A VAGINAL PESSARY RETAINED FOR TWENTY-NINE YEARS.

PERFORATION OF THE BLADDER AND FIXATION OF THE INSTRUMENT BY A LARGE PHOSPHATIC VESICAL CALCULUS; LITHOTRIPSY; RECOVERY.

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THE following case is of so uncommon a character that the notes of it will, I feel sure, be interesting to readers of THE LANCET.

The patient, a decrepit and emaciated old woman, aged 58, came under the notice of my colleague, Dr. J. A. Willett, in the out-patient department of the Samaritan Free Hospital for Women on Dec. 27th, 1911. She complained of the dribbling away of urine and of a slimy blood-stained discharge from the front passage, which she said had been going on for three weeks. On seeing that the patient had some sort of a pessary tightly fixed in the vagina Dr. Willett admitted her under my care. The following history was with difficulty elicited owing to the woman's exhausted condition. She had married at 25 years of age, and her only child had been born three years later, the labour being a bad one. The child, a girl, lived a few months. During the next few years the patient had four miscarriages at the third month or thereabouts. Some years later the womb dropped, and 29 years ago she went to a hospital and had a support inserted into the front passage. She had worn the same instrument ever since. About 14 years ago she had had it seen to, but the medical man did not remove it. She had used a Higginson's syringe regularly in order to keep the instrument clean. About two and a half years ago she had noticed that the urine was dribbling away, and that there was a blood-stained discharge from the front passage. These troubles continued for a time and then ceased. She kept on with her work until three weeks previously, when the dribbling and discharge came on again and she sought advice. Visual examination showed the vulva, the perineum, and the sacral region to be excoriated from contact with urine and discharge. Immoveably fixed in the vagina, and protruding from its orifice was seen a portion of a pessary encrusted with phosphatic deposit. The vaginal canal was so contracted that thorough examination by finger was impossible without the aid of an anæsthetic, and manipulation of the pessary failed to produce any appreciable movement of the impacted instrument.

On Jan. 3rd, 1912, an anæsthetic was administered by Dr. R. E. V. Hale, and assisted by the resident medical officer, Mr. D. W. Roy, I proceeded to dilate the vagina and remove the pessary. The vaginal tissues had overgrown the embedded sides of the instrument, and the granulations had to be dissected away. No amount of dragging on the pessary served to loosen it or draw it down; in fact, it seemed to be immoveably fixed in the upper part of the vagina, where a mass of granulations and phosphatic deposit could be made out, with a bar or limb of the instrument firmly fixed at that point. A sound was then introduced per urethram and a large calculus was detected filling the cavity of a contracted bladder. On pushing up the pessary, with the sound in the bladder, it was felt that the instrument had perforated that organ and was connected with, and probably embedded in, the calculus. It was obvious that with such a contracted bladder, no enlarging of the fistula or incising of the bladder per vaginam would allow of the extraction of such a large calculus, and the only method that could with safety be adopted was lithotripsy. A strong forceps was therefore passed alongside the limb of the pessary into the bladder and the lower portion of the stone broken up. The instrument then became loose and was extracted, free bleeding following its removal. The remaining portion of the calculus was then crushed and removed piecemeal by forceps and scoop and the debris washed out. On introducing the examining finger through the fistulous opening into the bladder it was felt that the walls were encrusted with thick phosphatic deposit which on being broken down left a granulating surface which bled profusely. The bladder was washed out again and again with hot boric solution without any effect on the hæmorrhage, but when a hot injection of hazeline was employed the bleeding promptly ceased. The

vagina was then douched with iodine (3 ii. to 1 pint), and lightly plugged with iodoform gauze, and the patient removed to bed. The severity of the operative measures, which extended over an hour, must have been a great strain on the patient, and her condition at the close was not all that could be desired. However, she rallied well, and on the following morning, much to my surprise, was in a very fair condition and comparatively free from shock. With the exception of occasional hæmaturia and rises of temperature she made an excellent recovery from the operation. Later on I hope to repair the vesico-vaginal fistula.

The instrument removed was what is called Greenhalgh's bendable pessary. It is made of tough copper wire covered with rubber, and its ends are joined by soft rubber tubing. (In my opinion, it is one of the most atrocious instruments ever invented for the torture of womankind.) One limb of the pessary had perforated the anterior vaginal fornix on the left side of, and in front of, the cervix uteri, and had penetrated the bladder, the opening into that organ being large enough to admit a finger. The anterior vaginal fornix was also separately perforated, on the right side, but the pessary had not passed through the walls of the bladder. The calculus was composed of phosphates. It completely filled the bladder and was about the size of a small Tangerine orange. For how long the calculus had been in the process of formation must remain a matter of conjecture, but its commencement probably dated from two and a half years ago when the dribbling of urine and bloody discharge were first noticed by the patient. Presuming that the penetration of the limb of the pessary into the bladder occurred two and a half years ago, a curious feature in this case is the fact that the opening in that organ should have become blocked up and rendered almost water-tight for such a length of time by the deposit of phosphates around the end of the pessary within the bladder, and the granulations and concretions on the vaginal surface. The caked condition of the interior of the bladder and its contracted state seemed to point to the fact that for some time dilatation and contraction of that organ must have been incomplete. Whatever happened to cause the unblocking of the fistula, and the recurrence of the dribbling of urine can only be surmised. Possibly, in sitting down, some unusual pressure was put on the protruding end of the pessary, pushing it upwards and thus partly dislodging the phosphatic deposits in the vaginal fornix and in the bladder. It is to be presumed that the individual who inserted the pessary had placed it in its correct position—that is to say, with its posterior end behind the neck of the uterus. Owing, however, to the rotting and parting of the rubber tubing the instrument had become displaced, its ends being carried forward in front of the cervix uteri, and these pressing upon the fornix eventually resulted in ulceration and perforation of the vaginal wall and of the bladder.

The pessary, together with the phosphatic debris of which the calculus was composed, are now in the museum of the Royal College of Surgeons of England.

Brook-street, W.

TWO CASES OF PNEUMONIA TREATED WITH PNEUMOCOCCUS VACCINE.

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THE following notes may prove of some interest owing to the fact that the cases responded so readily to the injection of pneumococcus vaccine.

CASE 1.—The patient, a female child, aged 12, was seized with a severe rigor on Oct. 3rd, 1911, lasting for about half an hour. Previous to this she had suffered from a bad cold for the last ten days. On seeing the child for the first time on Oct. 4th her condition was as follows. Face flushed; respirations 30, short and catchy in character. Complained of pain in left side, and troublesome cough. Temperature 102° F. Physical examination showed impaired movement over the whole of the left side of the chest, together with increased vocal vibrations and moist râles. Just below the angle of the scapula was a small area of bronchial breathing, around which were some fine crepitations. The right side of the chest showed nothing abnormal. On the 6th the temperature was 103·6°, and the area of bronchial breathing had increased in size. On the 8th the temperature was 102°,

but the general condition of the patient had become much worse and the breathing was more laboured. The physical signs on the left side were unchanged, while on the right base the air entry was diminished and a small area of bronchial breathing was found just below the angle of the scapula. The child's condition remained much the same during the next few days. On the 13th the patient seemed very much worse, and at 11 P.M. 1 c.c. of pneumococcus vaccine (Parke, Davis, and Co.) was injected. On the 14th, at 8 A.M., all the acute symptoms had disappeared and the breathing was quiet and regular, the temperature having dropped to 98.6°. The patient continued to improve during the next few days. On the 20th the temperature rose to 100° and remained at this level for some days, but the general health of the patient continued to improve. On Nov. 6th an exploratory needle was inserted into the left side and pus was discovered. On the 7th I excised a portion of the sixth rib in the post-axillary line and let out about 6 oz of very thick but non-offensive pus, the anæsthetic being administered by my partner, Mr. W. R. L. Drawbridge. From this date the patient made an uninterrupted recovery.

CASE 2.—The patient, a man aged 45, was seized on Jan. 8th, 1912, with a rigor and pain in the right side. When I first saw him on the 10th he appeared to be acutely ill. The face was cyanosed; there was a troublesome cough, with a quantity of rusty sputum; and sharp pain in the right side was complained of. The temperature was 101° F. The physical signs showed a diminution of air entry into the right lung, the percussion note being dull at the base, with a large area of bronchial breathing over the right base behind. At 11 P.M. on the same evening the patient's condition became very critical; the respirations became more laboured and there were increased cyanosis and a failing pulse. Pneumococcus vaccine (1 c.c.) was then injected. On the 11th, at 5 A.M., the patient was much improved; the respirations were quieter and easy, there was less cyanosis, the pulse was stronger, and the temperature was normal. The patient continued to improve daily.

From a careful observation of these two cases I cannot help thinking that the pneumococcus vaccine was largely instrumental in bringing about a favourable result.

Ellesmere, Salop.

LITERARY INTELLIGENCE.—Messrs. Henry Frowde and Hodder and Stoughton announce for early publication in a very long list of works the following:—1. A new revised fifth edition of Cunningham's well-known "Manual of Anatomy," Vol. I., edited by Professor Arthur Robinson, professor of anatomy at the University of Edinburgh. Cunningham's work is so well known that there is no intention on the part of the professor who has revised it to alter it in any way except in accordance with the international terminology and where it has appeared that new colour illustrations are desirable or the method of dissection has to some extent been altered to suit surgical needs. In these parts of the work a very thorough revision has been made, and it is hoped that the work will remain a worthy memorial of its author. 2. A large "Practitioners' Encyclopædia," by many authors, comprising medicine in all its branches. Nearly 1000 pages. In one volume. Edited by J. Keogh Murphy, F.R.C.S. 3. A third volume of Thomson and Miles's "Surgery," dealing with "Operative Surgery." Pp. 500. With very numerous illustrations. This is in the press. It will be as small and compact as possible, but of very wide scope and very fully illustrated. 4. "A Text-book of Nursing, both Surgical and Medical," by E. W. Hey Groves and J. W. Fortescue-Brickdale, comprising anatomy and physiology as well as the methods of surgical and medical nursing, and designed to be complete in itself for nurses. Royal 8vo, pp. 388. 205 figures in the text. Companion to Despard's "Text-book of Massage." 5. "Surgery of the Rectum for Practitioners." By Sir F. C. Wallis. With about 130 illustrations. 6. "Gonococcal Infection." By Major C. E. Pollock, R.A.M.C., and Major Harrison. Pp. 222. 7. "Surgery of the Skull and Brain." A large monograph by L. B. Rawling, F.R.C.S. Pp. 252, 96 figures. 8. "Salvarsan in Syphilis and Allied Diseases." By J. E. R. McDonagh, F.R.C.S. About pp. 175. 9. "Kidney Diseases." By W. P. Herringham. A large practical work.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

MEDICAL SECTION, WITH SECTIONS OF SURGERY AND ANÆSTHETICS.

Exophthalmic Goitre.

A JOINT meeting of these sections was held on Feb. 27th, Dr. FREDERICK TAYLOR, the President of the Medical Section, being in the chair.

The discussion on Dr. T. P. Dunhill's paper entitled, "Partial Thyroidectomy under Local Anæsthesia, with Special Reference to Exophthalmic Goitre," which is published in full in THE LANCET of Feb. 17th, p. 422, was renewed.

Dr. HECTOR MACKENZIE said that he proposed first to make a few observations on the paper itself, next to say something about his own experience of the disease and its treatment, and finally, to attempt to arrive at a right conclusion as to what kind of treatment is best and safest. Dr. Dunhill had said that he had operated upon 230 cases of exophthalmic goitre with only four deaths, a result as remarkable as it was gratifying from the surgical point of view. He wished Dr. Dunhill had entered into more detail about his cases. Dr. Dunhill mentioned four types of the disease, but he did not tell them how many of his cases belonged to each class, so that he (Dr. Mackenzie) could form no idea as to how many of the 230 cases were acceptable as genuine examples of exophthalmic goitre. This made it difficult to judge his results. Dr. Dunhill said that in cases of the first class, with local anæsthesia and expert operating, the danger was *nil*, but he had made little use of general anæsthesia, and, therefore, his experience did not help much in deciding the comparative risks attending general and local anæsthesia. Sir Victor Horsley had used general anæsthesia, and had had only one death. His own experience had taught him that roughly about 25 per cent. of the cases make a complete recovery, under general medical treatment another 25 per cent. recover, but bear signs of their former illness, about 25 per cent. live on as chronic invalids, and 25 per cent. died from the disease. At St. Thomas's Hospital until 1908 few cases had been operated upon; since then the cases so treated numbered 19. Six had died, 4 had improved markedly, 4 showed some improvement, 3 were unchanged, 2 relapsed and were readmitted. Two other cases were not followed. Of the 6 fatal cases, 2 died shortly after the operation, 1 two days after, 1 four days after, 1 eight days after, and 1 a year after, following operation for adenoma. Ligation of the vessels had been performed in some, and thyroidectomy in others. During the last year 7 or 8 had been operated upon; 1 had died, the others expressed themselves as better, none were cured. Where Dr. Dunhill's paper failed to convince was that the cases had not been followed long enough, and it was impossible to say if they would relapse again. His own belief was that there was a certain type of case in which it was dangerous to operate, whether under local or general anæsthesia. These were examples of what is called lymphatism. He thought operation should never be employed as a last resource. He had for a long time been feeling his way towards the adoption of operative treatment, but his path had been beset with obstacles. There had been a relatively large proportion of deaths, and the results in those who had survived had been disappointing. Were it not for the risk to life from thyroidectomy he would not hesitate to recommend it as the most rational and practical method of treatment. There was a good prospect of recovery under medical treatment in the milder forms of the disease, and there did not seem to be so much better prospect after operation as to warrant incurring the risk. In acute and severe cases he did not consider the operation justifiable.

Dr. ALBERT KOCHER (Berne) read a paper on the Surgical Treatment of Graves's Disease. He said:—

Mr. President and Gentlemen,—It was with great pleasure that I accepted the very kind invitation of the secretary of your society to take part in to-night's debate on Exophthalmic Goitre. There are but few diseases on which more