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ORIGINAL LECTURES.

IMPERFORATE URETHRA—EXCISION OF THE SUPERIOR MAXILLA—REMOVAL OF AN ENORMOUS HAIR MOLE FROM THE FOREHEAD.

A Clinical Lecture Delivered at the Mercy Hospital, Chicago,

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We have here an unusual case. This patient is only eight hours old, and is brought here because the urethra is imperforate. Examining the end of the penis, the mucous membrane extends smooth and glistening over the end of the glans without a sign of an opening where the meatus should be. However, if I compress it laterally so as to throw the surface into wrinkles, there is a slight depression at the proper place for a meatus. Absence of the urethral canal is generally due to hypospadias, in which case the channel is not strictly non-existent, but is only uncovered, from the non-development of its floor, so that it is an open groove. In this case, however, the parts are anatomically finished, so to speak, but the canal was either never formed or it has become obliterated in utero. You will, however, bear in mind that just as the prepuce is sometimes found congenitally adherent to the glans, so we may suppose the walls of the urethra to be in some cases adherent to each other. The surgical literature of this subject is exceedingly scanty, because the cases are few. It is asserted by authors that new-born infants may die of the obstruction. Obviously our duty is first to see whether this may be a mere adhesion of the urethral walls, capable of being separated. If so, we may avoid any more serious operation. You will notice incidentally that this patient, though only eight hours old, takes its ether exactly like an adult, and seems to require fully as much anæsthetic in proportion to its size as any older person.

If I now take a large probe and sweep it along the fold which marks the site of the obliterated meatus, using some firmness of pressure, I find the parts separate under the effort, and a true meatus appears without a drop of blood being shed. Selecting now a metallic sound somewhat conical at the tip, but still blunt, and of the size of No. 2 of the English catheter scale, I press it into the meatus. There is considerable resistance, but holding the glans firmly, and pressing the tip slowly on in the line where the urethra should be, I find the instru-

ment gradually advancing, and no blood flows. We seem to be separating adhesions rather than perforating tissues. The force required is a good deal, and there is doubtless risk of making a false passage, but that will not be an irreparable evil. Patiently advancing the instrument in this way, you see that now, at the depth of an inch and a quarter, the tip of the sound enters a normal urethral canal and then glides on without resistance into the bladder.

Ordinary surgical text-books scarcely refer to the possibility of this operation except when the occlusion is so thin as to be merely a septum across the passage. I was led to attempt it in your presence by another case brought to me a few weeks ago, which seemed almost precisely like this. The child was two days old. No meatus could be found. Moderate use of a probe made no headway. Discouraged in trying to reopen the natural route, I went behind the scrotum and cut down upon the urethra at the middle of the perineum, thus giving a temporary outlet to the urine. After a time, owing to the contraction of the wound in healing, the flow of urine was impeded and some force was required for its expulsion. One day, to the surprise of all parties, the urine burst suddenly forth by the natural route, where there had been merely an adhesion of the urethral walls, which yielded to the pressure of the fluid behind the obstruction. In all probability, had I been more persevering, I might have succeeded by the same operation which I have shown you to-day.

Excision of the Superior Maxilla.—Six months ago this patient had a small tumor on the gum at the seat of the second upper molar tooth. It was removed by a surgeon, but it has returned again. It is now nearly the size of a hen's egg, extending backwards to the last molar, and inwards to the middle of the hard palate. The growth is too soft to be an osteo-sarcoma. It is therefore either ordinary sarcoma, or a carcinoma. As the glands of the neck are not perceptibly affected, there is hope that it may be sarcoma. No microscopic examination has been made, owing to the haste of the patient. We will remove the growth.

First comes the extraction of the canine tooth in front of the tumor, to make room for dividing the jaw; next we divide the upper lip in the middle, carry the incision around the alæ of the nose, and thence straight upwards. The second incision passes from the angle of the mouth upwards and outwards, and then we dissect off the cheek from the tumor

and draw it backwards. The duct of Steno is entangled in the growth, and must be sacrificed. Professor Marshall, who is present with his dental engine, now divides the arch of the jaw, the nasal process, and the anterior root of the zygoma. With a thin chisel I divide the arch of the hard palate, and seizing the growth with lion-jaw forceps, readily bring it away. You see that it fills the antrum, without adhering to it except at its posterior and outer border. These places have therefore to be cleared out with the gouge-forceps and bone-scoop, and the cavity cauterized with crystalized chromic acid. Replacing the cheek by the aid of suitable sutures, we will return the patient to bed. The operation would have been more hopeful of permanent success had I seen the patient earlier.

Hair Mole of the Forehead.—This infant has an enormous hair mole extending from the transverse suture of the skull forwards and down over the whole right side of the forehead as far as to the upper border of the eyelid. The hair upon it is exceedingly thick, and darker than that on other parts of the scalp. However, the dark eyelashes show that, as the patient grows older, her hair will become black, and match that on the mole. The skin on the centre of the growth is nearly black with pigment, and thick and wrinkled.

The immense size of the mole renders it necessary to consider carefully the wisest way of dealing with it. No amount of electrolysis of hair bulbs will answer here. The following plan promises best: First I dissect the skin of the mole from the top of the eyelid and carefully take it away up to the place where the brow ought to be. We must now make an eyebrow, which I will do by cutting two arched incisions, leaving a strip of the mole between them to match the form and length of the brow on the opposite side. As we do not know exactly how the contraction of the wound in healing will affect the form and position of the new brow, I make it a little wider than is ultimately needed, so that at a future time I shall have room to trim it to an exact correspondence with its fellow. Now I will raise the skin above the arch, and dissect it off as high as is necessary to give her a forehead as high on this side as on the opposite part. I will not remove that part of the mole embraced in the limits of the hairy scalp because, as she grows older, it will match the rest of her hair in color, and by dressing it low on the forehead she will be able to cover nearly the whole cicatrix from view.

Having thus removed all that is necessary of the mole, I take from the outer side of the patient's thigh some thin shavings of skin and graft them upon the raw area, to assist the process of cicatrization, and improve the smoothness of the surface. In grafting for this purpose we shave the grafts very thin, but apply them in large pieces, from half an inch to an inch in length, which often adhere very perfectly. I have had them succeed an inch and a half in length. The result in this case will be to remove a hideous deformity, and to restore the patient to a reasonable degree of comeliness, and perhaps even to some measure of positive beauty.

ORIGINAL ARTICLES.

THE TREATMENT OF CICATRICES IN THE COLLUM UTERI AND IN THE ROOF OF THE VAGINA.¹

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When, as long ago as 1862, and then more fully in 1874, Emmet indicated the operative treatment of rents in the cervix, which he considered as the sources of a whole series of gynecological maladies, these conditions had, up to this time, been very little observed. They had been recognized as the cause of a relatively infrequent eversion (E. Martin) or of an ectropium (Roser).

Emmet, on the other hand, regarded these rents as the sources of catarrhs of the cervix and of the *corpus uteri*. He emphasized the difficulty and even occasional impossibility of healing these catarrhs as long as the rent exists. He further pointed out that these scars are the source of long-continuing, ever-spreading irritation in the pelvis. Finally, he very particularly insisted that such rents hinder the proper development of the uterus, if it become pregnant, and that in consequence, in a great number of cases, abortion is occasioned by them, and that many women who habitually abort suffer from rents in the cervix. His proposition to heal these by operation, to perform trachelorrhaphy, excited very extraordinary notice at that time, since it occurred just when far more attention was being given to securing a widely-gaping aperture of the uterus, and the influence of the bilateral discussion was supreme.

Emmet's propositions made progress among the Americans very rapidly, considering all things; in Europe, however, it was quite the contrary, and this operation was received very doubtfully, especially in Germany, although at that time operative gynecology was in a state of active development. First there was opposed to the method of Emmet the general disinclination in Germany to favor operative interference with the *portio vaginalis*. Then the attempts which were made to perform trachelorrhaphy were not seldom followed by imperfect results; the old cicatricial formation soon showed itself again more or less, or, on the other hand, there was formed a stenosis, an evil which just at that time it seemed to be a duty to zealously overcome by dissections.

But even when, in Germany, the plastic operations on the *portio vaginalis* in great numbers were well received, and authors like Breisky, Spiegelberg, and Schröder, and among others the writer, busied themselves with this operation, the operation of Emmet remained a rarity. Although, perhaps not least by the recommendation of amputation of the *portio vaginalis* which I warmly advised in 1878, at the meeting of German Physicians and Naturalists in Cassel, as imperatively indicated for wider fields of usefulness, gynecology was led so far that excision and amputation of the lips of the *os uteri* were undertaken not solely on account of chronic metritis

¹ Read before the Boston Gynecological Society by E. W. Cushing, M.D., for the author, on December 10, 1885.