Original Articles.

THE END RESULTS OF SURGERY IN NEURASTHENICS AND ON NEURASTHENIA. (WITH A REPORT OF FORTY-NINE CASES).*

BY EDWARD REYNOLDS, M.D.

THE term "neurasthenia" has been, and still is, so loosely used that it is essential to clear thought that at the outset of any paper upon this subject the word "neurasthenia" should be defined in the sense in which it is to be used. Neurologists have of late tended to substitute the term "fatigue neuroses" for the shorter term "neurasthenia," which they think has been used to cover too many diverse conditions; but as surgeons we are not concerned with the subtleties of neurological classification and pathology, and for our purposes either term may be fully defined as implying merely a state of pathologically lowered resistance to the depressing influences of the environment, which state may be due to any one of many causes. Those causes are, however, of the first importance to us.

In June, 1910, the subject of the end results of surgical work in neurasthenics was discussed in a joint meeting of the American Surgical and Gynecological Societies, the disputants being in the main men selected by those associations as possessed of especially wide experience or long interest in this subject. The consensus of their opinions was strikingly close and, therefore, of much interest. It was, first, that neurasthenia is fundamental in the individual, i. e., that typical neurasthenias appear only in individuals who are in one way or another ill developed or underdeveloped. Second, that neurasthenia in itself is never an indication for surgical treatment, i. e., that operations upon neurasthenics undertaken for conditions which would not warrant those operations in sound individuals are always injurious to the neurasthenic. Third, and equally important, that neurasthenia is not necessarily a contra-indication to operation. Neurasthenics who are afflicted with remediable lesions which are causing symptoms sufficient to warrant operations in other individuals may expect the same benefit to their general health which would be expected in sound individuals. In short, neurasthenics should not be denied the benefits of surgery.

This, as I have abstracted it, is not only the consensus of some of the best minds upon the surgical side of the profession in America to-day, but seems in itself essentially reasonable.

Its three propositions seem to cover the subject very satisfactorily. The first proposition, — that neurasthenia is fundamental in the individual, born in him, developmental in its origin and likely to be present as a potential factor throughout his life, — is a rather recent pathological conception, which, however, seems to-day to be acceptable to the leading authorities of both the medical and surgical sides of the profession. It

probably lies at the bottom of a sound conception of the subject.

The two remaining propositions should be considered together, i. e., as a statement that neurasthenia is in itself neither an indication nor a contra-indication to surgery.

During the last decade we have been presented with reiterated and radical differences of opinion upon the treatment of neurasthenia. General practitioners have repeatedly and continuously referred their patients to surgeons, and the surgeons have operated, although the medical and neurological consultants have fulminated persistently and continuously against the operative treatment of neurasthenics. Now a persistent and radical difference of opinion between two sections of the profession, such as this has certainly been, always implies that each side is in part right and in part wrong.

In this question the characteristic mistake of the surgeon has been that he has too often neglected our second proposition. He has too frequently acted as if neurasthenia were in itself an indication for operation. We, as surgeons, must admit that there have been many unnecessary operations upon neurasthenics, and that our experience has taught us to recognize that many of these operations have resulted in prolonged and severe nervous disaster.

On the other hand, the medical and neurological consultants have too often failed to perceive the importance of the third proposition, — that neurasthenia is not in itself a contra-indication to operation, that neurasthenics should not be denied the benefits of surgery. Many of them are in fact still thundering entirely indiscriminate denunciations against any operative interference upon neurasthenics.

Throughout this controversy the general practitioner, with his characteristic, instinctive good sense, has known all along that some neurasthenics are benefited by surgery and some are not, though for the most part he on his part has not been very sure which was which.

We surgeons are ready to admit our mistakes of the past. It is time that the medical experts should do the same, and that both sides should unite with the general practitioner in an honest effort to establish the principles by which those neurasthenics who are to be benefited by surgery should be selected for operation, and those who are not to be so benefited should be reserved for merely medical treatment. The first step in this process must evidently be their classification in accordance with the causes by which their fatigue neuroses have been initiated.

Let us consider, then, in the light of our three guiding propositions, the varying life histories which may come to a neurasthenic.

As the result of poor inheritance, or poor environment, an individual comes into adult life with a potential capacity for neurasthenia, i. e., with an abnormally low capacity for resisting the depressing influences of civilization, or, in biological language, of his environment. Such an individual will retain his (or her) potential

* Read before the Medical Association of Central New York, Oct. 18, 1911.

capacity for neurasthenia, i. e., his intrinsically low capacity for resistance to the fatigues of life, to the end of the tale; but whether or no that individual undergoes a definite nervous breakdown, a fatigue neurosis, a neurasthenia, depends on circumstances, on the amount of the depressing influences to which he or she is subjected. If such an individual is subjected to an undue load of work, he or she will develop some part or the whole of the symptom-complex which we know as neurasthenia, where a sound individual would be merely over-tired; and in corollary, when neurasthenia is the result of over-work, and of over-work pure and simple, the main difference between the sound individual and the neurasthenic is that the sound man can be rested back into perfect health, while the neurasthenic can only be restored to his or her previous state of fair condition, but with an ever-present liability to the reappearance of neurasthenia if the undue strain is again incurred. Similarly, when an individual with an inborn potential capacity for neurasthenia has not been subjected to any increase of the ordinary fatigues of life, but has become the subject of some physical lesion which results in chronic suffering, the increase of load due to that suffering is often of itself sufficient to precipitate a fatigue neurosis, a neurasthenia. Even in these cases the first step in treatment usually is, and always should be, rest, but this relief cannot here be permanent. No one can properly be more than temporarily freed from the ordinary duties which are inherent in his circumstances and essential to his happiness. Hence in these cases where the nervous breakdown has been the result of the added load due to chronic pain or other suffering, the only logical and reasonable remedy is the relief of that suffering, if such is possible, and if in these cases the lesion and the symptomatology are such that in a sound individual we might expect restoration by operation to entire health, we may expect in a neurasthenic restoration to the pre-existent state of comparative health.

Neurasthenia is familiar to practitioners in every department of medicine and should properly be treated from an equally broad standpoint, but my subject to-day is the treatment of those neurasthenics who are afflicted with pelvic ailments, and to that I must now restrict myself for the sake of brevity and comparative completeness, though, indeed, even that one branch of the subject is overwide for comprehensive discussion in a short paper, and for that reason the best method of bringing it up for discussion may perhaps be the citation from a clinical standpoint of cases illustrative of a few of those causes of neurasthenia which are most common in gynecological practice.

The mere use of the generative organs may in some women precipitate a fatigue neurosis. One often sees such cases, i. e., a young woman has gone through her girlhood on the whole sufficiently well. She has never cared for the fatiguing sports, and she has usually had more or less dysmenorrhea. She has often been pretty,

attractive and gay, but has always been tired and exhausted at the close of the social season of late hours; she has never been very well, always delicate, but has not been a neurasthenic. She marries and becomes pregnant; perhaps she also overdoes her social duties during the early part of pregnancy. Pregnancy is succeeded by labor, the pains are inefficient and variable in frequency and force, she is attended after the good old-fashioned method, so-called, and after eighteen to twenty-four hours of exhaustive labor has a good hard forceps case. She is tremendously exhausted. She gets up pale and feeble. She nurses for a time, but nursing is painful and the breasts give out. She worries over her baby, and she takes up her social duties again. One or two more babies come along. She gets up worse each time. In a few years the familiar medical history of the chronic neurasthenic intervenes. She wears out her family practitioner and begins her round of the specialists. The picture is a familiar one.

Take an actual case of this kind:

Private Records, B. 2502, November, 1910. Thirty-one years old. Married six years. Three children, youngest two years old. Before marriage her catamenia were irregular, the intervals always long and attended by great pain, mostly right-sided. Since marriage they have become normal, and since the children were born the pain has been slight, but for three years there has been increasing post-catamenial depression and exhaustion. She has been complaining for fifteen months of a right-sided ovarian pain. For about the same length of time she has had a sensation of pressure in the rectum and has been troubled by belching and flatus and a great amount of the so-called "gas pain" in the upper abdomen. Her bowels have been irregular, often diarrheal, never really constipated. She has lost 30 lb. of weight and has become very nervous and extremely irritable. She has been for years in the hands of a first-class general practitioner, and during the last year under constant dietary treatment by a prominent expert. Her loss of weight has been progressive, and it has been necessary to restrict her diet more and more carefully. She is a very devoted mother but has spent the last six months in Europe, leaving her children at home and doing everything to rest and divert herself, but she has not improved.

On examination of this patient, there were no lacerations of consequence, but there was a large subinvolved uterus in retroversion, the vagina and cervix were greatly congested, and there was somewhat indefinite resistance on both sides of the uterus, possibly exudate. The uterus was too tender for re-position. She was instructed to place a glycerine suppository in the vagina each night on going to bed and report in a fortnight. At the end of that time tenderness was almost gone and what was at first thought to be exudate was made out to consist of enlarged ovaries with probably somewhat congested tubes. The uterus was replaced and easily held in position by a pessary, but the patient was very conscious of its presence and much fatigued by each of two or three attempts to improve its shape. After a month of this preliminary treatment it was given up as inadvisable, the abdomen was opened, both ovaries were found enlarged to the size of English walnuts by numerous small cysts, little more than enlarged follicles; both were resected, removing all the cysts and leaving little less than a normal quantity of apparently normal

ovarian tissue. The uterus was lightly suspended. A long and somewhat distended and reddened appendix was removed. An intra-abdominal examination showed quite general abdominal ptosis, the stomach was somewhat distended but not descended, the transverse colon was very low, both kidneys were very movable, but all this generalized ptosis was thought to be simply the result of loss of supporting fat, and nothing was done for it. Convalescence was normal except for great nervousness and irritability. She was put gradually but almost at once on to a full and varied diet, which she was able to digest with little and steadily decreasing distress. At the end of ten weeks she had gained 14 lb., was entirely free from her abdominal pain, and much less fatigued by her catamenia. A year after her operation she considers herself entirely well, but is still somewhat easily tired and probably always will be.

This was a case of neurasthenic malnutrition associated with and presumably caused by the fatigue of marked post-catamenial depression and nervous excitation (irritability). An over-captious medical critic of the treatment adopted might perhaps say that the malnutrition of this case before operation was the result of an over-restricted diet, and that a change to an abundant and varied diet might in itself have relieved the indigestion, but the patient had had the advantage of nearly twelve months' treatment by a recognized expert of national reputation, who had directed her diet towards an increase of weight and believed her incapable of assimilating from a varied diet. His diagnosis was indigestion of neurasthenic origin and he was prompt in his support of an operation as soon as the pelvic condition was brought to his attention. The rectal pressure, moreover, and the dysmenorrhea and pain in the right lower quadrant were undoubtedly of pelvic origin, and the disappearance of the digestive symptoms was coincident with the relief of the pelvic condition. From the standpoint of practical medicine, at all events, this case was a failure till it came into the hands of the gynecologist, and an immediate success thereafter.

Imperfect generative development which is not important during maidenhood may be productive of symptoms after matrimony. The symptoms are often relieved by the generative development incident to maternity where this is possible, but these cases are often subject to secondary conditions which result in sterility until they are relieved by operation.

Private Records, B. 3194. A tall, slight, fragile-looking woman with small breasts and hips, twenty-four years old. Two years married without pregnancy, complaining of dysmenorrhea attended by nausea, and very anxious for children. From eighteen to twenty-two years of age she had supported herself by hard work as a clerk, her duties involving a good deal of moving about, whether well or unwell. In spite of an increasing dysmenorrhea and her general delicacy she had maintained fair health and had been an efficient worker. At twenty-one she married a man of large income and was relieved from all the fatigues of life, living in the country in a simple way, with few cares, and with everything that money could furnish. This change should *a priori* have been beneficial, but within a few months

after marriage her dysmenorrhea increased distinctly; ante-catamenial depression, which was previously unknown, became quite marked and was attended by nervous irritability and instability. This was at first limited to a few days before the period, but at the time of her first visit, i. e., after two years of matrimony, extended over the entire menstrual month with the exception of a period of relief immediately after the catamenia. On examination she had a moderate under-development of the entire generative system; the vagina was small, the uterus markedly small, in retroversion, and with a very small and undeveloped cervix, which after replacement of the uterus was sharply ante-flexed; the os, pinhole. On rectal examination it was easily ascertained that both ovaries were moderately enlarged, probably cystic, and there was of course marked congestion of the organs. The uterus was curetted. The os was enlarged and the cervix altered from its abnormal position and shape by a plastic on the posterior cervical wall and another for the elongation of the abnormally short anterior vaginal wall. The abdomen was then opened, the ovaries were reduced to normal or rather less than normal size by resection of their cystic portions and the uterus held forward by an extremely light stitch, such as it was thought would be only temporary in its results. Convalescence was normal, but the next two periods were attended by great nervous excitability. The second was, however, less bad than the first, and in the succeeding periods this gradually disappeared. She gained steadily in general condition, her dysmenorrhea being almost entirely relieved, and six months after operation reported herself pregnant. She reported by letter that she gained steadily in weight and general condition throughout pregnancy, having never felt so well as during the latter part of her pregnancy. Her labor was a long and hard one, and so far as could be judged from her report was well but not over promptly managed. She, nevertheless, got up well and when seen two months after delivery had gained flesh, strength and color and considered herself in better health than ever before.

In this case an under-developed uterus was unable to withstand the recurring congestions of marital life and became pathologically congested. Dysmenorrhea increased, and the ovaries entered upon a state of altered physiological condition which closely approached the pathological, and which in my experience is, when bilateral, usually associated with permanent sterility. The patient, though not thoroughly broken down, was in a state of extreme nervous excitability which furnished just ground for serious apprehension. With the institution of thorough drainage by alteration of the shape of the cervix and the correction of the abnormal condition of the ovaries, without the loss of any essential amount of ovarian tissue, her dysmenorrhea and its accompanying exhaustion was relieved. Her nervous excitability then steadily diminished, and with the supervision of pregnancy the process of generative development which had been arrested in early youth was resumed, and carried out to full development during the course of pregnancy. Such under-developed cases as this may often in time and with good care be relieved of a great part of their liability to nervous breakdowns, not as the direct result of an operation, but as the result of the renewed development of the generative organs which attends a pregnancy,

which was itself in part the result of operation.

A moderate auto-intoxication by the products of an inflammatory lesion may be the exciting cause of a neurasthenia.

Private Records, B. 3226. Thirty-one years old. Six years married. Two children, youngest three years old. Nothing abnormal in pregnancy or labor. For about three years has had a slight metrorrhagia. During the same period marked indigestion and progressive loss of weight. Has been for three years subject to coronal and suboccipital headaches, which have been much worse during the last year and are invariable at the catamenial period. Is subject to almost daily nausea, which is especially bad at the catamenia. The headache, nausea and loss of weight, taken in connection with the patient's condition and general appearance, suggested a chronic auto-intoxication, of pelvic origin, since they were increased in the catamenial week. A blood count was negative. The profuse flow appeared to be a purely pelvic symptom. On examination the perineum and cervix were moderately lacerated, the uterus was in retroversion, there was a rounded mass the size of a hen's egg at the right of the fundus. There was marked tenderness high up on the right side of the pelvis and none elsewhere. It will be noted that no pelvic pain had been complained of. The perineum and cervix were repaired and the abdomen opened, when a complete explanation of the symptoms became apparent. The left broad ligament contained a cyst of Morgagni of about the size of a tangerine orange by which the uterus was pressed into retroversion; it was of purely mechanical importance, but this condition was probably sufficient to explain the slight metrorrhagia and the catamenial exacerbation of symptoms. The right uterine appendages were normal, but the cecum and appendix lay low in the pelvis and, indeed, below the retroverted fundus. The whole inner surface of the caput coli on the median side up to and almost including the region of the ileo-cecal valve was discolored and the seat of a curious infiltration, the exact nature of which could not then be made out, although it was undoubtedly inflammatory. The whole diseased portion of the gut was excised, the appendix being included with it, and the abdomen was then closed.

Pathological examination of the portion of intestinal wall removed showed that its mucous membrane had been destroyed, and that the remainder of the wall was between a quarter and half an inch thick, infiltrated with round cells and studded with minute abscesses. Diagnosis: Chronic inflammation. It was an evident focus for auto-intoxication.

This patient, though not in all ways a typical neurasthenic, had that appearance and had been diagnosed and treated as such by a thoroughly competent metropolitan practitioner for more than two years, during which time every appropriate medical treatment had been used upon her and naturally without results. Her gain after operation was rapid and satisfactory.

In each of these cases the overload due to chronic suffering or auto-intoxication of pelvic origin appeared on consideration to have been enough to have upset the nervous balance of a poorly constructed individual. In each the relief of the chronic pathological condition which caused those symptoms proved sufficient to restore the patient to her previous reasonably good state of health. It would be easy to cite even from gynecological practice alone many other local

conditions which are capable of producing neurasthenia by the imposition of an overload due to chronic suffering, but time forbids; we are here concerned with the principles rather than with individual instances, and may now pass on to them.

Neurasthenics of all classes tend to attribute their ill health to localized conditions and the point most important in the selection of their treatment is an answer to the question, — How are we to distinguish between an individual whose neurasthenia is really due to local suffering, and another whose neurasthenia of general origin has led her (or him) into self-concentration upon an etiologically unimportant symptom? The differential diagnosis involved in answering this question is of confessedly great difficulty and is often sufficient to strain to the utmost the resources of our wisest diagnosticians. In individual cases it must always in the last analysis be dependent upon the clinical ability of the individual attendant. Two points are, however, always especially worthy of his consideration. These are the chronological sequence of the life history and the persistence of the symptoms complained of. It should further be noted that since impairment of memory and uncertainty in self-judgment are prominent symptoms of the fatigue neuroses, the assistance of the family practitioner is often of essential value to the specialist who is attempting to unravel such a life history.

If after cross examination of the patient and the family practitioner it becomes evident that the nervous breakdown has preceded the development of the local symptomatology, it may generally be concluded with certainty that that symptomatology is merely a neurasthenic exaggeration of an unimportant difficulty, and in such cases even the existence of a perceptible but not lethal lesion is rarely an indication for operation. When, upon the other hand, the local suffering has appeared first and the progress of the neurasthenia has followed the increasing development of the localized symptomatology, the burden of proof is upon him who asserts that the fatigue neurosis is of merely general origin. Here especially the neurological or medical expert who opposes operation is in danger of a mistake.

Again, the persistence of a symptom unchanged throughout a series of years, and more especially throughout the time which precedes and attends the development of a neurasthenia, is in neurasthenics of much more importance than the degree of complaint that it excites. Evanescent and varying symptoms of great intensity are the characteristics of neurasthenia, but steady reiteration year by year of one unvarying discomfort is indicative of a real lesion, and should this lesion be of such a nature as is capable of producing chronic fatigue or auto-intoxication, it may sometimes be of far more importance towards the production of a neurasthenia than would be judged by the amount of pain or discomfort which it excites. The importance which should be attributed to a chronic auto-intoxication

in especial is one of the points which has until recently been under-estimated.

It must never be forgotten that in determining for or against an operation the patient's vital condition and past history should be estimated as a whole of which the local condition is only one part. It is only upon this basis that a wise decision can be expected. Even when prolonged study upon this basis has convinced the surgeon that a given set of localized symptoms bear a causative relation to the neurasthenia his diagnostic duties are by no means ended. He must next check his conclusions by considering the results of a physical examination in connection with this symptomatology. Unless the lesions found correspond closely with the symptomatology and are such as would naturally give rise to it, his provisional conclusions are probably erroneous. Again, even when he has found a lesion which is sufficient to account for the symptomatology that he believes is causative of the neurasthenia, his treatment has yet to be determined by a study of the probable effect of the appropriate methods *per se* upon the neurasthenia.

Upon general principles the treatment of such a case might be either minor or operative, but in gynecological work upon neurasthenics it is an undoubted general principle that prolonged minor treatment is to be avoided. Even in those instances in which it is locally successful, it is almost certain to be generally deleterious. Unless there is a probability that minor treatment will effect a prompt and radical cure, it is always inadmissible, and cases susceptible to such benefit are rarely of enough importance to provoke neurasthenia. In gynecological work, again, the removal of lesions by radical extirpation of the organs in which they are situated carries with it a degree of incidental nervous shock and after-consequences which renders them inadmissible in the treatment of neurasthenia, with one exception. When the victim of a neurasthenia of presumably pelvic origin is already past or near the menopause, and when the irritating lesion is one which interferes with the physiological regression of the organs, as, for example, when the uterus is distended by increasing fibroids, and especially interstitial fibroids, the radical operations are sometimes justified, since in these cases they are aiding and not opposing the natural tendencies. Even in these cases, however, the conservative operations are to be preferred, whenever they are surgically correct and feasible. For youthful neurasthenics the radical operations should be ruled out of contemplation.

One further possible error the gynecologist should be careful not to fall into; while it is true that a large proportion of those neurasthenias which are excited by local causes are excited by causes localized in the pelvis, the gynecologist must not forget that neurasthenia is frequently due to lesions situated in other portions of the body. When, for instance, the neurasthenia is attended by a constitutional condition which suggests auto-intoxication, the gynecologist should not attempt to relieve it by operations

directed to the relief of merely mechanical conditions in the pelvis, even though they may be provoking symptomatology. In such cases no operation should be undertaken until careful physical examination of the woman as a whole, if necessary with the aid of other specialists, has shown that there is no focus of auto-intoxication in the more distant organs (the ear, the tonsils or the digestive system).

These various exclusions of the cases which *should not* be operated on bring us at last to a selection of the cases which *should* be operated upon for the relief of neurasthenia.

When a careful study of the history has convinced the gynecologist that a given attack of neurasthenia is the result of an overload due to localized suffering; when his physical examination has revealed a lesion capable of producing that symptomatology, and which is susceptible of prompt, complete and permanent cure by a conservative operation, he is warranted in believing that the performance of that operation will result in a lessening of the overload, will, in short, be followed by an improvement in general health that will restore the neurasthenic to that degree of health which she is fundamentally capable of.

It would seem at first sight that these many exclusions would cut down the field for operative work among neurasthenics to a very rare indication, and this was true not many years ago; but recent progress in gynecology has steadily enlarged the scope of the conservative operations until we are to-day dealing by such methods with many cases which but a few years ago would have been subjected to radical operations if they were treated at all, and with many others whom we know to-day to be susceptible of prompt relief but who would have been told even ten years ago that operative treatment would do nothing for them.

When the medical or neurological consultant urges a patient to abstain from operative interference he has commonly in his mind the evil results of the unnecessarily radical operations of the past. He has long known, as we all know now, that the removal of the ovaries or uterus is usually disastrous to a neurasthenic who has not yet reached the menopause. He seldom realizes even now that a woman whose catamenial or other local suffering is plainly due to enlarged ovaries of the size of English walnuts or less, and whose increasing catamenial or post-catamenial depression is urging her steadily down hill, can usually be relieved of those symptoms completely and finally by the resection of the diseased portions of the ovaries, without the loss of enough ovarian tissue to be of a moment's consequence; and especially, he does not usually know that the temporary nervous fatigue involved in such an operation is very slight, and most essentially temporary. In the words of a distinguished contemporary, "Modern surgery disturbs the vital processes surprisingly little,"¹ and it may be added that in modern surgery the *non-mutilative*

¹ Dr. Maurice H. Richardson.

operations disturb the *nervous system* surprisingly little. The neurasthenic who is about to be operated upon should, however, be warned that while the operation itself will pull down her strength but little, so that she ought within two to three months, at most, to feel at least as well in general strength as before her operation, she must, nevertheless, not expect irrationally prompt results upon the neurasthenic state itself. The relief of pain or other suffering, though often in itself sufficient warrant for an operation, does not in itself dissipate the fatigue neurosis; that must be disposed of by the slower processes of vital recovery for which hygienic rest is as essential after operation as without it. The only difference which can be expected from operation is that with the disappearance of the overload due to chronic suffering, the hygienic general treatments which before operation merely enabled the patient to keep along in a neurasthenic state may be expected to bring her up into good health after the overload of chronic suffering has been removed. I am, then, accustomed to tell my neurasthenics that all that they may count upon is that they will have considerable and perhaps complete relief from the distressing symptoms immediately after operation, and at the end of two to three months they should feel that they are in every respect as well and strong as before operation; but that it will take from six months to a year after operation before they have obtained all the improvement which they may expect, i. e., before the individual has returned to her intrinsic, personal degree of normal health. Some cases do better than this, but this is all that it is safe to count upon, and it is best to be honest with the patient beforehand.

In spite of all these limitations as to the selection of cases, the number of neurasthenics who should be operated upon remains a large one, in gynecological practice at all events, and the degree of relief which most of these cases obtain is more than enough to justify their operations.

In preparation for a paper recently read before the Clinical Congress of Surgeons in Philadelphia I had occasion to tabulate 110 consecutive cases of the conservative surgery of the ovaries in connection with the standard gynecological operations. Out of this list there were 49 cases in which a diagnosis of neurasthenia was entered on the record blank at the time it was filled out, as a matter of routine, and without any thought of this compilation. All these cases were operated upon at least fifteen months ago. All were private patients and all have remained under observation since operation. In 40 of the 49 I have heard from the patient by word of mouth or letter, or have heard from her physician, that the general results of operation were satisfactory to the patient, — perhaps the best rough symptomatic test that we can apply.

The remaining 9 (18%) are not rated as successes. In 4 of them a dysmenorrhea has been relieved, but the neurasthenic state has not been satisfactorily benefited. Five extreme neurasthenics without dysmenorrhea were unim-

proved. These five women went through operations without benefit, but it is fair to remark that no one of them seems to have been made finally worse. *The conservative operations are not followed by lasting ill-effects.*

These 9 cases were evidently instances of mistaken diagnosis, i. e., cases in which neurasthenias which were believed after careful search to be of pelvic origin were in fact due to some other cause.

Eighty-two per cent of the cases have returned to what they consider good health. I am confident that this is a better showing on the operative treatment of neurasthenia than is ordinarily attained by the radical operations.

No man deserves credit who claims for himself or for his colleagues uniform success, and no man who makes such a claim will long be listened to. I am aware that in spite of the careful limitations of the operative field which I have endeavored to set forth above, that which I have now to say might be open to such an imputation. My defense is that I have here emphasized my failures and that I have, moreover, recently published a paper² which was mainly devoted to the causes of failure of gynecological operations among neurasthenics and which details many of my own unsuccessful cases, more especially in the past, as instances of what should not be done; to that I must refer those who criticize my conclusion. With that proviso I am ready to say that I believe the community to be full of individuals who are suffering the gravest injustice in being considered *malades imaginaires*, hysterics, incurable medical neurasthenics, when they are in fact susceptible of prompt cure, of restoration to a fair degree of health and happiness, by rational, conservative surgical operations. In the last few years my practice has taught me to believe, for my own purposes at least, that in spite of the great difficulties of diagnosis which are inherent in the selection of these cases, and in spite of the mistakes which so long as we are human we shall all make, there is no department of my work in which I have been able to effect so much towards those first ideals of our profession, the relief of suffering and the promotion of good health in the community, as I have been able to accomplish by the surgical treatment of neurasthenics.

THE CLASS METHOD IN THE HOME TREATMENT OF TUBERCULOSIS AND WHAT IT HAS ACCOMPLISHED.*

BY JOSEPH H. PRATT, M.D., BOSTON.

IN the organization of the first tuberculosis class I received help and inspiration from four men. Three of these men are members of this Association and are present to-day. To our honored president I owe the abiding conviction that in this fight against tuberculosis we should make the best possible use of the facilities at hand. From Dr. Charles L. Minor I learned

² BOSTON MED. AND SURG. JOUR., vol. clxiii, no. 4, p. 113.

* Read at the twenty-eighth annual meeting of the American Climatological Society, Montreal, June 13, 1911.