and was made to cut down upon the finger-tip. In this way an entirely new vaginal entrance was obtained, and a flap of tissue was raised to cover in the base of the bladder.

After freshening surfaces wherever necessary, this flap was secured in place by sutures, the opening made beside the needle being closed by one purse-string suture. The remnants of vaginal mucous membrane were now dissected up and united as closely as possible to the external skin. Iodoform powder was dusted over the wound, a sigmoid catheter was put in the bladder, and the knees were tied together.

Four days later the catheter was finally removed, and the patient passed water voluntarily, though a moderate amount of leaking continued for several days longer. The stitches were removed on the eleventh day, and from that time she had perfect control of the bladder, holding her water for two and even three hours at a time.

A plug was used a few times, but the patient soon left the hospital and returned to the care of her former physician.

I had the privilege of examining her once again during the following winter, when I found the condition just as I last saw it, save for a tight ring of cicatricial tissue just at the entrance where the mucous membrane and skin were separated by a narrow interval. This condition could very easily have been remedied by a trivial operation, but further treatment was not then permitted.

The second case is that of a physician's wife, fifty-two years of age, who has always enjoyed perfect health, and only consulted me because of the fear felt by her husband that there might be commencing malignant disease of the uterus. She had had two children, the youngest being twenty-three years of age. Menstruation had been perfectly regular up to within a few months, and without pain or discomfort. For a month there had been a slight but continuous bloody discharge.

I was told that for years the vagina had been shallow, but that recent examination had shown a puckering and apparent closure of the upper portion. This fact I confirmed readily enough, the vagina ending in a blind pouch about an inch below the cervix, marked by a dimple or depression which admitted a small probe, through a sinus, into a pocket which surrounded the cervix.

Operative interference was advised, and a few days later was undertaken. The sinus was slit laterally with a tenotomy knife, guided by a lachrymal director. It was then stretched widely with sinus dilators, and the finger explored the pouch beyond.

The cervix proved to be deeply lacerated on both sides, the scars involving the vagina so extensively as evidently to give sufficient explanation of the stenosis. The cervix and vagina had formed such extensive adhesions as almost wholly to obliterate the vaginal portion of the former. After peeling off these adhesions with the finger, the stenosed portion of the vagina was still further incised and was then packed with iodoform gauze.

The progress to complete recovery was rapid and painless. Some slight narrowing of the vagina still exists and the cervix has not been operated upon, but the patient has not one single symptom referable to her condition, so does not at present desire operative interference.

As regards the causes of the atresia in these two instances, there can be no doubt. In the first case a long second stage resulted in sloughing of the soft parts, how extensively we cannot say, but certainly so as to cause a vesico-vaginal fistula. Then there was probably a septic condition which favored either extension of the slough or of a neighboring vaginitis, with resultant cicatricial contraction, or more likely plastic adhesion of the walls of the vaginal outlet. At the same time a septic ovaritis destroyed the functional activity of the ovaries, and menstruation ceased.

In the second case, the tears of the cervix extended far into the vagina on each side, so as to almost close it, either by their contraction, by direct adhesion, or, as I think most likely, by both processes combined. Partial retention of menstrual discharge and of the normal secretions, set up a sharp vaginitis, which increased the contraction and developed fresh adhesions.

I have no desire to enter upon a discussion of the general subject of atresia vaginae, whether congenital or acquired, but in view of the infrequency of the latter condition, I have thought that a brief report of these two cases might prove not only interesting, but instructive. There is nothing in the management of either case which calls for especial notice, unless it be worthy of remark that so much was accomplished in the first case as the result of a single operation.

It is worth our while, however, to consider that in each case a proper appreciation of the condition at the time of injury, would have suggested treatment which could not have failed to prevent any such complete closure as has been described. Of course, every one now examines to see if the perineum has suffered injury during labor, and most men practise immediate suture where, according to their judgment, it seems called for. But if these cases teach anything, they teach the importance, not only of a more careful supervision of the puerperium than is commonly practised, but the value and the absolute need of a vaginal examination before the final discharge of our parturient patients.

The best time for such an examination is near the end of the puerperal month, and no notions of convenience or of prejudice on our part, or of false modesty or timidity on the part of the patient, should be permitted to interfere with the performance of our manifest duty.

A PECULIAR CASE OF ACQUIRED ATRESIA OF THE EXTERNAL OS UTERI.

BY BARTON COOKE HIRST, M.D., OF PHILADELPHIA.

Mrs. E., aged forty-eight, married twenty-five years, never pregnant. Eight years ago the menstrual flow was absent for about eight months; after one reappearance, it did not return for a year; then again for nine months; and again for a year, since which time there has been no menstruation. Two months ago the woman began to experience discomfort in the lower abdomen. This became rapidly worse until the abdominal walls in the hypogastric and iliac regions were painful to the touch. With the increase of pain there developed very marked dysuria and irritability of the rectum.

On digital examination, a large cystic tumor was felt, filling up the entire pelvic cavity. It was impossible to find the cervix by the sense of feel. On inspection, a very slightly projecting nipple could be

seen in the centre of the vaginal vault, and a small dimple could be detected at the site of the external os. The diagnosis was plain.

Under ether, a trocar and canula were pushed through the cervix into the uterine cavity. On the withdrawal of the former, a stream of coffee-colored fluid was projected several feet from the woman's body. More than a pint was evacuated. The uterus contracted vigorously, and directly after the fluid ceased to flow its internal measurement was two and one-half inches.

The interesting and peculiar features of this case are the entire absence of a cause for the atresia; the menstrual history suggesting the menopause; the slow accumulation of fluid and late appearance of symptoms — five years after the cessation of menstruation.

A CASE OF RECURRENT PARALYSIS OF THE OCULO-MOTOR NERVE.¹

BY EDWIN E. JACK, M.D.,

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THE patient, a Swedish woman, twenty-six years of age, was first seen April 14, 1893. Some weeks previous to this she had been at the Infirmary, where the diagnosis of paralysis of the third nerve was made. She was an average-sized and healthy-looking woman, and with the exception of the present trouble, said she was and always had been perfectly well. She had measles when young, but nothing else. No history or physical signs of syphilis. Bowels and menstruation normal. The mouth and nose were slightly drawn up to the left, but a careful examination by Dr. J. J. Thomas showed no paralysis of any branch of the facial. The ears, examined by Dr. F. L. Jack, showed signs of hypertrophic catarrh. Hearing subnormal in left. The father is alive and well. The mother, who died twelve years ago at the age of about forty-five, of "rheumatism and dropsy," suffered with headaches during her life. Whether they were migrainous in character could not be told. Two brothers and two sisters are well.

Toward the end of January last, patient was taken with sudden and severe pain in the left brow, temple, cheek and side of nose. The pain was described as dull, like the blow of a hammer. With the pain there was loss of appetite and vomiting. This lasted for two or three days, during which time patient was in bed. During the first day the left lid began to droop, and in a day or so there was complete ptosis. In the course of two weeks the lid could be raised so as to uncover the pupil, and then there was diplopia, which has persisted in some degree till now.

Examination of the eyes April 14th: O. D. normal; V. = 1; H. O. S. — fundus normal. Pupil well dilated. Reaction to light extremely slight. Associated action with accommodation very feeble. V. = 0.1 — the poor vision being due to an almost total paralysis of the accommodation. With a rough correction of the refraction, V. = 1. There was diplopia everywhere except in the lower part of the field from just within the extreme right to the extreme left. O. S. did not move in perfectly. On quick convergence it tended to lag behind and on looking quickly at a

distance it deviated outward slightly. Marked limitation in upward movement, movements outward and downward normal. There was apparently a very slight ptosis. An examination October 12th showed practically the same conditions, except that there was no diplopia on the horizontal line.

Attacks similar to the one just described and with the same accompaniments, have occurred many times during the last ten years, beginning therefore at about the age of sixteen. Some years there have been only two or three attacks and in some five or six. In the last five years more than before, but within that time there has been no increase in frequency. The last interval, nine months, is the longest that has ever occurred, so that this year is likely to prove an exception to the previous ones. For the first few years there was no paralysis between the attacks, but the last four or five, the dilatation of the pupil, the paralysis of accommodation and in some degree the diplopia on looking upward, have been permanent. The ptosis and diplopia in the middle of the common field have usually disappeared within two or three weeks. The last time though a certain amount of ptosis remained for two months and the double vision in the middle of the field lasted longer than formerly; this has been the tendency lately. There has never been any connection with menstruation and never any headache between the attacks. The pain is limited to the region stated, never reaching to the occiput. There is a feeling of heat and sometimes of cold, but no chills. The pain comes on suddenly, without warning, and does not seem to be brought on by anything patient eats or does.

The earliest reported case of this kind was that of Gubler in 1860. Mauthner has published the account of a case seen in Graefe's clinic in 1864. With these exceptions all the cases, about twenty-eight, have been reported since 1882. Of these the majority, fifteen, are females. The age at which the attacks first came on varies from eleven months to thirty-one years, the greater number being under fifteen. In a few the age is not stated. In eleven the right side was affected, in sixteen the left, one doubtful. In most of the cases headache and vomiting preceded the paralysis, in some there was no vomiting, and in a few dizziness was present. Other symptoms occurred in separate cases, such as paresis of arm, trouble in articulation, tenderness in the region of the branches of the fifth, tinnitus and transient deafness, a twitching pain down arm and leg on opposite side, salivation and a general feeling of discomfort before the attack. The pain in most instances resembled that of migraine; in a few it was limited to the region around the eye, or in supraorbital nerve, and in one the whole head was involved. The duration of the attacks varied in different cases and in the same case from a few days to six months. The figures given, however, refer in some cases to the duration of the pain and in some to that of the paralysis. The intervals also varied, two weeks and four years being the limits. In at least sixteen, the attacks became worse and lasted longer. In all of these the paralysis, to some extent, became permanent. In a few only did the severity of the attacks decrease. In Von Hasner's case, the trouble came on before the establishment of the catamenia, later the attacks were coincident with them. In no other instance, I believe, has this coincidence been observed. In Dr. Wadsworth's case, toward the end of the headache, there was a discharge

¹ Read before the Boston Society for Medical Improvement, October 23, 1893.