Review, says that there are in England not a few competent practitioners of great ability and industry who, although willing to undertake anything honorable, do not receive \$500 a year; the same writer says one medical man in forty rises to a position of professional eminence and social dignity. I am quite sure that these statistics, though at first appalling, will, upon second thought, be recognized by us all as holding good in this country. It is, therefore, the duty of every member of the Philadelphia County Medical Society to consider the propriety of becoming a member of the Mutual Aid Association, not because he feels that he may need assistance from his colleagues during his life or after his death for his family, but because of the help required by his needy brothers. I cannot, it seems to me, do a better thing than to urge you to become members of the Mutual Aid Association this evening, and to see your attorney as early as possible tomorrow and insert in your wills a legacy, even though small, for this object.

In looking over some old books lately I was greatly interested by the provisions made in earlier times for organizations of this character. For instance, in the time of Richard II, about 1387, the Corporation of the Barber-Surgeons in London, adopted a series of ordinances or regulations which corresponded with what we now know as a by-law.

I read from this slip of paper a translation from the Norman French of one of these ordinances. It is noticeable that it is the *first* of the ordinances, not the second, third, or fourth. It reads as follows:

"Firstly, to the honor of God and all his Saints, and to stir up the Commons of the people to do well, and to have perseverance in well doing, it is ordained that if any brother of the Fraternity who has been of this Fraternity for seven years, by chance fall into trouble, or into poverty, and if he have nothing left of his own by which he may be able to live, and it be not through his own folly, that then he shall have each week from the common box tenpence half penny for his sustenance."

At a still later period the following paragraph is found in the regulations for the Government of the Guild of Surgeons. This Guild, it must be remembered, was contemporary with the Corporation of Barber-Surgeons, and at one time united with it, so that the descendants of English stock may consider ourselves as being a sort of posterity to these two old surgical organizations of Great Britain.

The following regulation was made in 1435 for the Government of the Guild of Surgeons.

"Also it is ordeined and assentid in this composioun that eueri Cirurgian of the fellowschipe in the craft of Cirurwgie to paiellid a quarter to a box that is viiid ayeer to the profit and worschip of the craft in helping and releuing the nede of the pore men of the same fellowschip."

In order to show the value of even a small legacy which I trust you are going to put in your will to-morrow for the benefit of this Association, I wish to point out to you the result of such legacy by Robert Ferbras, Citizen and Barber-Surgeon of London in 1470, who gave or bequeathed (it is not certain whether it was given before death or left in his will) two freehold houses in the Parish of St. John to be divided one moiety after the repairs among poor members of the Corporation of Barber-Surgeons in London. This provision, made over four hundred years ago, is to this day distributed by the officers of

the corporation among twenty-eight members and their widows. Do you not therefore see the amount of good that can be accomplished if each member of this society will do as did the barber-surgeons in the 15th century, whose name otherwise would probably have been lost to us.

I have made these quotations to show that even in the earliest times professional men found that the income derived from practice was not to be depended upon; that they knew it was a vocation bringing in no large remuneration, and that a warm feeling for their colleagues compelled them to do what lay in their power for those members of the profession who fell into pecuniary distress and left their families without a proper income.

PELVIC PERITONITIS. ITS TREATMENT BY ABDOMINAL SECTION.

BY W. H. LINK, A.M., M.D.,
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"The evil that men do lives after them, the good is oft interred with their bones."

Especially is this true of those men who, in times past, have originated the so-called systems in gynecology. Pernicious doctrines, false theories, and discarded methods live and flourish luxuriantly among the rank and file of the profession long after the great teachers who put them forth have mouldered into dust.

We hear men talk of ulceration as glibly as when gynecologists were nothing more than animated sticks of argenti nitras. There are yet those who labor diligently for weeks and torture patients for months trying to lift up with some sort of a pessary an enlarged and displaced uterus, fixed by inflammatory adhesions due to tubo-ovarian disease.

The rage for sewing up the lacerated cervix without looking higher for pathological conditions is still gratifying the mechanical dexterity of gynecological enthusiasts who have never taught their fingers to see through the vaginal vault.

The irregular and profuse hæmorrhages due to salpingitis or ovarian abscess are made worse or complicated with peritonitis by the use of the curette under the mistaken belief that causes for such conditions can exist only in the uterus itself.

The irritating electric current is shot through diseased tubes and ovaries day after day increasing tubal peristalsis and muscular contraction, inducing tubal leakage, causing pelvic peritonitis, multiplying the strength and enlarging the extent of adhesions, while still further provoking the exudation of plastic lymph. All this is done by honest, though misguided zeal, because somebody has taught that pelvic cellulitis is an entity and that, under the gentle and benign influence of the electric current, boggy masses and indurated tissue will melt away and disappear as by the touch of a magic wand.

The term cellulitis has for years satisfied the routinist whose confidence in iodine painting, hot douches and glycerine tampons is only paralleled by his previous devotion to a stick of caustic.

The past history of the medical profession has amply illustrated one fact, at least. The more visionary a system, the more enthusiastic its devotees. Cold facts, capable of demonstration, appeal to the reason only and the imagination has no sway. Hence the followers of Apostoli, like those of Hahnemann,

relying largely upon the imagination for their facts, continue chasing the rainbows of therapeutics, often finding, no doubt, the buried pot of gold. But the day has come when a reason is demanded for every procedure, and pathology speaks from the operating table as well as from the dead-house. Theories no longer precede facts but are the logical out-come of every day experience.

It is the every day experience, the magnificent surgical triumphs of Lawson Tait, of Birmingham, and Joseph Price, of Philadelphia, that have revolutionized both the theory and the treatment of the pelvic diseases of women. It is the work of them and their followers that has retired pelvic cellulitis into "innocuous desuetude" and given us instead pelvic peritonitis, secondary to and coëxistent with diseased uterine appendages. Two thousand sections by Tait, and more than fifteen hundred by Price, have enabled them to demonstrate beyond cavil that indurated, convoluted, boggy and tender masses filling the vaginal vault and binding the uterus firmly in the bottom of the pelvis are nothing but agglutinated intestine, thickened omentum, or broad ligament, hypertrophied, indurated, convoluted, strictured, displaced and distended tubes, enlarged, cirrhotic, atrophied, or degenerated ovaries, circumscribed collections of pus or blood, complicated not unfrequently by an extra-uterine pregnancy, while very often several of these conditions exist synchronously, tamped into the lower part of the pelvic basin like concrete, the entire mass smothered over with a copious exudate of plastic cement. The tubes may, and do, often become occluded. This may occur at either the pavilion or uterine extremity, or at one or more points along the tube itself, the resulting strictures enclosing as many abscesses as there are pockets in the tube lumen. There may be as many as six or seven strictures in each tube. The pockets may be filled with water, blood or pus, constituting a hyro-, hæmato-, or pyo salpinx. The walls of each tube may be distended and thinned to the point of bursting, or they may be thickened while the tube lumen remains normal in size, the walls when cut having the appearance of scar tissue and possessing very little vitality. In connection with this diseased condition of the tubes, the ovaries may be enlarged and tender, contracted and puckered, or degenerated into a mere shell or envelope filled with a large collection of pus or blood. The symptoms attending such conditions are many, but easily recognized; amenorrhœa, premenstrual pain, irregular menstruation, menorrhagia, scant menstruation, ovarian neuralgia, easily disordered stomach, a waxy color of the skin, a doughy appearance or expression of the face, painful coition, irritable bladder, often both vesical and rectal tenesmus, constant sense of uneasiness on one or both sides, marked pain on the left side when the bowels move, increased when constipation has existed for some time; inability to go up or down stairs, ride a horse-back, in a buggy, in a street-car or any jolting vehicle, without great pain, which is often attended or succeeded by marked nausea. There are frequent headaches, always back-ache, and in the great majority of cases an offensive and profuse muco-purulent leucorrhœa. There are irregular attacks of the most agonizing pelvic pain of a sharp cutting or tearing character, due to local or circumscribed peritonitis, a result of tubal leakage. These attacks are most frequently attended by elevation of temperature, nausea, coated tongue and

anorexia. The belly is exquisitely tender, and the patient has to keep her bed. Should a large amount of pus from sudden traumatism leak into the peritoneal cavity, or should an abscess, by reason of its gradually thinning walls, give way, the patient dies suddenly from shock or from a rapidly diffused septic peritonitis. Should the leakage be no more at one time than protective adhesions and plastic lymph can shut off from the general peritoneal cavity into circumscribed collections, she only goes from bad to worse, becoming finally a chronic bed-ridden, morphia ruined, pain hunted, miserable, useless to herself, a burden to her husband, a disgrace to her children and friends, dead to the world; alive only to pain and suffering. This condition of things, a living death, is the daily experience of poor sufferers in almost every community in the United States, and they are consoled with the statement that their condition will be better just so soon as "the change of life occurs." Thus hoping against fate, they patiently submit day after day, and month after month, to have their vault painted, their vagina stuffed with boroglyceride tampons, their cervix sewed up, their uterus dilated, sounded, curetted, burnt, douched and pessariated. Fistulous tracts from ovarian pus collection burrowing along the rectum and opening at the side of the anus are slit up through the sphincter, and persistently refuse to behave as fistulæ in ano should. Compression of bowel and pelvic blood-vessels by heterogeneous pelvic adhesions gives rise to the most obstinate constipation or distressing hæmorrhoids, which recur as often as removed. The belly is beslimed with poultices, the stomach drugged with opium, until finally, the nervous system giving way under such prolonged irritation, betrays its grievances by erratic manifestations and both mind and body are found to be a wreck.

The chief causes or etiological factors underlying these conditions are specific and puerperal infection. But exposure at or about the menstrual periods, the long continued prevention of conception, traumatisms, the acute exanthemata may, and often do, prove potent causes. It has been a universal experience with me to find endometritis coexistent with tubo-ovarian disease. Medical treatment of these cases can be but palliative at best. This fact should invariably be set before the patient at the outset. Opium as a means of relief from pain, should be positively forbidden. It can only lead to a baleful habit and in no wise become a curative therapeutics.

The best results can be obtained by treating the patient as though preparing for an abdominal section. Keep her in bed. Put her on a liquid diet. Give a teaspoonful of epsom salts every hour till seven or eight doses are taken, or she has a large number of profuse watery dejections. Give her a thorough scrubbing from head to foot and follow with an alcohol sponge bath. Most frequently this regime brings rapid and great relief. But for permanent results, for radical cure, nothing short of a section with removal of diseased strictures and the breaking up of old adhesions is entitled to the least consideration or will have the least effect.

To illustrate the foregoing principles and their application I submit the following cases and their treatment.

Mrs. Z. Y., aged 35, married 12 years. II. para. Had a bad getting up from her last confinement six years ago. Barren since. Had suffered from profuse hæm-

orrhages at menstrual periods. Very irregular. Marked premenstrual pain. Had chronic leucorrhœa, very offensive at times. Had back-ache, headache and disordered stomach. Had had repeated attacks of pelvic peritonitis during last six years confining her to bed for weeks at a time. Had been completely cured by electricity. Had been unable to sleep on either side since cured. Suffered constant pain on both sides of pelvis, much increased at menstrual periods. After being constipated, suffered great pain on left side whenever bowels moved. Walked in a stooping or bent posture. A sudden jar or shake gave her great pain. Could not run up or down stairs nor run a sewing-machine without attacks of pelvic pain following such exercise. Sexual intercourse markedly painful.

Was called to see her in an attack of pelvic peritonitis which lasted six weeks. Temperature ranging from 101 to 105. Pulse running up to 155. Belly over region of ovaries most exquisitely tender to the touch. Digital examination showed uterus firmly fixed by adhesions, vaginal vault full on both sides, while bimanually, an ovarian abscess could be felt on the right, and a large mass of some sort on the left. Both tubes were distended, hypertrophied and tender. Her suffering was so great that the attending physician was compelled to administer large doses of morphia hypodermically to enable her to endure the awful pain of which she complained. Death seemed only a matter of days. She was informed that surgery held out the only hope of cure for her, and she eagerly accepted it. In the meanwhile my friends Dr. Byers and Dr. Fullenwider saw her, and concurred in both diagnosis and prognosis.

On the morning of November 17, 1891, twenty-four hours after she had been prepared, I proceeded to do a section assisted by Dr. Fullenwider, Dr. Clark, and Dr. Byers and Dr. Lamar. Through a median incision I removed both tubes and from each side a large ovarian abscess. The one on the right was so thinned by distention that it burst at once upon attempting to draw it from the pelvis, deluging the pelvic cavity with pus and blood. The collection on the left side was buried in adhesion and was bound to the sigmoid flexure by adhesive inflammation. It was enucleated and delivered whole. It contained thick creamy pus and was of such size as to obliterate both tube and ovary. After irrigating the abdominal cavity with hot water and putting in a drainage tube patient was put to bed suffering some from shock from which she soon rallied. On second day she was attacked with catarrhal pneumonia which kept her temperature up and caused great annoyance from the resulting cough for two weeks. Her pelvic pain entirely disappeared and the drainage tube was removed on the third day. Her convalescence was uneventful from the second week on. She is now in the best of health, doing her own work, has no pain or soreness, walks erect and has gained in weight as well as strength.

Case 2.—Mrs. F. V. Married. III. para. Nine years ago had a miscarriage and suffered at time from puerperal peritonitis. Never been well since. Face and hands swelled every month. Was in bed two weeks of every four vomiting and cramping. Pain radiating from left iliac fossa running across bowels and locating itself apparently in region of gall-bladder. Vesical tenesmus most distressing. Constant desire to urinate. Back-ache almost constant. Profuse leucorrhœa. Sexual intercourse almost un-

endurable and she suffered with a most intense and excruciating headache for days afterward. She was losing her memory and feared that she would go crazy. She had had almost every kind of treatment following divers diagnoses. Malaria, neuralgia of the stomach, gall-stones, gravel, hysteria, dyspepsia, had each its turn, and yet she suffered.

Digital examination disclosed a uterus completely retroverted and firmly bound in that position by adhesions. There was a bilateral laceration of the cervix, which was soft and patulous. On each side the vault was very tender, in the right, moderately filled, the broad ligament thickened, and on the left a large mass could be felt, but fluctuation could not be elicited. Tubo-ovarian disease with tubal and ovarian pus was diagnosed and a section advised as the only means of relief. It was accepted. But to set at rest all doubts in the matter, I asked Dr. McMurtry to examine the case, which he did, finding the pathological conditions as above, and he fully seconded both the diagnosis made and the treatment suggested. On the morning of the first day of December, 1891, assisted by Dr. Byers, Dr. Hatfield and Dr. Clark, I opened the abdomen in the median line, broke up the adhesions binding down the uterus, enucleated a large sanguino-purulent tubo-ovarian cyst on the left, and a hydro-salpinx and atrophied ovary on the right. After irrigating the abdominal cavity with hot water and placing a drainage tube, she was put in bed suffering very little from shock. She made a rapid recovery, temperature, pulse and respiration remaining normal throughout. On the fifteenth day she sat up, and on the twenty-first day walked about the house. Her health has been constantly improving. Her pains are gone and she now is able to go about and enjoy life, instead of spending from one-half to two-thirds of her time in the doctor's hands.

The chief objection urged against such treatment is that it unsexes. This objection is more imaginary than real. The disease has already completely unsexed. Rotten eggs bring forth no chickens, and degenerated ovaries, pus tubes, and displaced, diseased, adherent uteri are poor machinery with which to conceive, nurture and bring forth children. Even sexual intercourse in most cases is impossible on account of pain. And if a section cannot make a mother of any such, it at least restores to her the power of discharging her duty to her husband. A thing about as important as child-bearing.

HEART SOUNDS AND CARDIAC MURMURS.

Read before Vermont State Medical Society, October 14, 1891.

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The study of heart sounds and cardiac murmurs, with reference to their diagnosis by physical signs, requires an accurate knowledge of the anatomy, and physiological mechanism of the heart.

By heart sounds we mean the normal sounds produced by the action of the heart, while new or additional or adventitious sounds are called cardiac murmurs. Murmurs are not modifications of the normal heart sounds, but are new sounds, which are added to, or take the place of the normal sounds, on account of mechanical defects in the action of the heart. These mechan-