used a flexible catheter instead of a silver tube to drain off the urine, and that the contraction of the muscle had closed the catheter and so forced the urine to find another means of egress. He further stated that he would attempt the closure of the fistulous opening by cutting flaps from both sides. This secondary operation he would postpone for a couple of weeks, until the patient had time to regain flesh and strength.]