monizes with my hypothesis if we consider that a greater number of spermatozoids and more active ova will reach the ovum in the uterus than would in the Fallopian tubes and in the ovaries, and should any given cause act to reduce one sex, the other sex would thrive the better and would reproduce a majority of the rarer sex, thus restoring the equilibrium, and insuring an equal number of either sex in the progeny.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, January 7th, 1886.

THE PRESIDENT, B. F. BAER, M.D., IN THE CHAIR.

W. H. H. GITHENS, M.D., SECRETARY.

DR. HOWARD A. KELLY exhibited recent specimens of

PYO-SALPINX, HYDRO-SALPINX AND PAPILLOMA OF THE
HILUM AND GELATINOID THICKENING OF
THE FALLOPIAN TUBE.

The histories of the cases will be given at some future time.

DR. WILLIAM GOODELL stated that while he recognized the necessity for operation in pyo-salpinx, he does not think it necessary in hydro-salpinx. He now refuses to operate in some cases of cystic disease in which one ovary may contain a cyst as large as an orange, or in which the tube may be distended to the size of a sausage, because the sufferings of the patient and her general symptoms are not severe enough to warrant the operation. In many of these cases the symptoms may all be removed by the rest treatment, and it should first be tried. Small cysts are frequently found in ovaries, especially when uterine fibroids are present, but they do not necessarily develop into large ones. In many cases the cause of pelvic symptoms can be diagnosed by exclusion only, and even when small cysts or dilated tubes can be felt, treatment should be first tried, and will be sometimes successful without operation. He thinks the error of the present time is in the direction of too much surgical interference.

DR. E. E. MONTGOMERY remarked that there was a class of cases suffering from small ovarian cysts or distended tubes in which the rest treatment or any other loss of time could not be thought of, and in which operation seemed imperative. This was on account of the pecuniary condition of the patient, who may be self-supporting or who may be the only support of others; the suffering and exhaustion of the disease incapacitate them from work; relief is imperatively demanded, and he considered operation justified.

DR. GOODELL recognized this element of poverty, and has operated for this reason in some instances. He was led to make his remarks by a case now under his care. A lady was sent to him for operation after an opinion had been given by an experienced gynecologist of another city that relief could be obtained by operation only. On one side the ovary was enlarged, and the other ovary was prolapsed and

tender. Rest treatment had wholly cured her. In these remarks he did not mean to cast reflection on any of Dr. Kelly's cases. Pus was present in all of them, and operation seemed to be demanded in all.

DR. B. F. BAER has been strongly impressed lately with the views expressed this evening by Dr. Goodell. Dr. Baer thought all conservative means should be tried before operating.

DR. KELLY replied that he had presented the specimens purely from an anatomical and pathological standpoint, and that he will give the histories at some future time, when the results of operation are well demonstrated. In each of them operation was imperatively demanded to save life. It is in such cases as those presented this evening that the great work in the future must largely lie. If the details of ovariectomy have been perfected, in such cases as these the chapter is only being opened. They are not examples of Battey's operation, or Tait's operation, but stand as representatives of classes of disease well defined with equally well defined indications for treatment. The extraordinary difficulty of digging such masses as these out of the pelvis makes operative interference very fatal, although it is the only resort.

DR. WM. GOODELL read a paper entitled

A YEAR'S WORK IN LAPAROTOMY.

During the past year he had had forty-four cases of laparotomy, with four deaths, as follows:

	Cases.	Deaths.	Recovery.
Ovariectomy	28	2	26
Oophorectomy	9	1	8
Hysterectomy	2	1	1
Exploratory incision	4		4
Pelvic abscess	1		1
Totals	44	4	40

Of these forty-four cases, twenty-five had been operated on at his private hospital, with two deaths; twelve were operated on at the Hospital of the University of Pennsylvania, with one death; and seven were operated on at the homes of the patients, with one death. Of these four deaths, one only was due to septicæmia, and that a case of oophorectomy, occurred in a private room of the Hospital of the University. It was not, however, due to hospitalism, but to the adverse circumstances of the case. The ovary and oviduct were filled with pus, and so matted by inflammation to adjacent structures that only a portion of them could be removed, and that in fragments. The pus unavoidably escaped into the peritoneal cavity, which was carefully cleansed and a drainage-tube put in, yet a fatal inflammation set in. Another death was due to shock after removal of the womb containing a fibroid tumor with extensive adhesions, and weighing seventeen pounds. The two deaths after ovariectomy were not due to septicæmia, and are somewhat mysterious. One case was operated on at the patient's home in Bedford, Pa., and Dr. Goodell did not see her again. The cyst was parovarian, weighing forty-three pounds; was without an adhesion and was easily removed. The stitches in due time were removed, the bowels were opened, and everything did well for twelve

days. Then obstinate vomiting set in and the lady died on the seventeenth day. Six months previously she had had an analagous attack of obstinate vomiting in which her life was despaired of. The fourth death took place from a supposed attack of malaria to which the patient was liable. Both ovaries had been removed, the larger one weighing about thirty pounds. There were omental adhesions and very firm parietal ones, needing a number of ligatures. She recovered promptly from the operation, the wound united, the stitches were removed, and she was allowed to sit up out of bed. On the seventeenth day malarial fever with bilious vomiting set in, and she died rather suddenly on the twenty-first day, with symptoms of heart-clot.

Of the nine oöphorectomies, four were performed for ovaralgia, three for bleeding fibroid, one for epilepsy, and one for a menorrhagia which had resisted every known therapeutic measure. In three cases of ovariectomy, all of them with papillary cysts, rupture had taken place a few hours before the operation; but although the peritoneum seemed thickened and injected, no bad result followed. He considered papillary cyst to be benign in the very great majority of cases, and that the danger from the escape of the ovarian fluid into the abdominal cavity was very much overrated. He had not refused to operate in a single instance of ovarian tumor, no matter how low the patient was or how firm were the adhesions. He had consequently had several exceedingly difficult operations. Out of his twenty-eight ovariectomies there were twenty-one with adhesions. In four the adhesions were universal; in eight more they were intestinal; and in three they were uterine. This very large proportion of adhesions, when compared with those of European operations, he could explain only on the theory that physicians in this country have not been educated up to the idea of an early operation, and to a recognition of the evils of tapping. In the successful case of hysterectomy a tumor weighing eight pounds was removed, together with a portion of the enlarged womb. As the uterine cavity was not involved, the large pedicle was transfixed, tied and dropped. The four exploratory incisions were made with a view of removing the ovaries on account of fibroid tumors of the womb. But in each the tumor was so fixed by adhesions that the ovaries could not be reached, and the patients had previously stipulated that in that case the uterine growth was not to be removed. All did well. So also did a case of pelvic abscess communicating with the bladder and rectum. It was opened *per vaginam* by means of the abdominal incision, by which its exact position and size were determined.

With regard to the technique of the operation for laparotomy, Dr. Goodell stated that he used the ordinary knot and Staffordshire knot indifferently; that he now in the long incision cuts directly through the umbilicus instead of going around it on the left side; that he includes the recti muscles and all the tissues in the abdominal sutures; and that while not a very firm believer in the spray part of antiseptic surgery, he had resorted to the atomizer in every case but

one, and that one did as well without it as most do with it.

DR. MONTGOMERY thought Dr. Goodell should be congratulated upon his success, which is remarkable for operations in unselected cases in the United States. He thinks the knowledge of the safety attending the application of Monsel's solution to oozing abdominal surfaces very gratifying. He would have used it recently but for the fear of bad after effects. He must, however, again enter his plea for the second ovary. In young women small ovarian cysts are common, they are frequently found in post-mortem examinations where there had not been the slightest evidence during life of their presence; and evidently these small cysts do not necessarily develop into large ones. The two cases of secondary ovariectomy reported by Dr. Goodell are not sufficient to warrant the rule of removing the second ovary when it is but slightly diseased. As a counter-weight to Dr. Goodell's cases he would mention that in the instance of a young married woman from whom he removed an ovarian tumor, and in which he left the other ovary, which was slightly affected, pregnancy has since occurred, followed by the delivery of a living child.

DR. HOWARD KELLY remarked that Dr. Keith had had remarkably good results from the application to oozing surfaces of a solution of permanganate of iron. He has observed the gradual disuse of carbolic acid in washing-waters in operations. Dr. Kelly prefers boiled or distilled water as used abroad, as he is sure that carbolic acid and other germicides are frequent causes of poisoning and bad results after operation. He asked Dr. Goodell what were his rules respecting the use of the drainage-tube in operations on the abdominal cavity?

DR. BAER had experimented with Monsel's solution. In one case in which he used it he attributed the fatal result to it. The coagulation by the iron is unsightly, and he should now consider it a last resort. He had had very good results from pressure by packing sponges against the bleeding points, combined with external pressure. He withdraws the sponges at the last moment before tightening sutures, and then bandages the abdomen tightly.

DR. GOODELL remarked that Dr. Montgomery was perfectly right in his defense of the second ovary, and he himself had performed double ovariectomy in only seventeen cases of the twenty-eight. He did not believe that every ovary studded with cysts would inevitably degenerate into an ovarian tumor. So, in the case of slightly diseased ovaries in young married women, he would be disposed either to let them alone or to remove the diseased portion only. But in women approaching the climacteric, or when other conditions would make it advisable, he would remove the second ovary as useless in itself and as a possible source of future trouble. He has used the drainage-tube but three times during the past year; once in the unfinished case of oöphorectomy, again in the case of torn bladder, and in the case requiring over thirty ligatures and with universal adhesions. In general he uses it when a free oozing of blood is to be expected, but he regards it as a source of trouble and removes it as soon as possible.