rather than correctness. Too many branches are taught and too many hours are spent in school. In many schools children of ten years of age are compelled by reason of excessive lessons to spend hours at home which should be devoted to play or to sleep in the preparation of lessons. To regular school duties in many instances, especially with young girls, is added a semi-weekly music lesson which involves several hours a day of close application to routine "practising" at the piano in a constrained position. The exercise is monotonous and wearisome to the last degree to minds and bodies already overtaxed by study and several hours of confinement to the school-room. Recreation even is converted into a fresh tyranny. Almost every girls' school has a well-equipped gymnasium where muscular exercise is made compulsory in movements designed to cultivate the physical system and where all movements must be executed with the precision and exactness of military drill. While engaged in writing this paper I chanced to visit a gymnastic exhibition in a well-appointed school where girls varying from ten to fourteen years of age were taught. Their movements were marvellously precise and correct, and were executed with dash and enthusiasm. I was struck, however, with the nervous strain apparent in the countenances of many of these young girls. It did not seem play or recreation, but a task to be executed with as much expenditure of nervous and mental energy as any form of study. These are every-day examples of the trend of our present educational methods, and they might be indefinitely multiplied; but I spare you the further details. Is it any wonder, under these circumstances, that the mental disorders of childhood are increasing in frequency? Is it not our duty as medical men to protest against the burdens which are thus unnecessarily placed upon growing and immature brains?

THE DECLINE OF THE PESSARY.¹

BY JOHN G. BLAKE, M.D.

THE writer who states that fac-similes of the cylindrical vaginal speculum were found in the ruins of Pompeii and Herculaneum makes no mention of a pessary; and yet when we stop to think that the genius who hit upon the means of exploring the vagina and cervix must soon have been convinced of the necessity for something to maintain a corrected displacement, or straighten a tortuous canal, we are disappointed at his inventive limitations, which exhausted themselves so soon. However, we may feel certain, that when the need became urgent, the man appeared, as in the other emergencies of life. When the race needs anything badly, it usually goes to work and produces it. Unfortunately the names of both inventors of the original instruments are lost to fame as completely as the builders of the Pyramids, the Cathedral of Cologne, and other world wonders.

Their modern followers have been more successful; and we have Smith, Brown, Jones and Robinson's pessaries without number. In fact, as the "Encyclopedia of Gynecology" states, there is scarcely a man prominent in this department of disease who has not either invented or improved a speculum or pessary. They seem to have emulated the example of the gentleman who was claimed to be a benefactor of his race, because

he made two blades of grass grow where but one sprang before. Dr. Bigelow once remarked in my hearing, when examining and explaining the merits and defects of aural specula to a class of medical students, that one could see almost as well with some of them as without them—which might in another sense be applied to pessaries. However, as their production belonged to a certain stage—long since passed away—in the mechanical development or evolution of knowledge of the treatment of uterine disease, they have deserved well for what they have accomplished. To those of them that are dead and buried, we will remember that "nil nisi bonum mortuis" is a generous and manly motto. No one invents pessaries now. To the practitioners of to-day, the condition of things gynecological existing in our medical community only a generation ago can hardly be realized. A view of the os a few times during my course in the school, through a cylindrical speculum in the hands of Dr. Minot, and the application of argt. nit. (which was the classical treatment for that classical but misnamed disease, ulceration of the womb,) was the extent of instruction. Lectures were delivered by the elder Storer on the diseases of women, mostly on those connected with parturition, and that was all. Indeed, there was a well-marked scepticism in the older medical mind about the existence or necessity for much treatment beyond the use of a ring or some simple form of support; and other treatment was formed on this view. It would be difficult to convince my younger hearers of the extent to which their use was carried. An anecdote will best illustrate. A well-known professional brother was called upon by a young lady for advice and treatment. After examination he introduced a pessary. On returning home, and reporting to her mother, the latter visited the doctor and reproached him with considerable warmth for resorting to such measures. The doctor in his blandest tones assured her that there was no impropriety whatever, and then began to talk of her own condition. Before she left the office, she, too, wore a pessary.

This is among the humorous features; but there is another and graver side, in the evils resulting from their abuse and non-fitness. Most of us have seen more or less severe pelvic inflammations and ulcerations resulting from their use under wrong conditions. This applies to all forms, but perhaps more especially to the varieties of stem pessaries. Many treatises on uterine disease contain plates showing the evil of their use in ill-selected cases and unsuitable conditions, resulting in laceration and deviation of the uterine canal. Skene, in one or two plates, shows it very clearly. Indeed, these evils had reached such a height, that for a time it was quite the correct thing to inveigh against the use of stems under any conditions. Yet of all the forms of mechanical devices available, the stem, under proper restrictions and in appropriate cases, was most capable of good results. It is so now, for certain purposes; although the necessity for its use has diminished with the adoption of other methods of treatment.

This leads me to speak of the conditions which call for such use. As we all know, the vast majority of uterine displacements are of the backward variety—either retroversion or retroflexion, of various degrees, accompanied by more or less hypertrophy of tissue of the fundus and body. In flexions there is atrophy of the muscular fibre at the point of flexion. One would naturally suppose that a knowledge of this fact would be followed by efforts to remove this condition before

¹ Read before the Obstetrical Society of Boston, April 14, 1894.

attempting to restore and maintain the organ in its normal position. As one writer puts it, you cannot have pathological displacement without inflammation; and without the removal of this condition, no permanent result can attend any plan of treatment. Before recent measures were devised, this was not always easy of accomplishment; a partial removal was not followed by permanently good results with any form of pessary. In the minds of some of the best gynecologists the whole plan (treatment by pessaries) is unsatisfactory. Here is the view of one. Fritsch, a German writer, declares that it is easier to perform laparotomy than to apply an accurately fitting pessary. He had spent ten years in learning the treatment by pessaries, and considered it the most difficult in the whole range of gynecology. The same author criticises their use, declaring that the pessary heals palliatively, but injures definitively; for it distends the fornix vagina so enormously, that even after it has been worn for years, a cure is not to be hoped for. On the contrary, retroflexion of the uterus returns after the removal of the pessary. The longer the uterus has been displaced, the longer the time necessary to enable the relaxed ligaments to return to a normal condition; and a few days have been sufficient after its withdrawal, to have the uterus fall back into its old position. Other authors disagree with this view, and claim permanently good results in a large number of their cases. The truth is, that where the circumstances of the patient admits of the necessary rest and time, good results attend their use in a large number of cases. The constitutional requirements should be always carefully and faithfully attended to.

Among the means for attaining permanent cures, may be mentioned narrowing the vagina, pregnancy followed by prolonged rest in bed, dilating and curetting, and shortening the round ligaments. The first, as we know, is only called for in complete prolapse, where no instrument, without external support, will keep the uterus within the vagina, but where it can be accomplished by narrowing the canal and outlet. These cases are comparatively rare. Pregnancy, followed by long rest in bed, has in my experience perfectly cured many cases of severe long-standing backward displacement. The operation of dilating, curetting and packing is particularly adapted to the cure of ante flexions, and to the removal of enlargements which attend all forms of backward displacement. In the conditions of narrow cervical canal so common in ante flexions, giving rise to painful menstruation and producing sterility, there is no procedure which is followed by happier results than this. In my experience, it has never been necessary to use a stem pessary after its thorough performance. Occasionally a repetition may be called for, but rarely. The combined dilating, curetting, and Alexander, is to my mind the true solution up to date of the vexed problem of backward displacements.

Ventral fixation, by opening the abdomen, and by various other methods (the vaginal, for instance) of fastening the uterus, has been advocated by many writers; I see no advantage in them over the simple, harmless, and in most cases effective operation in proper cases, of dispensing with pessaries. In my hands, it has certainly yielded satisfactory results, and has been wholly free from danger. I know this view differs from that of many. Lawson Tait, for example, speaks slightly of it because his two cases did not turn out very well. Perhaps after having done it fifty or a

hundred times, he may change his opinion. The early ovariectomists were not so easily discouraged, and did not condemn the operation because their first trials were not successful. *Experientia docet*; familiarity with the technique, and a more careful selection of suitable cases, combined with proper preparation by reducing the size of the uterus, may be followed by a more favorable view of its merits. To my mind, neither he nor any one else has yet devised a simpler, less dangerous, or more effective measure for the emancipation of women from the wearing of pessaries, than the two operations of dilating and curetting, and Alexander.

At a recent meeting of the Gynecological Society of New York, the merits and demerits of Alexander's operation were fully discussed. The views of Dr. Edebohls and Dr. Cleveland were so fair, and represented my own judgment so accurately, that I venture to present a condensed report for the benefit of those who may not have seen the original account in the *Gynecological Journal*.

Dr. Edebohls said that he didn't like Alexander at first. Abandoned it for six months after first five operations, and used anterior abdominal fixation. Didn't like the latter, because of the adhesions. He thought Alexander most nearly restored the uterus to its normal position, and most nearly allowed it its normal mutability. It did not fix the uterus by adhesions, nor bend it, nor tie it down to the vagina. It produced good and permanent anatomical results, if properly performed. The therapeutic results depended upon the clearness of the indication for operation. Absolute indications: freely movable retroverted uterus, and perfectly normal tubes and ovaries. One accident was caused by failure to recognize a small ovarian cyst. He had satisfactory therapeutic results by observing these indications. If retroversion returned, operation had been incorrectly done. In one failure, the operator had been unable to ante flex the uterus at the time of the operation. Hernia might occur. He had had two cases. One woman became pregnant three weeks after leaving the hospital, and had a well-marked hernia after several months. In the other case he operated both for retroversion and hernia, and hernia returned. Since he began closing inguinal canal, and uniting ligament with buried silkworm-gut sutures, he no longer feared hernia. The operator needed fine anatomical dissection, which only certain methodical minds were able to give perfectly. Failure was always due to lack of pursuing a certain measure carefully. He knew of no operation in gynecology more beneficial if properly done in proper cases.

Dr. Cleveland said he had taken up Alexander slowly, and only in the last few years. He done thirty cases, with results good enough to make him continue. Round ligaments are intended for a good purpose; they are fibro-muscular, and well adapted for suspending the uterus in its normal position, if there be such a thing. Indications should be as Edebohls said; though in some cases existing adhesions had been separated, and operation done with good results. Edebohls's operation was not identical with Alexander, and he preferred the latter. Buried sutures were unnecessary; suture the round ligament in the canal. Had some failures, but thought he was to blame; they were in early cases. Hernia was likely to follow the appearance of pus (or incorrectly

inserted sutures). Knot sutures under fascia; one and a quarter inch incision enough, except in a very fat person. In cutting down on the canal, feel for the least resisting point; this is the ring. Pressing thumb and finger on either side of ring, cut inter-columnar tissue, and bulging cushion of fat appears. Grasp this with forceps, and almost sure to get ligament, which is drawn down and sutured with silkworm-gut. Don't cut ligament after suture. Pass Hagedon, with carrying thread, under fascia, at lower angle of incision, and out on mons, three-quarters of an inch below; end of ligament put in loop of carrying thread, pulled through, sutured, and cut off. Necessary to draw ligament four inches out, to antevert uterus enough to make it remain. Afraid of buried silkworm-gut; had trouble from it. Used kangaroo tendon instead. Draining, like Edebohls, with silkworm-gut; removed them in twenty-four hours (Edebohls in one week). Two months necessary for sufficiently strong union. He recommended pessary for three months; though there were good results in some cases without it. Thought ligaments, even small ones, strong enough to hold uterus. Believed in old operation where sutures remained temporarily, but should stay in four weeks; then, after removal, a canal was left which gradually filled up with fibrous tissue, holding uterus firmly. Had recently seen patients twelve months after operation. Position good, all symptoms relieved. When this is not the case, there must be adhesions, or ovarian disease not discovered. Alexander is a good operation.

CHRONIC TUBERCULAR PERITONITIS IN CHILDREN.¹

BY FRANK E. PECKHAM, M.D., PROVIDENCE, R. I.

THIS paper will be confined to the chronic tubercular peritonitis in children where the disease is not due to tubercular extension from the lungs, pleuræ or some neighboring organ or structure, but to a tubercular peritonitis which in itself constitutes the disease.

It may begin very slowly and almost imperceptibly, or it may come on suddenly with very acute symptoms. Beginning gradually, the first symptom which attracts attention is the enlarged abdomen; and at the same time the child begins to lose flesh, although this is not very marked in the earlier stages of the disease. This enlargement consists of some tympanites and more or less fluid in the peritoneal cavity. This may subside in a few weeks or months if not interfered with, but is pretty apt to recur as the disease continues its course.

Some cases will recover, just as we see some cases of tuberculosis of the lungs recover under favorable circumstances; but the usual course of a tuberculous, unless arrested by some active interference, is a steady advance towards a fatal ending.

If the fluid disappears or (what up to within a few years has been the usual treatment) has been removed by tapping to give relief, then the enlarged tuberculous glands may be felt by palpation; and in the later stages of the disease, masses and constricting bands may also be felt. The masses are composed of patches of omentum matted together, and the bands are formed by adhesions. These masses are sometimes very large, and give one the impression of a solid tumor.

¹ Read before the Medical Improvement Club of Providence, June 18, 1894.

If the disease is uninterrupted in its course, the child becomes emaciated, there is loss of appetite, and the hectic fever of tuberculosis may be present. The child will naturally assume the position so common in peritonitis, lying flat on the back with the knees drawn up; and many cases are so sensitive that to jar the bed causes pain.

As the patient lies on the back in bed, the fluid will remain in the flanks and the tympanitic intestines will naturally gravitate to the epigastric region. Percussion will then demonstrate the presence of fluid, the area of dullness changing with the changed position of the body. The fever does not run so very high, 100° to 102°. The bowels may be constipated or diarrhea may be present. In the later stages other parts of the body may become involved, especially the lungs.

In marked contrast to the course of the disease just described, the onset may be sudden, with abdominal pain, considerable tympanites, vomiting, coated tongue and high fever. The whole course of the disease in such a case would be much more severe and the termination much quicker.

Fluid is not always present in this tuberculous process, and when present the amount is not usually large. The most frequent cause of abdominal effusion is cirrhosis of the liver. During the atrophic stage, the portal congestion results in effusion, and any marked congestion in the portal circulation would also cause some splenic enlargement. Therefore a careful examination of the outlines of the liver and spleen would eliminate cirrhosis. An effusion from cardiac and renal disease would be eliminated by an examination of the heart and urine. Pressure effusions from neoplasm, etc., would be recognized by palpation, and the history of the onset would also be of assistance.

The prognosis in these cases is excellent, the death-rate being about three per cent.; and even in the three per cent. that die the operation does no harm, and may prolong life even if only for a short time.

If the lungs have become involved, it is not a contra-indication to operation; for if only slightly affected, when the primary disease in the peritoneum is checked, this may all clear up. On the other hand, if the disease in the lungs is well advanced, operation is still indicated for the relief it affords, for the improved condition and for the additional strength imparted.

TREATMENT.

The treatment formerly was medicinal and waiting for the end, which was almost invariably fatal.

Then a little later, in the cases where the fluid collected in large enough quantities to distend the abdomen markedly, this was removed by paracentesis to give relief. Usually it reaccumulated; and repeated tapplings were necessary, until the child, emaciated and exhausted, succumbed to the inevitable. It was especially in this class of cases, after several tapplings, that the constricting bands and lumps were to be felt.

Next we come to treatment by laparotomy, and doubtless you are all familiar with the fact that Sir Spencer Wells did the first one by mistake, opening the abdomen for what he supposed to be an ovarian tumor, and finding tubercular peritonitis present, in which a cyst had been walled off by the inflamed peritoneum. The abdomen was closed, and the patient recovered. This was in 1862. Since then, laparotomy has come to be the recognized treatment in such cases; and the method has been perfected, until now the