of the collapse, the catamenia being one week ahead of time.

The following possibilities were presented for consideration. (1) Hemorrhage. (2) Intestinal obstruction: (a) incarceration; (b) volvulus. (3) Colic. (4) Hemorrhagic infarction of the lung.

Hemorrhage could not absolutely be excluded, but was thought improbable from the length of time that had elapsed since the operation; besides this, the physical signs of hemorrhage were not present. Intestinal obstruction from volvulus or incarceration could not be absolutely ruled out supposing that a large coil of intestine were involved. Colic of a severe type sometimes produces great prostration and collapse in a weak person, and it was thought that this was the explanation of the trouble, especially as it was found that she had been given egg-lemonade and milk during the afternoon. Embolic infarction was thought of, but was considered improbable because of the excruciating abdominal pain, which suggested some abdominal lesion; besides this, severe dyspnea, which is a prominent symptom when a large pulmonary vessel is suddenly occluded, was not present in this case.

After consulting with Dr. S. Breck, it was decided in view of the ease and general improvement which took place after an injection of morphine had been given to wait a while. The next day the urine was examined and was found to contain a trace of albumin and casts; the amount was scanty. All question about involvement of the bowel was set aside by a copious stool which was produced by giving salts. The diagnosis of pulmonary infarction was finally made with positiveness forty-eight hours after the collapse, when bright red sputum was expectorated in considerable amounts. Under the influence of forced stimulation with strychnia, alcohol and food, she improved very markedly until two days later or four days after the collapse; then, great edema of the left lower limb appeared during the course of the night. Soon after this, cough, pain in the lower part of the left chest, and rusty expectoration announced a pneumonia. She died a few days later.

The autopsy was performed by Dr. A. H. Wentworth, six hours after death. The kidneys showed evidence of slight cloudy degeneration, especially glomerular (post-operative). The spleen was slightly hyperplastic. Lungs: the left lower lobe was the seat of several embolic infarctions as well as the seat of true croupous pneumonia (secondary to infarction). In the left common iliac vein was a thrombus firmly adherent to the walls of the vessel and partially organized; it occluded the whole lumen and extended downward into the left femoral vein to the middle of the thigh. No thrombi were found in the veins of the left broad ligament. The peritoneum showed not the slightest trace of inflammation. The uterus was firmly held fixed to the abdominal wall by the sutures, and adhesions had already formed (nine days), but they were easily broken up. The omentum was firmly adherent along the whole line of incision internally. The union of the abdominal wound was firm. The catgut used in sewing the transversalis fascia was not in the least affected and was as solid as when first applied; it was medium sized catgut.

The bacteriological examination by Dr. F. B. Mallory showed the presence of pneumococci in the lung and in the emboli; no other germs were found in the emboli. The culture taken from the thrombus of

the iliac vein was not satisfactory owing to mixed infection while it was being taken.

The chief point of interest in this case was the great difficulty in arriving at a correct conclusion as to the cause of the collapse. The excruciating abdominal pain diverted attention from the true condition and suggested that some abdominal lesion was present. Of the three lesions possible, namely, hemorrhage, colic, and intestinal obstruction, the evidence was in favor of colic, and yet by a very small margin. Hemorrhagic infarction was merely thought of at the time, but was dismissed as being entirely improbable. So great was the perplexity that preparations were made for opening the abdomen; and it was only because of the very marked improvement following the injection of morphine, which seemed to favor the colic hypothesis, that it was decided to temporize.

The question arises in view of the disastrous result of this case, is it to be considered justifiable to subject a woman to abdominal section for the cure of retroversion without adhesions? For my own part I should be strongly disinclined to do it again, but should choose one of the vaginal operations. Dürhsen's is a good one, and is especially applicable to simple uncomplicated cases. In this operation the fundus of the uterus is fastened to the anterior wall of the vagina by sutures. In the cases complicated with adhesions, Pryor's operation¹ would appear to be feasible. He incises the posterior cul-de-sac, breaks up the adhesions and excites plastic inflammation by an iodoform-gauze packing which he places behind the cervix. This leads to the formation of an exudate which in contracting pulls back the cervix and acts very much as the normal utero-sacral ligaments do in keeping the fundus forward. Following Boileux's method,² Pryor treats affections of the appendages as the occasion demands at the same time, even extirpating them if it is necessary, through the incision in the posterior cul-de-sac.

LIQUOR AMNII ESCAPING FROM AN UNOC- CUPIED SUBDIVISION OF FETAL MEM- BRANES.

BY CHARLES H. MORROW, M.D., GLOUCESTER, MASS.

I WAS summoned on August 14, 1894, to attend Mrs. H., who had all the usual symptoms of an approaching abortion; the os was not dilated at any examination and no product of conception was known to have escaped, nor did any afterward escape to my knowledge. She believed that she was pregnant about four months, this being her second pregnancy. As the symptoms subsided without a perceptible diminution in the size of the uterus, it was thought that the treatment had prevented an abortion.

About November 1st she informed me that an escaping fluid compelled her to wear pads which only partially absorbed it, her clothing and lower extremities being generally somewhat moist; it was clear that the escaping fluid was the liquor amnii, and I informed her that in spite of the complication she might still bring forth a living child. She could take but little exercise and became anemic and debilitated.

She was taken in labor on November 28th, about six weeks from the time she had first noticed the es-

¹ New York Medical Record, July 20, 1895.

² De la pelvipéritonite chronique et aiguë et de son traitement. La Clinique Française. May 25, 1895.

caping fluid, and was delivered of a living female child of average weight, but presumably more than four weeks premature; the quantity of liquor amnii which escaped was excessive.

The secundines indicated a twin pregnancy; a partition wall, which was intact, caused the membranes to form two sacs, the larger of which had contained the fetus just delivered; the smaller sac had a capacity of more than a pint and when delivered had a tear two inches in length which allowed the escape of its contents; there was no evidence that a fetus had escaped from this smaller sac during labor; remembering the symptoms of an abortion when first called, I was about to search for evidence of fetal attachment, when, observing that my patient was losing some blood and the uterus not thoroughly contracted, my attention was employed in the attempt to overcome this obstinately persisting condition. When all danger had passed, I found that the nurse had removed and destroyed the interesting secundines.

SEPTA VAGINÆ: TWO CASES OBSERVED IN PRIVATE PRACTICE.

BY F. BOWDITCH CHAPMAN A.M., M.D., MIDDLETON, MASS.

THE comparative rarity of reports of vaginal septa and the interest of such cases to the obstetrician and gynecologist has led me to report the following cases observed in my private gynecological practice.

CASE I was a married woman of forty-seven years, the mother of two children. The patient came to my office complaining of leucorrhea and a displaced uterus. She said she had worn pessaries of different patterns at various times during the past few years, but stated that they never remained in position for any considerable time and gave no definite relief. They had been introduced by a country practitioner who had never examined her with the speculum. Examination bimanual and with Sim's speculum determined retroversion of the uterus and marked chronic endometritis. The digital examination found an obstacle in an irregular semilunar-shaped septum, almost entirely closing the posterior cul-de-sac, taking origin from the posterior wall about one inch below the cervix. The septum was markedly thickened on the left side, and was continued in two incomplete fibrous ridges toward the anterior column. Examination with speculum was necessarily unsatisfactory, the patient complaining, moreover, of considerable pain and tenderness from pressure of the instrument. The appearance of the septum with good light was somewhat like ordinary scar tissue as we find it in mucous membranes. There was an old laceration of the cervix, but not noticeably associated with the other abnormal condition.

The patient was anesthetized the following day, the septum divided, and examination completed. There was moderate hemorrhage. The retroverted uterus was moderately adherent. The cervix was dilated and the entire endometrium thoroughly curetted and swabbed out with iodine. I did not think the laceration of the cervix sufficient to merit repair. The retroversion was treated by persistent tamponades of glycerized cotton, and the pessary eventually fitted. The case first came under observation June 6, 1894; the pessary was fitted September 28th. The patient was last seen by me in November; she was not then wearing the pessary — said she did not need it, but that it never caused her discomfort.

There was, I think, no neurosis connected with this case, and I am inclined to think the pain complained of in examination was due to erosion caused by the irritating discharge from the cervix. There was no history of traumatism in labor or of instrumental delivery. Her last confinement—in 1880, I think—was followed by a tedious convalescence. Nevertheless, I have been inclined to regard the case as possibly of traumatic origin, especially on account of the thickness of the septum and its divergence to the left.

CASE II was an unmarried girl of seventeen years, first seen by me August 22, 1894. The patient was brought to me by her mother, who said the girl had never menstruated but complained of pelvic pain. The girl was large, but ill-nourished in appearance. Digital examination was interrupted by an almost complete transverse septum of the vagina. The hymen was incomplete. The septum was apparently of uniform thickness, and gave the impression to the examining finger of a rather inelastic complete hymen. It was perforated sufficiently to barely admit the tip of the index finger, and was located about one and one-half inches from the introitus. Examination with speculum was unsatisfactory and painful. The membrane was ruptured with the branched steel dilators, further dilated with the fingers, and the examination completed. Anesthetic was refused, and the dilatation was, of course, painful. Slight hemorrhage followed.

The completed bimanual examination discovered an undeveloped uterus, abnormal in shape, and with markedly elongated cervix. The speculum was re-introduced, the uterus drawn down with the tenaculum, and a probe introduced after a few trials; finally a small sound was passed. The instruments seemed to enter two distinct pockets. I am satisfied it is a bicorn uterus. The genitalia were normal in other respects.

General hygienic directions were given and iron ordered.

The patient passed from my observation shortly after, but was returned by her mother in February, 1895, on account of a small tumor in the right breast. It was removed, and the microscopic examination showed it benign. The girl was reported by her mother as having menstruated normally in December. From her statement she suffers no unusual distress before or during her menstruation.

There is no history of late menstruation in the family. The parents were born in Nova Scotia. The girl has been occasionally under my care for minor indispositions and is now (November, 1895) as well as most girls of her age, and her menstrual functions are normal.

THEN AND NOW. — In the year of our Lord, A. D. 1870. Scene, surgical ward.

Surgeon. — How is Jones doing?

House Surgeon. — Extremely well, sir; the wound is suppurating nicely.

Surgeon. — That's all right.

In the year of our Lord, A. D. 1894. Scene, same surgical ward.

Surgeon. — How is that amputation of the breast?

House Surgeon. — I'm sorry to say, sir, the wound is suppurating.

Surgeon. — What! Suppurating!!! Do you say suppurating? Well, I'll be —