straight up, then depressing the knife down and out 90 degrees, and with the cutting edge turned slightly toward the eyeball, I push forward until the point touches the inner wall of the sac. I then bring my knife up perpendicular, and holding it lightly but firmly, pointing slightly backward and outward, push it straight down until it reaches the floor of the nose. I then pull it back, turn it a quarter of a circle and push it down again, withdraw it nearly again and turn it a quarter more and cut again, and still once more, making four cuts down through the stricture. This is all done very quickly. I then pass the largest Theobald probe I can into the nose (generally a 12 or 14), bandage up the patient's eye and send him home, giving him a wash of boracic acid, dilute hydrocyanic acid, cocaine and water, to use freely. I probe the two following days with the same sized probe I used on the day of the operation. Then I probe every other day for the next week, then twice the next week, and once the next; then again in two weeks. This generally suffices although not always. If patients need any more probings, I am very apt to use a slightly smaller probe, especially if they have been three or four weeks without having any probe passed. I *never* leave the probe in. I pass it and immediately withdraw it.

In making the incisions in the stricture and dilating, we have a certain amount of exudation thrown out into the cuts; this cut is again forced open the next day, and at each succeeding probing, and another chance for a new exudate given. In this way when we are done with our probing, we have or should have four cicatrices that retract rather than contract, and leave us an opening through which tears can pass. The extended sac will generally diminish and return to nearly its normal size, or near enough to cause no further trouble.

When we have a largely distended sac that will not contract, there is ordinarily nothing left but extirpation or cauterization. No one will claim that all cases of epiphora or lachrymal obstruction can be cured. We have too many that are apparently just as badly off when they leave off treatment as when they began. I certainly think that the free incision of the stricture and the proper probing afterwards will do more in my hands than any other method that I have used.

Clinical Department.

A CASE OF DOUBLE OVARIOTOMY DURING PREGNANCY.¹

LABOR COMPLICATED BY UTERINE INERTIA.

BY R. A. KINGMAN, M.D., BOSTON.

THE case which I am about to report to you may well be considered ancient history, having occurred several years ago, and yet it presents several interesting and suggestive features, which render it worthy of record.

Lucy H., married, thirty-seven years of age, presented herself for examination at the Boston Dispensary in May, 1892. She stated that some eight or nine months previous she had consulted a prominent member of this Society who told her she had an ova-

rian tumor, but that there was no necessity for operation at that time.

Now, however, she had reason to believe she was pregnant, and for that reason sought further advice. The data were not conclusive; but it seemed probable that the pregnancy was of about two and one-half months' duration.

Examination showed a tumor of typical ovarian characteristics, extending to the lower ribs on the left. It was of a size corresponding to six or seven months' pregnancy. At its upper and left-hand margin there was a hard mass, the size of a man's hand, of limited mobility. At no point was pain elicited on palpation.

Crowded into the pelvis was a separate elastic tumor, which just filled the pelvic cavity. This was apparently continuous with the cervix, and was assumed to be the pregnant uterus.

May 30th the patient entered St. Elizabeth's Hospital, and was operated on June 1st. A median incision disclosed a cyst of the left ovary, which contained over a quart of clear fluid. The hard portion noticed at the upper left-hand margin proved to be a papillary mass which was adherent to parietes and viscera, but was easily separated from them.

The only unusual condition noted in consequence of the pregnancy was the extreme vascularity of the pedicle, which consisted of the whole breadth of the broad ligament. It seemed one mass of dilated, tortuous veins. This was ligated with pedicle silk, the cobbler's stitch being used.

The toilet of the peritoneum was being hastily performed, the desire being to expose the uterus as little as possible, when a second globular tumor was felt beneath the uterus. For a moment, remembering the diagnosis as made at the previous examination, I thought the lower tumor might be the pregnant uterus, the upper one being the bladder. This, of course, was a foolish thought, only excusable in view of my somewhat limited experience; and yet the two tumors were exactly in the median line, of the same size, and feeling almost identical to the fingers. Ocular inspection instantly showed that the lower tumor was another cyst, developed from the right ovary.

This was removed in the same manner, the same varicose condition being present.

The uterus was of the size of a very large navel orange.

The recovery of the patient was as comfortable and uneventful as could be wished, there being almost no shock and never any symptom of threatening miscarriage.

In order to follow this case to its conclusion I attended Mrs. H. in her confinement, which occurred December 17th, six and a half months after the laparotomy. Her pregnancy had been a comfortable one, and the scar had yielded but little.

I was called to her after she had been in labor about three hours, the pains at no time being strong. I found the abdomen no larger than it commonly is at eight months and on palpation noticed that the uterine wall was very thin, the fetal parts being felt with the greatest ease. The presentation was by the head, O. L. A., the os being almost fully dilated.

As I observed them, the pains were feeble and ineffectual, though the patient made great outcry with each one. They were regular and of proper frequency, but produced no result. The patient soon became unmanage-

¹ Read before the Obstetrical Section of the Suffolk District Medical Society, February 24, 1897.

able, throwing herself about the bed and refusing utterly to make any effort at expulsion. Small doses of ether were given with a few of the pains, but with the effect only of making her happy and comfortable. No progress being made and none in prospect, the head being in the pelvis and so small that a single strong expulsive effort would have expelled it, I gave a very little ether and extracted the child with forceps. For this manœuvre only one hand was used, and no appreciable effort was required.

The uterus was held continuously by myself, and the placenta was easily expressed after an interval of twenty minutes.

Immediately following the placenta there came a severe hemorrhage. The uterus refused to contract; in fact remained so soft and flabby that it could not be wholly compressed between the hand in the vagina and the external hand. Add to this the lack of a competent nurse and the fact that the patient persisted in trying to pull my hand away from the abdomen, and it will be seen that I had to work under difficulties.

For a time I held the flood in check by seizing the cervix in my fingers and compressing it firmly, at the same time jamming cervix and fundus together. After a time, however, the fingers would tire, and then the blood would spurt as badly as ever. Ice and hot water had been used in the mean time under my direction.

At this juncture it occurred to me to try vinegar, of which I had often heard but which I had never used. A large pledget of absorbent cotton wet in vinegar was accordingly thrust into the uterine cavity and compression used as before. The result was instantaneous. There was no more hemorrhage, and the uterus contracted so that I felt safe in removing the cotton at the end of half an hour.

This patient had a normal convalescence.

The baby was not weighed, but was certainly not over four and a half pounds. It grew rapidly, and at one year weighed about forty pounds.

The points of interest which I would briefly mention are as follows:

(1) The dangerous advice given by the first physician consulted. The impression is far too common that an ovarian tumor, being a benign growth, may be neglected.

(2) The occurrence of pregnancy in spite of the advanced cystic disease of both ovaries.

(3) The easy convalescence after operation, demonstrating the tolerance of the pregnant uterus.

(4) The evidence against the Tyler-Smith theory of the determining cause of labor. This theory supposes that labor comes on in consequence of the increased congestion and nervous disturbance accompanying the recurring menstrual epoch, though why the ninth or tenth rather than the eighth or eleventh is not stated. One of my friends called my attention to this so-called ovarian theory, and jokingly suggested that the ovaries being removed and the cause of the menstrual nixus being therefore absent, I might find that labor would be indefinitely postponed. As a matter of fact, labor came on just when it was expected.

(5) The lack of development of the uterus and the small size of the child. Were these conditions due to the absence of the ovaries or to the cutting off of a part of the blood-supply? I am inclined to believe

that the presence or absence of the ovaries has little influence upon the development of the pregnant uterus. The ovarian artery, however, cannot but be an important factor, it acquiring the size of three to four millimetres in diameter at the close of the gestation period, being in fact only a trifle smaller than the uterine artery. The ovarian vein is said to develop until it exceeds the uterine vein in size, equalling the internal or external iliac. Complete closure of this portion of the uterine circulation must of necessity interfere to some extent with the development of the uterus and its contents.

(6) The resultant post-partum hemorrhage and the simple means by which it was controlled. Packing the uterus with iodoform gauze might have produced the same result and been a more surgical procedure, but it would have been less simple in its application, would have required more time, and it presupposes the possession of the gauze and sterilized instruments for its insertion. Vinegar is always obtainable; and in the two cases in which I have used it, the effect has been all that could be desired, and no evil after-result has been noted.

A CASE OF OVARIOTOMY DURING PREGNANCY.¹

PATIENT FIVE MONTHS PREGNANT; REPLACEMENT OF RETRODEVIIATED INCARCERATED FUNDUS; NORMAL LABOR AT TERM.

BY W. L. BURRAGE, M.D., BOSTON.

D. H., age twenty-six; married two years; one child, thirteen months; no abortions. First seen October 25, 1893. Had an attack of flowing in August, 1892, two weeks after her baby was born and had not flowed since except that she had a normal menstruation of five days, May 10, 1893. Was in labor five days; ether and forceps used; baby weighed ten pounds and a quarter; in bed three weeks after labor; nursed child. She noticed prolapse of the parts at the vulva as soon as she got up, and the condition persisted in spite of treatment by her doctor with packing and a ring pessary.

Early in September she thought she might be pregnant, being unable to eat her usual articles of diet, and having cravings as at her previous pregnancy. Accordingly she weaned her child. She noticed at this time that her womb came outside the body; and she suffered with dysuria and was unable to sit or walk with comfort. She also suffered from constipation and from pain above the pubes, that had been increasing in severity ever since. She complained chiefly of this pain when I saw her at the Carney Hospital, October 25, 1893. I found the cervix uteri enormously elongated, with as much as an inch and a half projecting from the vulva; deep laceration of the perineum; pelvis filled with a semi-solid tumor, apparently the retroflexed uterus about four and a half months pregnant. Above and on the right, lying on the pelvic brim, was a tumor of indefinite outline, the size of a cocoanut.

By forcible bimanual manipulation I was able to partly dislodge the pelvic tumor, and the patient was kept in bed until six days later, October 31st, when she was given ether and a thorough examination made. Dr. F. W. Johnson kindly saw the case with me in consultation. We found the fundus uteri out of the pelvis, and the cervix high; and we also made out a

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